XAVIER BECERRA, State Bar No. 118517
Attorney General of California
KATHLEEN BOERGERS, State Bar No. 213530
Supervising Deputy Attorney General
NELI N. PALMA, State Bar No. 203374
Deputy Attorney General
1300 I Street, Suite 125
Sacramento, CA 94244-2550
Telephone: (916) 210-7913
Fax: (916) 324-5567
E-mail: Neli.Palma@doj.ca.gov
Attorneys for Plaintiff the State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; DOES 1-100,

Defendants,

4: 19-cv-02769-HSG

DECLARATION OF NELI N. PALMA IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Date:	October 10, 2019
Time:	2:00 P.M.
Dept:	2, 4th Floor
Judge:	The Honorable Haywood S. Gilliam, Jr.
Trial Date:	Not set
Action Filed:	May 21, 2019

I, Neli N. Palma, declare:

1. I am a member of the California State Bar, admitted to practice before this Court, employed by the Office of the California Attorney General as a Deputy Attorney General, and counsel to Plaintiffs in this action. I have personal knowledge of the facts set forth herein, and if called upon as a witness, I could testify to them competently under oath.

2. Attached hereto as Exhibit A is a true and correct copy of the 2018-19 budget for the California Department of Education, available online via ebudget.ca.gov.

3. Attached hereto as Exhibit B is a true and correct copy of the letter from the OCR director to complainants, dated June 21, 2016.

4. Attached hereto as Exhibit C is a true and correct copy of the HHS notice of violation, dated January 18, 2019.

5. Attached hereto as Exhibit D is a true and correct copy of the white paper, Wendy Chavkin, et al., "Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences' and Policy Responses." 123 Int'l J. Gynecol. & Obstet. 3 (2013).

6. Attached hereto as Exhibit E is a true and correct copy of an undated 2011 memorandum, summarizing polling done on behalf of the Christian Medical Association and the Freedom2Care Foundation.

7. Attached hereto as Exhibit F is a true and correct copy of a memorandum, dated April 8, 2009, summarizing polling done on behalf of the Christian Medical & Dental Association.

8. Attached hereto as Exhibit G is a true and correct copy of a comment letter submitted by the American Academy of PAs, dated March 26, 2018, available online via regulations.gov.

9. Attached hereto as Exhibit H is a true and correct copy of a comment letter submitted by the American Nursing Association and the American Academy of Nursing, dated March 23, 2018, available online via regulations.gov.

10. Attached hereto as Exhibit I is a true and correct copy of a comment letter submitted by the California Primary Care Association, dated March 27, 2018, available online via regulations.gov.

11. Attached hereto as Exhibit J is a true and correct copy of a comment letter submitted by the California LGBT Health & Human Services Network, dated March 27, 2018, available online via regulations.gov.

12. Attached hereto as Exhibit K is a true and correct copy of a comment letter submitted by the National Association of County and City Health Officials, dated March 27, 2018, available online via regulations.gov.

13. Attached hereto as Exhibit L is a true and correct copy of a comment letter submitted by Physicians for Reproductive Health, dated March 27, 2018, available online via regulations.gov.

14. Attached hereto as Exhibit M is a true and correct copy of a comment letter submitted by the Association of American Medical Colleges, dated March 26, 2018, available online via regulations.gov.

15. Attached hereto as Exhibit N is a true and correct copy of a comment letter submitted by the National Association of Councils on Developmental Disabilities, dated March 22, 2018, available online via regulations.gov.

16. Attached hereto as Exhibit O is a true and correct copy of a comment letter submitted by the Oregon Foundation for Reproductive Health, dated March 27, 2018, available online via regulations.gov.

17. Attached hereto as Exhibit P is a true and correct copy of a comment letter submitted by the North Carolina Justice Center, dated March 27, 2018, available online via regulations.gov.

18. Attached hereto as Exhibit Q is a true and correct copy of a comment letter submitted by the National Center for Lesbian Rights, dated March 26, 2018, available online via regulations.gov.

19. Attached hereto as Exhibit R is a true and correct copy of a comment letter submitted by the Anti-Defamation League, dated March 26, 2018, available online via regulations.gov.

20. Attached hereto as Exhibit S is a true and correct copy of a comment letter submitted by Justice in Aging, dated March 27, 2018, available online via regulations.gov.

21. Attached hereto as Exhibit T is a true and correct copy of a comment letter submitted by the Consortium for Citizens with Disabilities, dated March 27, 2018, available online via regulations.gov.

22. Attached hereto as Exhibit U is a true and correct copy of a comment letter submitted by Disabilities Rights Education & Defense Fund, dated March 27, 2018, available online via regulations.gov.

23. Attached hereto as Exhibit V is a true and correct copy of a comment letter submitted by the Disability Coalition of New Mexico, dated March 27, 2018, available online via regulations.gov.

24. Attached hereto as Exhibit W is a true and correct copy of a comment letter submitted by the National Organization for Women, dated March 27, 2018, available online via regulations.gov.

25. Attached hereto as Exhibit X is a true and correct copy of a comment letter submitted by the County of Santa Clara, dated March 27, 2018, available online via regulations.gov.

26. Attached hereto as Exhibit Y is a true and correct copy of a comment letter submitted by the San Francisco Department of Public Health, available online via regulations.gov.

27. Attached hereto as Exhibit Z is a true and correct copy of a comment letter submitted by Family Voices, dated March 27, 2018, available online via regulations.gov.

28. Attached hereto as Exhibit AA are true and correct copies of individual comments, available online via regulations.gov.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed on the 4th of June in Sacramento, California.

Neli N. Palma
Deputy Attorney General

EXHIBIT A

6100 Department of Education

California's public education system is administered at the state level by the Department of Education, under the direction of the State Board of Education and the Superintendent of Public Instruction, for the education of approximately 6.2 million students. Administrative branches of the Department include the Executive Branch; the Systems Support Branch; the Teaching and Learning Support Branch; the Performance, Planning, and Technology Branch; and the Legal and Audits Branch.

The primary duties of the Superintendent and the Department are to provide technical assistance to local school districts and to work with the educational community to improve academic performance. Major goals of the Department include: (a) holding local agencies accountable for student achievement in all programs and for all groups of students, (b) building local capacity to enable all students to achieve to state standards, (c) expanding and improving a system of recruiting, developing, and supporting teachers that instills excellence in every classroom, preschool through adult, (d) providing statewide leadership that promotes effective use of technology to improve teaching and learning, (e) increasing efficiency and effectiveness in the administration of K-12 education, including student record keeping and good financial management practices, (f) providing broader and more effective communication among the home, school, district, county, and state, (g) establishing and fostering systems of school, home, and community resources that provide the physical, emotional, and intellectual support to help students succeed, (h) advocating for additional resources and additional flexibility, (i) providing statewide leadership that promotes good business practices so that California schools can target their resources to serve students, and (j) improving the effectiveness and efficiency of the Department.

Because the Department of Education's programs drive a need for infrastructure investment, the Department has a capital outlay program to support this need. For the specifics on the Department's capital outlay program see "Infrastructure Overview."

3-YEAR EXPENDITURES AND POSITIONS

		Positions			Expenditures		
		2016-17	2017-18	2018-19	2016-17*	2017-18*	2018-19*
5200	Instruction	867.4	874.6	874.6	$65,974,174	$68,587,951	$72,557,395
5205	Instructional Support	694.0	662.6	662.6	1,231,509	1,166,114	1,061,287
5210	Special Programs	414.2	394.7	394.7	5,939,415	6,730,706	7,135,034
5220	State Board of Education	10.4	9.8	9.8	2,017	2,680	2,681
5240	State-Mandated Local Programs	-	-	-	462,897	1,401,547	841,972
9900100	Administration	229.8	275.5	275.5	30,401	39,264	54,291
9900200	Administration - Distributed	-	-	-	-30,401	-39,264	-54,291
9990	Unscheduled Items of Appropriation	-	-	-	391,228	392,185	7,700
TOTALS, POSITIONS AND EXPENDITURES (All Programs)		**2,215.8**	**2,217.2**	**2,217.2**	**$74,001,240**	**$78,281,183**	**$81,606,069**

FUNDING		**2016-17***	**2017-18***	**2018-19***
0001	General Fund	$1,204,665	$1,456,162	$1,758,691
0001	General Fund, Proposition 98	44,567,257	47,297,643	48,632,348
0044	Motor Vehicle Account, State Transportation Fund	-	-	896
0140	California Environmental License Plate Fund	391	405	405
0178	Driver Training Penalty Assessment Fund	1,515	-	-
0231	Health Education Account, Cigarette and Tobacco Products Surtax Fund	18,237	15,253	13,998
0342	State School Fund	18,841	19,168	19,168
0349	Educational Telecommunication Fund	-	-	716
0687	Donated Food Revolving Fund	3,825	6,590	6,591
0814	California State Lottery Education Fund	1,201,552	1,201,767	1,200,858
0890	Federal Trust Fund	7,324,591	7,702,721	8,247,630
0903	State Penalty Fund	-	895	-
0942	Special Deposit Fund	2,261	2,193	2,193
0986	Local Property Tax Revenues	19,237,722	20,075,802	21,218,845
0995	Reimbursements	425,149	464,849	461,521
3085	Mental Health Services Fund	131	156	156
3170	Heritage Enrichment Resource Fund	-	40	40
3286	Safe Neighborhoods and Schools Fund	9,465	11,296	16,066
3309	Tobacco Prevention and Control Programs Account, California Healthcare,	-	31,963	-

*** Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.**

6100 Department of Education - Continued

	Research and Prevention Tobacco Tax Act of 2016 Fund			
3321	Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD	-	-	22,847
6036	2002 State School Facilities Fund	15	1,901	-
6044	2004 State School Facilities Fund	553	1,162	2,636
6057	2006 State School Facilities Fund	1,552	35	464
8080	Clean Energy Job Creation Fund	-16,482	-8,818	-
TOTALS, EXPENDITURES, ALL FUNDS		**$74,001,240**	**$78,281,183**	**$81,606,069**

LEGAL CITATIONS AND AUTHORITY

DEPARTMENT AUTHORITY

Education Code, Section 33300

PROGRAM AUTHORITY

California Education Code, and select federal laws including, but not limited to, Every Student Succeeds Act, Carl D. Perkins Career and Technical Education Improvement Act, Workforce Investment Act, Individuals with Disabilities Education Act, Child Care and Development Fund and Healthy Hunger Free Kids Act.

MAJOR PROGRAM CHANGES

- An increase of $3.7 billion Proposition 98 General Fund to fully implement the Local Control Funding Formula, which includes a 2.71 cost-of-living adjustment and $570 million above the cost-of-living adjustment as an ongoing increase to the formula.
- An increase of $1.1 billion Proposition 98 General Fund on a one-time basis for discretionary grants that support local needs and priorities while offsetting outstanding K-12 mandate debt.
- An increase of $300 million Proposition 98 General Fund on a one-time basis for the Low-Performing Students Block Grant to assist pupils performing at the lowest levels on the state's academic assessments.
- An increase of $167.2 million Proposition 98 General Fund on a one-time basis to increase the availability of inclusive early education and care for children aged zero to five years old.
- An increase of $164 million Proposition 98 General Fund to establish a K-12 specific component of the Strong Workforce Program to encourage local educational agencies to offer high-quality career technical education programs that are aligned with needed industry skills and regional workforce development efforts.
- An increase of $150 Proposition 98 General Fund to establish the Career Technical Education Incentive Grant Program as an ongoing program.
- An increase of $109.2 million non-Proposition 98 General Fund to reflect an increase in CalWORKS child care cases.
- An increase of $57.8 million Proposition 98 General Fund for county offices of education to provide technical assistance to school districts, of which $4 million will go towards geographical regional leads.
- An increase of $50 million Proposition 98 General Fund on a one-time basis for the Classified School Employee Summer Assistance Program to provide a state match to classified school employees who elect to have a portion of their monthly pay withheld and repaid during the summer recess period.
- An increase of $50 million Proposition 98 General Fund on a one-time basis for the Classified School Employee Professional Development Program to provide professional development opportunities for classified school employees.
- An increase of $39.7 million non-Proposition 98 General Fund to increase the reimbursement rate adjustment factors for child care providers serving infants, toddlers, and children with exceptional needs.
- An increase of $34.2 million non-Proposition 98 General Fund beginning in 2019-20 to make permanent the existing limited-term Regional Market Reimbursement Rate hold harmless provision.
- An increase of $32.3 million non-Proposition 98 General Fund and $28.4 million Proposition 98 General Fund to reflect costs associated with new child care policies implemented part-way through the 2017-18 fiscal year, including an update of the Regional Market Reimbursement Rate to the 75th percentile of the 2016 regional market rate survey and 2,959 new slots for full-day State Preschool.
- An increase of $31.6 million Proposition 98 General Fund and $16.1 million non-Proposition 98 General Fund to increase

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6100 Department of Education - Continued

child care provider reimbursements by approximately 2.8 percent.

- An increase of $27.1 million Proposition 98 General Fund on a one-time basis to convert the paper-based English Language Proficiency Assessment for California (ELPAC) to a computer-based assessment and to develop an ELPAC assessment specific to students with exceptional needs.
- An increase of $26.4 million federal Child Care and Development Fund to increase inspections of licensed child care providers from once every three years to annual inspections.
- An increase of $21.1 million Proposition 98 General Fund on a one-time basis and $24.8 million Proposition 98 General Fund ongoing to reflect increased programmatic costs in the Charter School Facility Grant Program.
- An increase of $20 million Child Care and Development Fund on a one-time basis for licensed child care teacher professional development.
- An increase of $15.8 million non-Proposition 98 General Fund and $204.6 million federal Child Care and Development Fund for the Alternative Payment Program to provide 13,407 new voucher slots, of which 11,307 are available until June 30, 2020.
- An increase of $15 million Proposition 98 General Fund on a one-time basis for the Kids Code After School Program to increase opportunities for students in after-school programs to access computer coding education.
- An increase of $15 million Proposition 98 General Fund on a one-time basis to expand the state's Multi-Tiered Systems of Support framework to foster positive school climate in both academic and behavioral areas.
- An increase of $13.3 million Proposition 98 General Fund on a one-time basis for the California Collaborative for Educational Excellence and a co-lead county office of education to help school districts build capacity for community engagement in the Local Control Accountability Plan process.
- An increase of $11.5 million Proposition 98 General Fund to support the California Collaborative for Educational Excellence in its role within the statewide system of support.
- An increase of $10 million Proposition 98 General Fund for Special Education Local Plan Areas to assist county offices of education in providing technical assistance to school districts serving students with exceptional needs within the statewide system of support.
- An increase of $4.4 million Proposition 98 General Fund over two years for property tax relief for schools impacted by the fires of 2017 and an additional $25 million Proposition 98 General Fund relief through the Local Control Funding Formula.
- An increase of $1 million Proposition 98 General Fund on a one-time basis for the California-Grown Fresh School Meals Grant Program to encourage the purchase of California-grown food by schools.
- An increase of $972,000 Proposition 98 General Fund to allow the Fiscal Crisis and Management Assistance Team (FCMAT) to coordinate with county offices of education to offer more proactive and preventive services to fiscally distressed school districts.
- An increase of $144.1 million Proposition 98 General Fund to provide a 2.71 percent cost-of-living adjustment for categorical programs that remain outside the Local Control Funding Formula, including Special Education, Child Nutrition, Foster Youth, American Indian Centers, American Indian Early Childhood Education, and the Mandate Block Grant.

DETAILED BUDGET ADJUSTMENTS

	2017-18*			2018-19*		
	General Fund	Other Funds	Positions	General Fund	Other Funds	Positions
Workload Budget Adjustments						
Workload Budget Change Proposals						
• District LCFF 2018-19 Transition Funding	$-	$-	-	$3,556,177	$-	-
• One-Time Funding for Discretionary Grants and Mandate Reimbursement	294,756	-	-	300,000	-	-
• Proposition 98 Reappropriation for Discretionary Grants and Mandate Reimbursement	-	-	-	225,331	-	-
• Add Funding for the Career Technical Education Incentive Grant	-	-	-	150,000	-	-
• LCFF Transition Funding for Basic Aid Districts	-	-	-	109,623	-	-

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6100 Department of Education - Continued

• Proposition 98 Reversion Account for Discretionary Grants and Mandate Reimbursement	-	-	-	80,331	-	-
• County Office of Education Augmentation for Statewide System of Support	-	-	-	55,200	-	-
• Increase Child Care Reimbursement Rate Adjustment Factors	-	-	-	39,668	-	-
• Increase the Standard Reimbursement Rate: State Preschool	-	-	-	31,629	-	-
• K-14 Education Fire-Related Property Tax Loss Backfill	12,339	-	-	19,181	-	-
• Increase the Standard Reimbursement Rate: Child Care	-	-	-	16,104	-	-
• Add Alternative Payment Program Slots	-	-	-	15,833	204,590	-
• Funding for the California Collaborative for Educational Excellence	-	-	-	11,534	-	-
• Special Education Local Plan Areas Augmentation for Statewide System of Support	-	-	-	10,000	-	-
• Proposition 98 Reappropriation for California School Information Services	-	-	-	6,508	-	-
• One-Time Funding for Facility Improvements	-	-	-	6,000	-	-
• Proposition 98 Reappropriation for the California Collaborative for Education Excellence	-	-	-	5,600	-	-
• Regional County Office of Education Leads	-	-	-	4,000	-	-
• SoCal ROC Transition Funding	-	-	-	3,000	-	-
• Add funding for Special Olympics Unified Champion Schools Program	-	-	-	2,000	-	-
• Base Child Care Development Fund Grant Adjustment	-	-	-	1,998	-	-
• One-Time Funding for Suicide Prevention Training	-	-	-	1,700	-	-
• Fire-Related Property Tax Loss Backfill for Basic Aid School Districts	2,399	-	-	1,292	-	-
• California College Guidance Initiative Augmentation	-	-	-	1,000	-	-
• Increase FCMAT Oversight Funding	-	-	-	972	-	-
• Add One-Time Funding for the Instructional Quality Commission	-	-	-	938	-	-
• One-Time Carryover for the Career Technical Education Pathways Program	-	-	-	680	-	-
• Personnel Funding to Support Subsidized County Child Care Pilot Programs	-	-	-	624	-	-
• Sexual Health Education Backfill	-	-	-	600	-	-
• One-Time Funding for Ella T. v California Legal Costs	-	-	-	595	-	-
• Proposition 98 Reappropriation for the History Social Science Framework-Genocide Awareness Resources	-	-	-	500	-	-
• One-Time Funding for Teacher Dismissal Hearing Costs	-	-	-	339	-	-
• Adjust State Assessments Funding to Offset Reduction in Federal Grant	-	-	-	304	-	-
• K-12 Accountability: Dashboard Improvements	-	-	-	300	-	-
• One-Time Funding for Employment Lawsuit Legal Costs	-	-	-	297	-	-
• Personnel Funding for State Preschool Expansion	-	-	-	293	-	-
• Personnel Funding to Support a Centralized Uniform Complaint Procedures Process and Database	-	-	-	257	-	-

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6100 Department of Education - Continued

• Personnel Funding for Computer-Based ELPAC and Alternative ELPAC Assessments	-	-	-	252	-	-
• Personnel Funding for High School Equivalency Exam Fee Waiver Backfill	-	-	-	197	-	-
• One-Time Funding for Education Commission of the States Dues	-	-	-	150	-	-
• Personnel Funding for the Information Security and Privacy Office	-	-	-	143	-	-
• Personnel Funding to Support District Reorganization Workload	-	-	-	131	-	-
• Personnel Funding for Educational Equity Compliance Reviews (AB 699)	-	-	-	128	-	-
• Personnel Funding for Data Collection and Reporting Requirements for the District of Choice Program	-	-	-	119	-	-
• Personnel Funding for Universal Meal Service Support (SB 138)	-	-	-	108	-	-
• Ongoing Funding for Teacher Dismissal Hearing Costs	-	-	-	60	-	-
• Title IV Student Support and Academic Enrichment Grant	-	-	-	-	165,005	-
• Adjust Federal Funds for the Title I Program	-	-	-	-	160,574	-
• One-Time Federal Funds Carryover for the Title I Program	-	-	-	-	123,756	-
• TANF Stage 2 Child Care Adjustment	-	-	-	-	70,636	-
• Adjust Federal Funds for the Federal Individuals with Disabilities Education Act	-	-	-	-	34,391	-
• Annual Licensed Child Care Provider Inspections	-	-	-	-	26,400	-
• One-Time Federal Immediate Aid to Restart School Operations Funds (Local Assistance)	-	-	-	-	13,864	-
• One-Time Federal Funds Carryover for the Vocational Education Program	-	-	-	-	13,714	-
• One-Time Federal Funds Carryover for the Migrant Education Program	-	-	-	-	13,000	-
• One-Time Federal Funds for the Early Math Initiative	-	-	-	-	11,122	-
• Child Care Development Fund Quality Adjustment (2017 BA)	-	8,822	-	-	8,822	-
• One-Time Federal Funds Carryover for the Adult Education Program	-	-	-	-	7,500	-
• Adjust Federal Funds for the Adult Education Program	-	1,567	-	-	7,126	-
• One-Time Federal Funds Carryover for the 21st Century Community Learning Centers Program	-	-	-	-	5,000	-
• 21st Century Community Learning Centers Base Grant Adjustment (2017 BA)	-	3,921	-	-	3,921	-
• One-Time Funding for Special Education Dispute Resolution Costs	-	-	-	-	3,050	-
• Align Federal Student Assessment Funding to Estimated Costs	-	2,133	-	-	2,133	-
• One-Time Federal Funds Carryover for Migrant Education Program State Level Activities	-	-	-	-	2,000	-
• One-Time Federal Funds Carryover for the Individuals with Disabilities Education Act	-	-	-	-	2,000	-
• One-Time Federal Project School Emergency Response to Violence Funds	-	-	-	-	2,000	-
• Adjust State Special Schools Reimbursement for the Education Technology Voucher Program	-	-	-	-	1,897	-
• Add One-Time Federal Carryover for Assessments	-	-	-	-	1,148	-

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6100 Department of Education - Continued

• One-Time Federal Funds Carryover for the Federal Individuals with Disabilities Education Act Preschool Grant Program	-	-	-	-	1,020	-
• One-Time Federal Funds Carryover for the English Language Acquisition Program	-	-	-	-	1,000	-
• One-Time Federal Funds Carryover for the Neglected and Delinquent Children Program	-	-	-	-	965	-
• Adjust Federal Funds for the Neglected and Delinquent Children Program	-	447	-	-	932	-
• One-Time Federal Funds Carryover for Charter Schools Grant Program	-	-	-	-	923	-
• One-Time Federal Funds to Support Equitable Services for Eligible Private Schools	-	-	-	-	733	-
• One-Time Funding for the Standardized Account Code Structure System Replacement Project	-	-	-	-	716	-
• One-Time Federal Funds to Supplement 2017-18 Equitable Services for Eligible Private Schools	-	-	-	-	670	-
• Increase Title II State Administrative Funding for the Workforce Innovation and Opportunity Act (WIOA)	-	-	-	-	645	-
• Personnel Funding for Special Education Litigation Unit	-	-	-	-	625	-
• One-Time Federal Funds Carryover for the Early Head Start-Child Care Partnership Program	-	-	-	-	602	-
• One-Time Federal Immediate Aid to Restart School Operations Funds (State Operations)	-	-	-	-	533	-
• Reimbursement Funding for the Collaborative to Provide Technical Assistance	-	-	-	-	500	-
• One-Time Federal Funds Carryover for the State Improvement Grant Program	-	-	-	-	491	-
• One-Time English Learner Reclassification Support	-	-	-	-	437	-
• Cross-Agency Work to Support the Statewide System of Support (State Operations)	-	-	-	-	381	-
• Adjust Early Head Start-Child Care Partnership Program Grant Funding	-	-	-	-	323	-
• One-Time Federal Funds Carryover for the Mathematics and Science Partnerships Program	-	-	-	-	323	-
• One-Time Federal Funds Carryover for the McKinney-Vento Homeless Children Education Program	-	-	-	-	298	-
• One-Time Federal Funds Carryover for the Rural and Low Income Schools Program	-	-	-	-	231	-
• Personnel Funding for Child Care Slot Expansion	-	-	-	-	135	-
• One-Time Federal Funds Carryover for the Project AWARE Grant Program	-	-	-	-	131	-
• One-Time Federal Funds to Support the Early Math Initiative	-	-	-	-	100	-
• One-Time Federal Funds for the Newborn Hearing Screening Program	-	-	-	-	50	-
• Inclusive Early Education Expansion Program (Local Educational Agencies)	167,242	-	-	-	-	-
• One-Time Funding for the Classified School Employees Professional Development Block Grant Program	50,000	-	-	-	-	-
• Provide Funding for Lowest-Performing Students Block Grant	300,000	-	-	-	-	-
• Adjust Federal Funds for the Public Charter Schools Grant Program	-	-	-	-	-14	-

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6100 Department of Education - Continued

• Adjust Federal Funds for the Rural and Low Income Schools Program	-	-	-	-	-63	-
• Adjust Federal Funds for State Assessments	-	-	-	-	-304	-
• Redirect Title I Federal Funds to Support Cross-Agency Work Related to the Statewide System of Support (Local Assistance)	-	-	-	-	-381	-
• Adjust Federal Funds for the McKinney-Vento Homeless Children Education Program	-	-	-	-	-435	-
• Adjust Federal Funds for Individuals with Disabilities Act State Level Activities	-	-	-	-	-625	-
• Adjust Federal Funds for Individuals with Disabilities Act State Operations	-	-	-	-	-811	-
• Adjust Federal Funds for the 21st Century Community Learning Centers Program	-	-	-	-	-839	-
• Adjust Federal Funds for Migrant Education Program State Level Activities	-	-	-	-	-925	-
• Adjust Federal Funds for the Migrant Education Program	-	-	-	-	-1,070	-
• Reflect Base Child Care Development Fund Grant Adjustment Offset	-	-	-	-	-1,998	-
• Adjust Federal Funds for the Federal Individuals with Disabilities Education Act Preschool Grant Program	-	-	-	-	-2,660	-
• Redirect Federal Individuals with Disabilities Education Act Funding for Special Education Dispute Resolution Costs	-	-	-	-	-3,050	-
• Adjust Federal Funds for the Vocational Education Program	-	-	-	-	-6,165	-
• Remove One-Time Funding for the California Educator Development (CalED) Program	-	-	-	-	-11,327	-
• Adjust Federal Funds for the Supporting Effective Instruction Local Grants	-	-	-	-	-13,316	-
• Adjust Federal Funds for the Title I Basic Grant Program	-	29,728	-	-	-15,411	-
• Adjust Federal Funds for the English Language Acquisition Program	-	-	-	-	-17,390	-
• Decrease Mandate Reimbursement Program Funding to Reflect the Repeal of the California High School Exit Exam	-	-	-	-1	-	-
• Align K-12 School Dashboard Funding with Contract Amount	-	-	-	-120	-	-
• County Office of Education System of Support Funding Alignment	-	-	-	-1,400	-	-
• Align Student Assessment Funding to Estimated Costs	-2,133	-	-	-2,133	-	-
• Base Child Care Development Fund Grant Adjustment (2017 BA)	-	9,008	-	-9,008	9,008	-
• Technical Offset Adjustment to K-14 Fire-Related Property Tax Loss Backfill	-12,339	-	-	-19,181	-	-
• Reflect TANF Stage 2 Child Care Adjustment Offset	-	-	-	-70,636	-	-
Totals, Workload Budget Change Proposals	**$812,264**	**$55,626**	**-**	**$4,559,217**	**$828,637**	**-**
Other Workload Budget Adjustments						
• Education Protection Account Revenue Adjustment	372,408	372,409	-	841,583	841,583	-
• CalWORKs Stage 2 and Stage 3 Child Care Caseload Adjustments	-	-	-	109,233	-	-
• Special Education Program for Individuals with Exceptional Needs Cost-of-Living Adjustment	-	-	-	100,127	-	-
• Backfill One-Time Special Education Fund Swap	-	-	-	64,243	-	-
• LCFF Floor Growth Adjustment	51,585	-	-	61,040	-	-

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6100 Department of Education - Continued

• State Preschool Cost-of-Living Adjustment	-	-	-	29,916	-	-
• County Office of Education Minimum State Aid Adjustment	25,854	-	-	25,854	-	-
• Child Care Programs Cost-of-Living Adjustment	-	-	-	23,972	-	-
• Full Year Costs of Prior Year Preschool Slots	-	-	-	19,130	-	-
• Full Year Costs of Prior Year Child Care Rate Adjustments	-	-	-	18,997	-	-
• Align Student Assessment Funding to Estimated Costs	-	-	-	18,160	-	-
• Full Year Costs of Prior Year Child Care Hold Harmless	-	-	-	13,272	-	-
• LCFF Additional Funding Adjustment	5,794	-	-	13,195	-	-
• District LCFF Minimum State Aid Adjustment	9,355	-	-	9,355	-	-
• Add 2,959 Full-Day State Preschool Slots	-	-	-	8,457	-	-
• Backfill Prior Year One-Time Federal Carryover for Child Care	-	-	-	7,641	-	-
• Mandate Block Grant Cost-of-Living Adjustment	-	-	-	6,234	-	-
• Child Nutrition Program Cost-of-Living Adjustment	-	-	-	4,333	-	-
• Adjust General Fund to Reflect Removal of Federal Carryover for Assessments Costs	-	-	-	2,785	-	-
• Early Education Program for Individuals with Exceptional Needs Cost-of-Living Adjustment	-	-	-	2,429	-	-
• Foster Youth Program Cost-of-Living Adjustment	-	-	-	699	-	-
• Adults in Correctional Facilities Cost-of-Living Adjustment	-	-	-	235	-	-
• American Indian Education Centers Cost-of-Living Adjustment	-	-	-	112	-	-
• Allocation for Other Post-Employment Benefits	81	69	-	81	69	-
• American Indian Early Childhood Education Program Cost-of-Living Adjustment	-	-	-	15	-	-
• K-12 District Local Property Tax Revenue Offset Adjustment	-	560,665	-	-	1,766,167	-
• County Office of Education Local Property Tax Revenue Offset Adjustment	-	7,771	-	-	93,633	-
• One-Time Child Care Development Fund Quality Adjustment	-	-	-	-	25,955	-
• Reflect Proposition 56 Local Assistance Funding	-	-	-	-	21,114	-
• K-12 Lottery Adjustment	-	17,373	-	-	16,464	-
• One-Time Federal Child Care and Development Carryover	-	-	-	-	4,877	-
• Reflect Proposition 56 State Operations Funding	-	-	-	-	1,111	-
• Motor Vehicle Account Allocation for the Bus Driver Instructor Training Program	-	-	-	-	896	7.8
• Adjust Proposition 56 Tobacco Tax Initiative Funding	-	-	-	-	622	-
• State School Fund Adjustment	-	249	-	-	249	-
• Lottery Revenue Adjustment for State Special Schools	-	3	-	-	3	-
• Special Education Local Property Tax Revenue-Fire Related Backfill	267	-	-	-	-	-
• Adjust Proposition 47 State Operations Funding	-	-	-	-	-72	-
• Adjust County Office of Education Funding for Health and Physical Education Drug-Free Schools Program	-	-214	-	-	-601	-

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6100 Department of Education - Continued

• Shift the Bus Driver Instructor Training Program to the Motor Vehicle Account	-	-	-	-	-896	-7.8
• Adjust School District Funding for Health and Physical Education Drug-Free Schools Program	-	-420	-	-	-1,063	-
• Adjust Proposition 47 Local Assistance Funding	-	-	-	-	-1,356	-
• Remove Federal Carryover for Assessments Costs	-	-	-	-	-2,785	-
• Remove Prior Year One-Time Child Care Development Fund Carryover	-	-	-	-	-7,641	-
• Education Protection Account Offset Adjustment	-	-372,409	-	-	-841,583	-
• Adjust Mandate Block Grant to Reflect Revised Average Daily Attendance	-	-	-	-133	-	-
• ASES Local Assistance Workload Adjustments	-138	-	-	-141	-	-
• Early Education Program for Individuals with Exceptional Needs Growth Adjustment	-	-	-	-242	-	-
• Expenditure by Category Redistribution	2,427	2,428	-	-975	-975	-
• Align Student Assessment Funding to One-Time Federal Carryover	-	-	-	-1,148	-	-
• Child Nutrition Program Growth Adjustment	-	-	-	-2,607	-	-
• Reflect Base Adjustments for Special Education Programs	-	-	-	-3,793	-	-
• Child Care Programs Growth Adjustment	-	-	-	-4,157	-	-
• Reflect One-Time Federal Child Care and Development Carryover Offset	-	-	-	-4,877	-	-
• State Preschool Growth Adjustment	-	-	-	-5,325	-	-
• County Office Education Protection Account Offset Adjustment	-3,499	-	-	-7,892	-	-
• Special Education Program for Individuals with Exceptional Needs Growth Adjustment	-	-	-	-10,003	-	-
• County Office of Education LCFF Growth Adjustment	-23,733	-	-	-17,424	-	-
• County Office of Education Local Revenue Adjustment	3,664	-	-	-27,348	-	-
• Special Education Local Property Tax Revenue Offset Adjustment	-	3,596	-	-31,558	36,571	-
• District LCFF Education Protection Account Offset Adjustment	-369,193	-	-	-833,974	-	-
• District LCFF Property Tax Adjustment	-361,178	-	-	-1,421,646	-	-
• Miscellaneous Baseline Adjustments	-25,952	-150,158	-	1,346,450	-248,718	-
• Salary Adjustments	3,649	3,140	-	3,649	3,140	-
• Benefit Adjustments	1,506	1,295	-	1,648	1,417	-
• Retirement Rate Adjustments	1,429	1,228	-	1,429	1,228	-
• Budget Position Transparency	-2,427	-2,428	-28.0	975	975	-26.0
• SWCAP	-	-	-	-	2,468	-
• Carryover/Reappropriation	1,474	226	-	-	-	-
• Lease Revenue Debt Service Adjustment	-964	-	-	-1,471	-	-
Totals, Other Workload Budget Adjustments	**$-307,591**	**$444,823**	**-28.0**	**$360,535**	**$1,712,852**	**-26.0**
Totals, Workload Budget Adjustments	**$504,673**	**$500,449**	**-28.0**	**$4,919,752**	**$2,541,489**	**-26.0**
Totals, Budget Adjustments	**$504,673**	**$500,449**	**-28.0**	**$4,919,752**	**$2,541,489**	**-26.0**

PROGRAM DESCRIPTIONS

5200 - INSTRUCTION

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6100 Department of Education - Continued

This program provides direct educational services to children and adults in the state's public elementary and secondary school system. The following elements are included in this program:

School Apportionments:

Supplements local resources to fund general education programs.

Other Compensatory Programs:

Includes Migrant Education, California Indian Education Centers, Education for Homeless Children, and Federal Title I.

Adult Education Programs:

Provides citizenship training and education to improve literacy skills, employability, and parenting abilities to adults served by public high school and unified districts. Adult education programs also meet the special needs of the disabled, older persons, and non- or limited-English speaking adults.

Special Education Programs for Exceptional Children:

Provides special education services. Under state law and the federal Individuals with Disabilities Education Act (20 USC 1400 et seq.), individuals with exceptional needs are entitled to a free, appropriate public education. Students requiring special education are served either by local educational agencies using state, federal, and local property tax funds or by the State Special Schools operated by the Department. The Special Schools (three centers for diagnostic services, two residential schools for the deaf and one residential school for the blind) provide highly specialized services including educational assessments and individual educational recommendations and a comprehensive residential and nonresidential educational program composed of academic, nonacademic and extracurricular activities.

Vocational Education:

Offers a sequence of courses that provide the academic knowledge and skills needed to prepare for further education and careers in current or emerging employment sectors. Programs include Partnership Academies, Agricultural Education, and Regional Occupational Centers and Programs, and the federal Career and Technical Education Program.

5205 - INSTRUCTIONAL SUPPORT

Instructional Support provides resources to complement the Instruction Program. The following elements are included in this program:

Curriculum Services:

Provides materials and resources for curriculum planning and development in language arts, mathematics, science, history-social science, foreign language, visual and performing arts, health, nutrition, safety, physical education, and environmental/energy education. Provides funding for the K-12 High Speed Network and Rural and Low Income Schools Grants.

"Now is the Time" Advancing Wellness and Resilience in Education:

Provides federal funding to develop a comprehensive, coordinated, and integrated partnership with multiple service systems to help address critical mental health needs of California's kindergarten through grade twelve students.

Administrative Services to Local Educational Agencies:

Provides leadership, guidance, and technical expertise to schools to manage and improve operations, more efficiently use scarce resources, and publish specified documents.

Supplementary Program Services:

Identifies, develops, and disseminates innovative and exemplary programs and practices to schools and aids in the development of alternative educational options. Examples include Foster Youth Services, Career Technical Education Incentive Programs, English Language Acquisition, and Specialized Secondary Programs.

Public Charter Schools:

Public charter schools are created or organized by a group of teachers, parents, community leaders or a community-based organization, and provide instruction in any combination of grades, kindergarten through grade twelve.

Assessments:

Includes the California Assessment of Student Performance and Progress Program, which provides funding to districts for assessments, the English Language Proficiency Assessments for California, and California High School Proficiency Exams.

5210 - SPECIAL PROGRAMS

6100 Department of Education - Continued

Child Development:

Provides a full range of child care and development services, including part- and full-time child care and development and supportive services to children from low-income families and families with special needs. Several different programs exist to target resources to specific populations or to address specific needs. The California State Preschool Program provides a wide range of educational services in part-day settings for pre-kindergarten (three and four year old) children from low-income families and parent education for the parents of eligible children. The After School Education and Safety program provides students in grades K-9 with academic support, homework assistance, and enrichment programs, in a safe after-school environment. Child care services for families participating in the California Work Opportunity and Responsibility to Kids (CalWORKs) program help public assistance recipients achieve and maintain self-sufficiency. The Department administers child care for CalWORKs Stages 2 and 3.

Early Head Start-Child Care Partnership:

Provides federal funding for high quality infant and toddler child care to low income families enrolled in subsidized programs administered by county offices, family child care home education networks, center-based homes, and tribal governments receiving federal Child Care and Development funds in selected northern California counties.

Child Nutrition:

Assists participating public and private schools, county offices of education, public and private residential child care institutions, camps, family day care homes, and non-residential adult day care centers in serving nutritious meals by providing educational and technical assistance, and federal and state subsidies. Subsidies are received from the United States Department of Agriculture (USDA) to fund the National School Lunch Program (NSLP), School Breakfast Program, Special Milk Program, Child and Adult Care Food Program, Summer Food Service Program, After School Meals Supplements Program under the NSLP, and Seamless Summer Feeding Option, Fresh Fruits and Vegetable Program, and nutrition education and training. Subsidies also are provided by the state through the state-mandated Child Nutrition Programs and the School Breakfast and Summer Food Start-Up and Expansion Grants Program.

Food Distribution:

Makes USDA Foods available to certain California public, private, and nonprofit agencies. The Department is designated as the California state agency for USDA Foods surplus distribution.

5220 - STATE BOARD OF EDUCATION

The State Board of Education sets K-12 education policy in the areas of standards, instructional materials, assessment, and accountability.

5240 - STATE-MANDATED LOCAL PROGRAMS

This program provides funding, pursuant to Section 6 of Article XIIIB of the California Constitution, to reimburse local entities for costs they incur in complying with certain state-mandated education programs.

DETAILED EXPENDITURES BY PROGRAM

		2016-17*	2017-18*	2018-19*
	PROGRAM REQUIREMENTS			
5200	**INSTRUCTION**			
	State Operations:			
0001	General Fund	$109,775	$111,278	$109,388
0814	California State Lottery Education Fund	-	162	162
0942	Special Deposit Fund	1,117	1,049	1,049
0995	Reimbursements	10,363	16,220	12,392
	Totals, State Operations	**$121,255**	**$128,709**	**$122,991**
	Local Assistance:			
0001	General Fund	$41,588,433	$43,287,715	$45,713,574
0342	State School Fund	18,841	19,168	19,168
0814	California State Lottery Education Fund	1,201,552	1,201,605	1,200,696
0890	Federal Trust Fund	3,413,906	3,440,700	3,847,869
0986	Local Property Tax Revenues	19,237,722	20,075,802	21,218,845

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6100 Department of Education - Continued

0995	Reimbursements	392,465	434,252	434,252
	Totals, Local Assistance	**$65,852,919**	**$68,459,242**	**$72,434,404**
	PROGRAM REQUIREMENTS			
5205	**INSTRUCTIONAL SUPPORT**			
	State Operations:			
0001	General Fund	$43,867	$45,238	$49,127
0044	Motor Vehicle Account, State Transportation Fund	-	-	896
0140	California Environmental License Plate Fund	31	45	45
0178	Driver Training Penalty Assessment Fund	1,515	-	-
0231	Health Education Account, Cigarette and Tobacco Products Surtax Fund	964	1,036	1,037
0890	Federal Trust Fund	92,799	119,194	111,928
0903	State Penalty Fund	-	895	-
0942	Special Deposit Fund	1,144	1,144	1,144
0995	Reimbursements	5,470	10,074	10,074
3170	Heritage Enrichment Resource Fund	-	40	40
3286	Safe Neighborhoods and Schools Fund	96	565	803
3309	Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund	-	1,574	-
3321	Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD	-	-	1,111
6036	2002 State School Facilities Fund	15	1,901	-
6044	2004 State School Facilities Fund	553	1,162	2,636
6057	2006 State School Facilities Fund	1,552	35	464
	Totals, State Operations	**$148,006**	**$182,903**	**$179,305**
	Local Assistance:			
0001	General Fund	$556,137	$427,434	$356,565
0140	California Environmental License Plate Fund	360	360	360
0231	Health Education Account, Cigarette and Tobacco Products Surtax Fund	17,273	14,217	12,961
0349	Educational Telecommunication Fund	-	-	716
0890	Federal Trust Fund	483,837	498,648	472,449
0995	Reimbursements	16,527	1,432	1,932
3286	Safe Neighborhoods and Schools Fund	9,369	10,731	15,263
3309	Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund	-	30,389	-
3321	Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD	-	-	21,736
	Totals, Local Assistance	**$1,083,503**	**$983,211**	**$881,982**
	PROGRAM REQUIREMENTS			
5210	**SPECIAL PROGRAMS**			
	State Operations:			
0001	General Fund	$6,511	$9,021	$7,979
0687	Donated Food Revolving Fund	3,825	6,590	6,591
0890	Federal Trust Fund	58,938	61,956	63,190
0995	Reimbursements	324	2,815	2,815
3085	Mental Health Services Fund	131	156	156
	Totals, State Operations	**$69,729**	**$80,538**	**$80,731**
	Local Assistance:			
0001	General Fund	$2,594,575	$3,067,945	$3,302,109
0890	Federal Trust Fund	3,275,111	3,582,223	3,752,194
	Totals, Local Assistance	**$5,869,686**	**$6,650,168**	**$7,054,303**
	PROGRAM REQUIREMENTS			
5220	**STATE BOARD OF EDUCATION**			
	State Operations:			

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6100 Department of Education - Continued

0001	General Fund	$2,017	$2,624	$2,625
0995	Reimbursements	-	56	56
	Totals, State Operations	**$2,017**	**$2,680**	**$2,681**
	PROGRAM REQUIREMENTS			
5240	**STATE-MANDATED LOCAL PROGRAMS**			
	Local Assistance:			
0001	General Fund	$462,897	$1,401,547	$841,972
	Totals, Local Assistance	**$462,897**	**$1,401,547**	**$841,972**
	PROGRAM REQUIREMENTS			
9990	**UNSCHEDULED ITEMS OF APPROPRIATION**			
	Local Assistance:			
0001	General Fund	$407,710	$401,003	$7,700
8080	Clean Energy Job Creation Fund	-16,482	-8,818	-
	Totals, Local Assistance	**$391,228**	**$392,185**	**$7,700**
	SUBPROGRAM REQUIREMENTS			
9900100	**Administration**			
	State Operations:			
0001	General Fund	$30,401	$39,264	$54,291
	Totals, State Operations	**$30,401**	**$39,264**	**$54,291**
	SUBPROGRAM REQUIREMENTS			
9900200	**Administration - Distributed**			
	State Operations:			
0001	General Fund	-$30,401	-$39,264	-$54,291
	Totals, State Operations	**-$30,401**	**-$39,264**	**-$54,291**
	TOTALS, EXPENDITURES			
	State Operations	341,007	394,830	385,708
	Local Assistance	73,660,233	77,886,353	81,220,361
	Totals, Expenditures	**$74,001,240**	**$78,281,183**	**$81,606,069**

EXPENDITURES BY CATEGORY

1 State Operations	Positions			Expenditures		
	2016-17	2017-18	2018-19	2016-17*	2017-18*	2018-19*
PERSONAL SERVICES						
Baseline Positions	2,249.7	2,245.2	2,243.2	$159,340	$155,230	$154,420
Budget Position Transparency	-	-28.0	-26.0	-	-4,855	1,950
Other Adjustments	-33.9	-	-	113	6,789	9,331
Net Totals, Salaries and Wages	**2,215.8**	**2,217.2**	**2,217.2**	**$159,453**	**$157,164**	**$165,701**
Staff Benefits	-	-	-	80,253	91,969	90,729
Totals, Personal Services	**2,215.8**	**2,217.2**	**2,217.2**	**$239,706**	**$249,133**	**$256,430**
OPERATING EXPENSES AND EQUIPMENT				$72,335	$122,279	$111,349
SPECIAL ITEMS OF EXPENSES				28,966	23,418	17,929
TOTALS, POSITIONS AND EXPENDITURES, ALL FUNDS (State Operations)				**$341,007**	**$394,830**	**$385,708**

2 Local Assistance	Expenditures		
	2016-17*	2017-18*	2018-19*
Grants and Subventions - Governmental	$73,660,233	$77,886,353	$81,220,361
TOTALS, EXPENDITURES, ALL FUNDS (Local Assistance)	**$73,660,233**	**$77,886,353**	**$81,220,361**

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6100 Department of Education - Continued

DETAIL OF APPROPRIATIONS AND ADJUSTMENTS

1 STATE OPERATIONS	2016-17*	2017-18*	2018-19*
0001 General Fund, Proposition 98			
APPROPRIATIONS			
006 Budget Act appropriation (State Special Schools)	$56,137	$55,298	$57,906
Allocation for Employee Compensation	-	1,405	-
Allocation for Other Post-Employment Benefits	-	18	-
Allocation for Staff Benefits	-	580	-
Section 3.60 Pension Contribution Adjustment	-	550	-
Totals Available	**$56,137**	**$57,851**	**$57,906**
Unexpended balance, estimated savings	-237	-	-
TOTALS, EXPENDITURES	**$55,900**	**$57,851**	**$57,906**
0001 General Fund			
APPROPRIATIONS			
001 Budget Act appropriation (Department State Operations)	$46,494	$47,391	$49,125
Allocation for Employee Compensation	-	1,164	-
Allocation for Other Post-Employment Benefits	-	25	-
Allocation for Staff Benefits	-	481	-
Budget Position Transparency	-	-2,427	-
Expenditure by Category Redistribution	-	2,427	-
Section 3.60 Pension Contribution Adjustment	-	456	-
002 Budget Act appropriation (State Special Schools Lease Revenue Debt Service)	12,757	13,075	11,604
Lease Revenue Debt Service Adjustment	-	-962	-
Lease Revenue and Tenant Adjustments	-	-2	-
003 Budget Act appropriation (Standardized Account Code Structure)	1,257	1,237	1,293
Allocation for Employee Compensation	-	30	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	12	-
Section 3.60 Pension Contribution Adjustment	-	12	-
004 Budget Act appropriation	-	-	938
005 Budget Act appropriation (State Special Schools)	42,702	38,154	39,878
Allocation for Employee Compensation	-	917	-
Allocation for Other Post-Employment Benefits	-	35	-
Allocation for Staff Benefits	-	378	-
Section 3.60 Pension Contribution Adjustment	-	358	-
009 Budget Act appropriation (State Board of Education)	2,556	2,519	2,625
Allocation for Employee Compensation	-	57	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	24	-
Section 3.60 Pension Contribution Adjustment	-	23	-
Pending Legislation (Special Olympics)	-	-	2,000
Education Code sections 8483.5 and 8483.51 (After School Education and Safety Program)	3,358	3,312	3,453
Allocation for Employee Compensation	-	76	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	31	-
Section 3.60 Pension Contribution Adjustment	-	30	-
Prior Year Balances Available:			
Item 6100-001-0001, Budget Act of 2015 as reappropriated by Item 6100-491, Budget Act of 2016	135	-	-

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6100 Department of Education - Continued

Item 6100-001-0001, Budget Act of 2015 as reappropriated by Item 6100-491, Budget Acts of 2016 and 2018	-	-	297
Item 6100-005-0001, Budget Act of 2016	-	1,474	-
Totals Available	**$109,259**	**$110,310**	**$111,213**
Unexpended balance, estimated savings	-1,515	-	-
Balance available in subsequent years	-1,474	-	-
TOTALS, EXPENDITURES	**$106,270**	**$110,310**	**$111,213**
0044 Motor Vehicle Account, State Transportation Fund			
APPROPRIATIONS			
001 Budget Act appropriation	-	-	$896
TOTALS, EXPENDITURES	**-**	**-**	**$896**
0140 California Environmental License Plate Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$45	$44	$45
Allocation for Employee Compensation	-	1	-
Totals Available	**$45**	**$45**	**$45**
Unexpended balance, estimated savings	-14	-	-
TOTALS, EXPENDITURES	**$31**	**$45**	**$45**
0178 Driver Training Penalty Assessment Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$1,611	-	-
Totals Available	**$1,611**	**-**	**-**
Unexpended balance, estimated savings	-96	-	-
TOTALS, EXPENDITURES	**$1,515**	**-**	**-**
0231 Health Education Account, Cigarette and Tobacco Products Surtax Fund			
APPROPRIATIONS			
001 Budget Act appropriation (Drug Free Schools)	$1,008	$992	$1,037
Allocation for Employee Compensation	-	24	-
Allocation for Staff Benefits	-	10	-
Section 3.60 Pension Contribution Adjustment	-	10	-
Totals Available	**$1,008**	**$1,036**	**$1,037**
Unexpended balance, estimated savings	-44	-	-
TOTALS, EXPENDITURES	**$964**	**$1,036**	**$1,037**
0687 Donated Food Revolving Fund			
APPROPRIATIONS			
001 Budget Act appropriation (Donated Food Revolving Fund)	$6,571	$6,539	$6,591
Allocation for Employee Compensation	-	28	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	11	-
Section 3.60 Pension Contribution Adjustment	-	11	-
Totals Available	**$6,571**	**$6,590**	**$6,591**
Unexpended balance, estimated savings	-2,746	-	-
TOTALS, EXPENDITURES	**$3,825**	**$6,590**	**$6,591**
0814 California State Lottery Education Fund			
APPROPRIATIONS			
Government Code section 8880.5 (State Special Schools)	$159	$159	$162
Lottery Revenue Adjustment for State Special Schools	-	3	-
Past Year Adjustments	133	-	-
Totals Available	**$292**	**$162**	**$162**
Unexpended balance, estimated savings	-292	-	-
TOTALS, EXPENDITURES	**-**	**$162**	**$162**
0890 Federal Trust Fund			

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6100 Department of Education - Continued

APPROPRIATIONS			
001 Budget Act appropriation (Department State Operations)	$166,101	-	$175,118
001 Budget Act appropriation (Department State Operations) as amended by Chapter 181, Statutes of 2017	-	175,817	-
Allocation for Employee Compensation	-	2,921	-
Allocation for Other Post-Employment Benefits	-	66	-
Allocation for Staff Benefits	-	1,205	-
Budget Position Transparency	-	-2,428	-
Expenditure by Category Redistribution	-	2,428	-
Section 3.60 Pension Contribution Adjustment	-	1,141	-
Totals Available	**$166,101**	**$181,150**	**$175,118**
Unexpended balance, estimated savings	-14,364	-	-
TOTALS, EXPENDITURES	**$151,737**	**$181,150**	**$175,118**
0903 State Penalty Fund			
APPROPRIATIONS			
001 Budget Act appropriation	-	$838	-
Allocation for Employee Compensation	-	31	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	13	-
Section 3.60 Pension Contribution Adjustment	-	12	-
TOTALS, EXPENDITURES	**-**	**$895**	**-**
0942 Special Deposit Fund			
APPROPRIATIONS			
Government Code section 16370 (California Career Resource Network)	-	-	$19
Past Year Adjustments	19	-	-
Technical Adjustments to Align Account Codes	-	19	-
Government Code section 16370 (Endowment Fund)	-	-	224
Past Year Adjustments	224	-	-
Technical Adjustments to Align Account Codes	-	224	-
Government Code section 16370 (Miscellaneous Education Donations and Registration)	928	928	901
Past Year Adjustments	-27	-	-
Technical Adjustments to Align Account Codes	-	-27	-
Government Code section 16370 (General Education Diplomas)	1,586	1,567	1,038
Allocation for Employee Compensation	-	28	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	12	-
Past Year Adjustments	-480	-	-
Section 3.60 Pension Contribution Adjustment	-	11	-
Technical Adjustments to Align Account Codes	-	-581	-
Education Code section 1330 (UI Administration)	72	72	11
Past Year Adjustments	-61	-	-
Technical Adjustments to Align Account Codes	-	-61	-
TOTALS, EXPENDITURES	**$2,261**	**$2,193**	**$2,193**
0995 Reimbursements			
APPROPRIATIONS			
Reimbursements	$16,157	$29,165	$25,337
TOTALS, EXPENDITURES	**$16,157**	**$29,165**	**$25,337**
3085 Mental Health Services Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$140	$138	$156
Allocation for Employee Compensation	-	10	-
Allocation for Staff Benefits	-	4	-

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6100 Department of Education - Continued

Section 3.60 Pension Contribution Adjustment	-	4	-
Totals Available	**$140**	**$156**	**$156**
Unexpended balance, estimated savings	-9	-	-
TOTALS, EXPENDITURES	**$131**	**$156**	**$156**
3170 Heritage Enrichment Resource Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$40	$40	$40
Totals Available	**$40**	**$40**	**$40**
Unexpended balance, estimated savings	-40	-	-
TOTALS, EXPENDITURES	**-**	**$40**	**$40**
3286 Safe Neighborhoods and Schools Fund			
APPROPRIATIONS			
Government Code section 7599.2(b)	$493	$565	$803
Totals Available	**$493**	**$565**	**$803**
Unexpended balance, estimated savings	-397	-	-
TOTALS, EXPENDITURES	**$96**	**$565**	**$803**
3309 Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund			
APPROPRIATIONS			
001 Budget Act appropriation	-	$1,574	-
TOTALS, EXPENDITURES	**-**	**$1,574**	**-**
3321 Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD			
APPROPRIATIONS			
Revenue and Taxation Code section 30130.57(b)(1) and (f)	-	-	$1,111
TOTALS, EXPENDITURES	**-**	**-**	**$1,111**
6036 2002 State School Facilities Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$30	$1,828	-
Allocation for Employee Compensation	-	40	-
Allocation for Staff Benefits	-	17	-
Section 3.60 Pension Contribution Adjustment	-	16	-
Totals Available	**$30**	**$1,901**	**-**
Unexpended balance, estimated savings	-15	-	-
TOTALS, EXPENDITURES	**$15**	**$1,901**	**-**
6044 2004 State School Facilities Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$833	$1,139	$2,636
Allocation for Employee Compensation	-	13	-
Allocation for Staff Benefits	-	5	-
Section 3.60 Pension Contribution Adjustment	-	5	-
Totals Available	**$833**	**$1,162**	**$2,636**
Unexpended balance, estimated savings	-280	-	-
TOTALS, EXPENDITURES	**$553**	**$1,162**	**$2,636**
6057 2006 State School Facilities Fund			
APPROPRIATIONS			
001 Budget Act appropriation	$2,175	$35	$464
Totals Available	**$2,175**	**$35**	**$464**
Unexpended balance, estimated savings	-623	-	-
TOTALS, EXPENDITURES	**$1,552**	**$35**	**$464**
Total Expenditures, All Funds, (State Operations)	**$341,007**	**$394,830**	**$385,708**

2 LOCAL ASSISTANCE	**2016-17***	**2017-18***	**2018-19***

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6100 Department of Education - Continued

0001 General Fund, Proposition 98

APPROPRIATIONS			
106 Budget Act appropriation	-	-	$11,534
107 Budget Act appropriation (County Offices of Education Fiscal Oversight)	5,299	5,299	6,271
113 Budget Act appropriation (Student Assessment Program)	110,225	-	128,517
113 Budget Act appropriation (Student Assessment Program) as amended by Chapter 181, Statutes of 2017	-	110,549	-
Align Student Assessment Funding to Estimated Costs	-	-2,133	-
119 Budget Act appropriation (Foster Youth Programs)	25,379	25,775	26,474
122 Budget Act appropriation (Specialized Secondary Program Grants)	4,892	4,892	4,892
149 Budget Act appropriation (Proposition 98 - After School Education and Safety Program Supplement)	-	-	50,000
149 Budget Act appropriation (Proposition 98 - After School Education and Safety Program Supplement) as amended by Chapter 181, Statutes of 2017	-	50,000	-
150 Budget Act appropriation (American Indian Early Childhood Education Program)	550	559	574
151 Budget Act appropriation (American Indian Education Centers)	4,078	4,142	4,254
158 Budget Act appropriation (Adults in Correctional Facilities)	15,096	15,096	15,331
161 Budget Act appropriation (Special Education)	3,195,281	3,124,258	3,299,416
Past Year Adjustments	-2,654	-	-
166 Budget Act appropriation (Partnership Academies)	21,428	21,428	21,428
167 Budget Act appropriation (Agricultural Vocational Education)	4,134	4,134	4,134
168 Budget Act appropriation (Proposition 98) Career Technical Education Incentive Grant	-	-	150,000
170 Budget Act appropriation (Proposition 98 - Career Technical Education Initiative Program)	-	15,360	15,360
172 Budget Act appropriation (College and Career Planning Website and Online Educational Resources)	-	5,500	6,500
172 Budget Act appropriation (College and Career Planning Website)	2,500	-	-
182 Budget Act appropriation as amended by Chapter 318, Statutes of 2016 (K-12 High Speed Network)	4,500	-	-
196 Budget Act appropriation (State Preschool)	-	-	1,215,467
196 Budget Act appropriation (State Preschool) as amended by Chapter 249, Statutes of 2017	-	1,122,428	-
196 Budget Act appropriation as amended by Chapter 318, Statutes of 2016 (State Preschool)	974,854	-	-
201 Budget Act appropriation (Child Nutrition Start-up Grants)	1,017	1,017	1,017
203 Budget Act appropriation (Child Nutrition)	158,780	162,502	164,228
209 Budget Act appropriation (Teacher Dismissal Apportionments)	40	40	100
295 Budget Act appropriation (State Mandates Reimbursements)	47	49	48
296 Budget Act appropriation (State Mandates Block Grant)	218,763	230,161	236,262
Education Code sections 42238.02 and 42238.03 (School District Apportionments)	22,586,839	25,643,565	31,079,421
District LCFF Education Protection Account Offset Adjustment	-2,318	-369,193	-
District LCFF Minimum State Aid Adjustment	9,355	9,355	-
District LCFF Property Tax Adjustment	-448,351	-361,178	-
Fire-Related Property Tax Loss Backfill for Basic Aid School Districts	-	2,399	-
K-14 Education Fire-Related Property Tax Loss Backfill	-	12,339	-
LCFF Additional Funding Adjustment	6,063	5,794	-
LCFF Floor Growth Adjustment	-15,682	51,585	-
Shift Former Categoricals into Base Continuous LCFF Item	6,160,829	6,160,671	-
Technical Adjustment to LCFF	-26,083	-26,083	-
Technical Offset Adjustment to K-14 Fire-Related Property Tax Loss Backfill	-	-12,339	-
Pending Legislation (State System of Support Regional Lead)	-	-	4,000
Education Code sections 2574 and 2575 (County Office of Education Apportionments)	429,861	419,948	441,938
County Office Education Protection Account Offset Adjustment	2,034	-3,499	-
County Office of Education LCFF Growth Adjustment	-22,355	-23,733	-

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6100 Department of Education - Continued

County Office of Education Local Revenue Adjustment	-7,749	3,664	-
County Office of Education Minimum State Aid Adjustment	25,854	25,854	-
Article XIII, Section 36 of the California Constitution (Proposition 30) (transfer to Education Protection Account)	6,708,585	6,436,705	7,278,288
Education Protection Account Current Year Correction	-	1	-
Education Protection Account Revenue Adjustment	-	372,408	-
Chapter 15, Statutes of 2017 (Proposition 98–Equity Performance and Improvement Team)	-	2,500	-
Chapter 15, Statutes of 2017 (Proposition 98–California-Grown Fresh School Meals Grant Program)	-	1,500	-
One-Time Funding for California-Grown Fresh School Meals Grant Program	1,000	-	-
Add One-Time Funding for the Local Control Funding Formula Budget Overview Electronic Template Development	200	-	-
Add One-Time Funding to Update the LCAP Electronic Template	200	-	-
Computer-Based ELPAC and Alternative ELPAC Assessments	27,075	-	-
Chapter 15, Statutes of 2017 (Bilingual Teacher Professional Development Program)	-	5,000	-
Education Code section 53070 (Career Technical Education Incentive Grant Program)	292,162	-	-
One-Time Homeless Students Grant	250	-	-
Education Code section 41329.57(a)(1) (Oakland Unified School District)	1,768	1,710	1,707
Loan Repayment Adjustment for Oakland Unified School District	-	72	-
Education Code section 41329.57(a)(1) (Vallejo City Unified School District)	515	490	492
Loan Repayment Adjustment for Vallejo Unified School District	-	23	-
Education Code section 41329.575 (South Monterey County Joint Union High School District)	300	264	265
Loan Repayment Adjustment for South Monterey County HSD	-	35	-
Public Resources Code section 26233 (Transfer to Clean Energy Job Creation Fund)	398,800	376,200	-
One-Time Funding for the Classified School Employees Professional Development Block Grant Program	-	50,000	-
One-Time Funding for the Classified School Employees Summer Assistance Program	50,000	-	-
Provide Funding for Lowest-Performing Students Block Grant	-	300,000	-
Inclusive Early Education Expansion Program (Local Educational Agencies)	-	167,242	-
Education Code sections 8483.5 and 8483.51 (After School Education and Safety Program)	546,642	546,688	546,547
ASES Local Assistance Workload Adjustments	-	-138	-
Provide Funding for After School Kids Code Grant Program	15,000	-	-
Community Engagement Initiative	13,274	-	-
Multi-Tiered Systems of Support-Improving School Climate	15,000	-	-
Chapter 29, Statutes of 2016 (Proposition 98-Evaluation Rubrics Support and Development)	500	-	-
Chapter 15, Statutes of 2017 (LCAP E-template and Dashboard)	-	400	-
Special Education Local Property Tax Revenue-Fire Related Backfill	-	267	-
Chapter 15, Statutes of 2017 (SoCal ROC Transition Funding)	-	4,000	-
Education Code section 42238.03 (District Local Control Funding Formula Adjustment)	6,160,829	6,160,671	-
Shift Former Categoricals into Base Continuous LCFF Item	-6,160,829	-6,160,671	-
Chapter 15, Statutes of 2017 (District LCFF Transition Funding)	-	1,362,383	-
Chapter 29, Statutes of 2016 (District LCFF Transition Funding)	2,941,980	-	-
Pending Legislation (District LCFF Transition Funding)	-	-	3,556,177
One-Time Funding for Discretionary Grants and Mandate Reimbursement	103,003	-	-
Chapter 15, Statutes of 2017 (Discretionary Grants - Mandate Funding)	-	876,581	-
One-Time Funding for Discretionary Grants and Mandate Reimbursement	-	294,756	-
Pending Legislation (Discretionary Grants and Mandate Reimbursements)	-	-	300,000
Prior Year Balances Available:			
Chapter 15, Statutes of 2017 (LCAP E-template and Dashboard)	-	-	300

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6100 Department of Education - Continued

Chapter 15, Statutes of 2017 (SoCal ROC Transition Funding)	-	-	3,000
Chapter 29, Statutes of 2016 (Proposition 98-Evaluation Rubrics Support and Development)	-	500	500
Totals Available	**$44,558,760**	**$47,239,792**	**$48,574,442**
Unexpended balance, estimated savings	-47,403	-	-
TOTALS, EXPENDITURES	**$44,511,357**	**$47,239,792**	**$48,574,442**
0001 General Fund			
APPROPRIATIONS			
194 Budget Act appropriation (Child Development)	$940,982	-	$1,324,850
194 Budget Act appropriation (Child Development) as amended by Chapter 249, Statutes of 2017	-	1,016,706	-
Pending Legislation (Sweetwater USD Facility Improvements)	-	-	6,000
Pending Legislation (Suicide Prevention Training)	-	-	1,700
Public Resources Code section 26233 (Transfer to Clean Energy Job Creation Fund)	8,435	8,818	-
Past Year Adjustments	-25	-	-
Prior Year Balances Available:			
Reappropriation, Proposition 98 per Item 6100-488	-	219,809	238,958
Reappropriation, Proposition 98 per Item 6100-488, Budget Act of 2016	141,046	-	-
Reappropriation, Proposition 98 reversion account per Item 6100-485	12,377	104,880	80,331
Totals Available	**$1,102,815**	**$1,350,213**	**$1,651,839**
Unexpended balance, estimated savings	-59	-	-
TOTALS, EXPENDITURES	**$1,102,756**	**$1,350,213**	**$1,651,839**
Loan repayment per Chapter 14, Statutes of 2003 (Oakland Unified School District)	-2,095	-2,095	-2,095
Loan repayment per Chapter 53, Statutes of 2004 (Vallejo Unified School District)	-2,266	-2,266	-2,266
NET TOTALS, EXPENDITURES	**$1,098,395**	**$1,345,852**	**$1,647,478**
0140 California Environmental License Plate Fund			
APPROPRIATIONS			
181 Budget Act appropriation (Environmental Education)	$360	$360	$360
TOTALS, EXPENDITURES	**$360**	**$360**	**$360**
0178 Driver Training Penalty Assessment Fund			
APPROPRIATIONS			
Transfer to various funds per Section 24.10	($23,221)	(-)	(-)
TOTALS, EXPENDITURES	**-**	**-**	**-**
0231 Health Education Account, Cigarette and Tobacco Products Surtax Fund			
APPROPRIATIONS			
101 Budget Act appropriation (Drug Free Schools-County Offices)	$4,409	$3,687	$3,086
Adjust County Office of Education Funding for Health and Physical Education Drug-Free Schools Program	-	-214	-
Reflect Current Year Estimated Savings	-	214	-
102 Budget Act appropriation (Drug Free Schools-District Grants)	13,135	10,938	9,875
Adjust School District Funding for Health and Physical Education Drug-Free Schools Program	-	-420	-
Reflect Current Year Estimated Savings	-	420	-
Prior Year Balances Available:			
Item 6100-102-0231, Budget Act of 2014	35	-	-
Item 6100-102-0321, Budget Act of 2016	-	226	-
Totals Available	**$17,579**	**$14,851**	**$12,961**
Unexpended balance, estimated savings	-80	-634	-
Balance available in subsequent years	-226	-	-
TOTALS, EXPENDITURES	**$17,273**	**$14,217**	**$12,961**
0342 State School Fund			
APPROPRIATIONS			
Education Code section 14002	$38,214,635	$39,624,896	$40,790,019

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6100 Department of Education - Continued

Past Year Adjustments	-1,201,847	-	-
State School Fund Adjustment	-	-526,342	-
TOTALS, EXPENDITURES	**$37,012,788**	**$39,098,554**	**$40,790,019**
Less funding provided by General Fund	-36,993,947	-39,079,386	-40,770,851
NET TOTALS, EXPENDITURES	**$18,841**	**$19,168**	**$19,168**
0349 Educational Telecommunication Fund			
APPROPRIATIONS			
Pending Legislation (Standardized Account Code Structure System Replacement Project)	-	-	$716
TOTALS, EXPENDITURES	**-**	**-**	**$716**
0814 California State Lottery Education Fund			
APPROPRIATIONS			
Government Code section 8880.5	$1,184,232	$1,184,232	$1,200,696
K-12 Lottery Adjustment	-	17,373	-
Past Year Adjustments	17,320	-	-
TOTALS, EXPENDITURES	**$1,201,552**	**$1,201,605**	**$1,200,696**
0890 Federal Trust Fund			
APPROPRIATIONS			
101 Budget Act appropriation (Project School Emergency Response to Violence)	-	-	$2,000
102 Budget Act appropriation (Immediate Aid To Restart School Operations)	-	-	13,864
104 Budget Act appropriation (Project Advancing Wellness and Resilience in Education Grant)	2,313	1,998	1,469
112 Budget Act appropriation (Public Charter Schools)	35,400	40,964	26,873
113 Budget Act appropriation (Student Assessment Program)	24,121	-	21,129
113 Budget Act appropriation (Student Assessment Program) as amended by Chapter 181, Statutes of 2017	-	20,937	-
Align Federal Student Assessment Funding to Estimated Costs	-	2,133	-
119 Budget Act appropriation (Title I, Neglected and Delinquent)	1,215	-	3,112
119 Budget Act appropriation (Title I, Neglected and Delinquent) as amended by Chapter 181, Statutes of 2017	-	1,215	-
Adjust Federal Funds for the Neglected and Delinquent Children Program	-	447	-
125 Budget Act appropriation (Migrant Education and English Language Acquisition Program)	280,272	291,945	273,597
134 Budget Act appropriation (Title I School Improvement)	1,839,393	-	2,218,510
134 Budget Act appropriation (Title I School Improvement) as amended by Chapter 181, Statutes of 2017	-	1,816,694	-
Adjust Federal Funds for the Title I Basic Grant Program	-	29,728	-
136 Budget Act appropriation (McKinney-Vento Homeless Children Education)	7,930	9,711	9,262
137 Budget Act appropriation (Rural and Low Income Schools Grant)	1,436	3,512	3,680
156 Budget Act appropriation (Adult Education)	93,918	-	102,515
156 Budget Act appropriation (Adult Education) as amended by Chapter 181, Statutes of 2017	-	94,774	-
Adjust Federal Funds for the Adult Education Program	-	1,567	-
161 Budget Act appropriation (Special Education)	1,251,134	1,248,885	1,279,921
166 Budget Act appropriation (Vocational Education)	123,410	122,193	117,683
193 Budget Act appropriation (Title II, Mathematics and Science Partnership Grants)	20,656	2,703	323
194 Budget Act appropriation (Child Development)	648,873	-	938,039
194 Budget Act appropriation (Child Development) as amended by Chapter 181, Statutes of 2017	-	747,495	-
Base Child Care Development Fund Grant Adjustment (2017 BA)	-	9,008	-
Child Care Development Fund Quality Adjustment (2017 BA)	-	8,822	-
195 Budget Act appropriation (Title II, Part A-Improving Teacher Quality Grant)	-	238,878	235,316
195 Budget Act appropriation as amended by Chapter 318, Statutes of 2016 (Title II, Part A-Improving Teacher Quality Grant)	251,110	-	-
197 Budget Act appropriation (21st Century Community Learning Centers)	132,821	-	138,153

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6100 Department of Education - Continued

197 Budget Act appropriation (21st Century Community Learning Centers) as amended by Chapter 181, Statutes of 2017	-	135,071	-
21st Century Community Learning Centers Base Grant Adjustment (2017 BA)	-	3,921	-
201 Budget Act appropriation (Child Nutrition)	2,677,586	2,672,340	2,672,340
240 Budget Act appropriation (Advanced Placement Exam Fees)	13,676	11,064	11,064
294 Budget Act appropriation (Early Head Start - Child Care Partnership Grant)	6,710	5,566	3,662
Totals Available	**$7,411,974**	**$7,521,571**	**$8,072,512**
Unexpended balance, estimated savings	-239,120	-	-
TOTALS, EXPENDITURES	**$7,172,854**	**$7,521,571**	**$8,072,512**
0986 Local Property Tax Revenues			
APPROPRIATIONS			
District Local Revenue	$17,632,405	$18,479,316	$19,992,782
K-12 District Local Property Tax Revenue Offset Adjustment	481,548	560,665	-
Technical Adjustment to K-12 Offsetting Property Tax Revenues Tracking Account	199	-123,375	-
County Offices Local Revenue	535,156	564,576	591,924
County Office of Education Local Property Tax Revenue Offset Adjustment	7,771	7,771	-
Technical Adjustment to K-12 Offsetting Property Tax Revenues Tracking Account	-21	-11,435	-
Special Education Local Revenue	577,923	602,581	634,139
Special Education Local Property Tax Revenue Offset Adjustment	3,468	3,596	-
Technical Adjustment to K-12 Offsetting Property Tax Revenues Tracking Account	-727	-7,893	-
TOTALS, EXPENDITURES	**$19,237,722**	**$20,075,802**	**$21,218,845**
0995 Reimbursements			
APPROPRIATIONS			
Reimbursements	$408,992	$435,684	$436,184
TOTALS, EXPENDITURES	**$408,992**	**$435,684**	**$436,184**
3207 Education Protection Account			
APPROPRIATIONS			
Article XIII, Section 36 of the California Constitution (Proposition 30)	$6,708,585	$6,436,705	$7,278,288
Education Protection Account Revenue Adjustment	-	372,409	-
TOTALS, EXPENDITURES	**$6,708,585**	**$6,809,114**	**$7,278,288**
Less funding provided by General Fund	-6,708,585	-6,809,114	-7,278,288
NET TOTALS, EXPENDITURES	**-**	**-**	**-**
3286 Safe Neighborhoods and Schools Fund			
APPROPRIATIONS			
Government Code section 7599.1 (c)	$9,369	$10,731	$15,263
TOTALS, EXPENDITURES	**$9,369**	**$10,731**	**$15,263**
3309 Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund			
APPROPRIATIONS			
101 Budget Act appropriation as amended by Chapter 249, Statutes of 2017	-	$30,389	-
TOTALS, EXPENDITURES	**-**	**$30,389**	**-**
3321 Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD			
APPROPRIATIONS			
Revenue and Taxation Code section 30130.57(b)(1)	-	-	$21,736
TOTALS, EXPENDITURES	**-**	**-**	**$21,736**
8080 Clean Energy Job Creation Fund			
APPROPRIATIONS			
139 Budget Act appropriation	$398,800	$376,200	-
Prior Year Balances Available:			
Item 6100-139-8080, Budget Act of 2015	192,213	-	-
Item 6110-139-8080, Budget Act of 2013	82,869	-	-
Item 6110-139-8080, Budget Act of 2014	125,377	-	-
Totals Available	**$799,259**	**$376,200**	**-**

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6100 Department of Education - Continued

Unexpended balance, estimated savings	-408,531	-	-
TOTALS, EXPENDITURES	**$390,728**	**$376,200**	**-**
Less funding provided by General Fund	-407,210	-385,018	-
NET TOTALS, EXPENDITURES	**-$16,482**	**-$8,818**	**-**
Total Expenditures, All Funds, (Local Assistance)	**$73,660,233**	**$77,886,353**	**$81,220,361**
TOTALS, EXPENDITURES, ALL FUNDS (State Operations and Local Assistance)	**$74,001,240**	**$78,281,183**	**$81,606,069**

FUND CONDITION STATEMENTS

	2016-17*	2017-18*	2018-19*
0178 Driver Training Penalty Assessment Fund S			
BEGINNING BALANCE	$457	$741	$741
Prior Year Adjustments	885	-	-
Adjusted Beginning Balance	$1,342	$741	$741
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Revenues:			
4136500 Traffic Violation Penalties	24,585	-	-
Transfers and Other Adjustments			
Revenue Transfer from Driver Training Penalty Assessment Fund (0178) to Corrections Training Fund (0170) per C.S. 24.10.	-9,800	-	-
Revenue Transfer from Driver Training Penalty Assessment Fund (0178) to Peace Officers' Training Fund (0268) per C.S. 24.10.	-9,200	-	-
Revenue Transfer from Driver Training Penalty Assessment Fund (0178) to Victim Witness Assistance Fund (0425) per C.S. 24.10.	-4,121	-	-
Revenue Transfer from Drivers Training Penalty Assessment Fund (0178) to Traumatic Brain Injury Fund (0311)	-360	-	-
Total Revenues, Transfers, and Other Adjustments	$1,104	-	-
Total Resources	$2,446	$741	$741
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (State Operations)	1,515	-	-
8880 Financial Information System for California (State Operations)	3	-	-
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	187	-	-
Total Expenditures and Expenditure Adjustments	$1,705	-	-
FUND BALANCE	$741	$741	$741
Reserve for economic uncertainties	741	741	741
0342 State School Fund S			
BEGINNING BALANCE	$2,647	$2,029	$2,029
Prior Year Adjustments	-1,002	-	-
Adjusted Beginning Balance	$1,645	$2,029	$2,029
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Revenues:			
4154000 Royalties - Federal Land	22,472	22,472	22,472
4171300 Donations	78	78	78
Total Revenues, Transfers, and Other Adjustments	$22,550	$22,550	$22,550
Total Resources	$24,195	$24,579	$24,579
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (Local Assistance)	37,012,788	39,098,554	40,790,019
6870 Board of Governors of the California Community Colleges (Local Assistance)	4,075,305	4,457,234	5,011,378

*** Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.**

6100 Department of Education - Continued

Expenditure Adjustments:			
Less funding provided by General Fund (Local Assistance)	-36,993,947	-39,079,386	-40,770,851
Less funding provided by General Fund (Local Assistance)	-4,071,980	-4,453,852	-5,007,996
Total Expenditures and Expenditure Adjustments	$22,166	$22,550	$22,550
FUND BALANCE	$2,029	$2,029	$2,029
Reserve for economic uncertainties	2,029	2,029	2,029
0349 Educational Telecommunication Fund [S]			
BEGINNING BALANCE	$1,324	$1,323	$1,323
Prior Year Adjustments	-1	-	-
Adjusted Beginning Balance	$1,323	$1,323	$1,323
Total Resources	$1,323	$1,323	$1,323
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (Local Assistance)	-	-	716
Total Expenditures and Expenditure Adjustments	-	-	$716
FUND BALANCE	$1,323	$1,323	$607
Reserve for economic uncertainties	1,323	1,323	607
3170 Heritage Enrichment Resource Fund [S]			
BEGINNING BALANCE	$260	$351	$404
Prior Year Adjustments	-1	-	-
Adjusted Beginning Balance	$259	$351	$404
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Revenues:			
4172500 Miscellaneous Revenue	98	98	98
Total Revenues, Transfers, and Other Adjustments	$98	$98	$98
Total Resources	$357	$449	$502
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (State Operations)	-	40	40
9892 Supplemental Pension Payments (State Operations)	-	-	4
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	6	5	3
Total Expenditures and Expenditure Adjustments	$6	$45	$47
FUND BALANCE	$351	$404	$455
Reserve for economic uncertainties	351	404	455
3207 Education Protection Account [S]			
BEGINNING BALANCE	-	-	-
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (Local Assistance)	$6,708,585	$6,809,114	$7,278,288
6870 Board of Governors of the California Community Colleges (Local Assistance)	829,150	841,576	899,564
Expenditure Adjustments:			
Less funding provided by General Fund (Local Assistance)	-6,708,585	-6,809,114	-7,278,288
Less funding provided by General Fund (Local Assistance)	-829,150	-841,576	-899,564
FUND BALANCE	-	-	-
3321 Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD [S]			
BEGINNING BALANCE	-	-	-
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Transfers and Other Adjustments			
Revenue Transfer From the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund (3304) to the Tobacco Prevention and Control	-	-	22,225

* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

6100 Department of Education - Continued

Programs Account Fund (3321) per Revenue and Tax Code Section 30130.55(b)(2)			
Revenue Transfer From the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund (3304) to the tobacco Prevention and Control Programs Account Fund (3321) per Revenue and Tax Code Section 30130.55(b)(2)	-	-	622
Total Revenues, Transfers, and Other Adjustments	-	-	$22,847
Total Resources	-	-	$22,847
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (State Operations)	-	-	1,111
6100 Department of Education (Local Assistance)	-	-	21,736
Total Expenditures and Expenditure Adjustments	-	-	$22,847
FUND BALANCE	-	-	-
8080 Clean Energy Job Creation Fund [S]			
BEGINNING BALANCE	$409,163	$409,894	$409,732
Prior Year Adjustments	123	-	-
Adjusted Beginning Balance	$409,286	$409,894	$409,732
Total Resources	$409,286	$409,894	$409,732
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
3340 California Conservation Corps (State Operations)	5,559	5,816	-
6100 Department of Education (Local Assistance)	390,728	376,200	-
6870 Board of Governors of the California Community Colleges (Local Assistance)	56,595	46,664	-
7120 California Workforce Development Board (State Operations)	3,000	3,000	-
Expenditure Adjustments:			
Less funding provided by General Fund (Local Assistance)	-407,210	-385,018	-
Less funding provided by General Fund (Local Assistance)	-49,280	-46,500	-
Total Expenditures and Expenditure Adjustments	-$608	$162	-
FUND BALANCE	$409,894	$409,732	$409,732
Reserve for economic uncertainties	409,894	409,732	409,732

CHANGES IN AUTHORIZED POSITIONS

	Positions			Expenditures		
	2016-17	2017-18	2018-19	2016-17*	2017-18*	2018-19*
Baseline Positions	2,249.7	2,245.2	2,243.2	$159,340	$155,230	$154,420
Budget Position Transparency	-	-28.0	-26.0	-	-4,855	1,950
Salary and Other Adjustments	-33.9	-	-	113	6,789	6,789
Workload and Administrative Adjustments						
Cross-Agency Work to Support the Statewide System of Support (State Operations)						
Educ Programs Consultant	-	-	-	-	-	173
One-Time Federal Funds to Support the Early Math Initiative						
Temporary Help (Limited Term 06-30-2019)	-	-	-	-	-	100
One-Time Federal Immediate Aid to Restart School Operations Funds (State Operations)						
Temporary Help (Limited Term 06-30-2019)	-	-	-	-	-	200
Personnel Funding for Child Care Slot Expansion						
Educ Programs Consultant	-	-	-	-	-	87
Personnel Funding for Computer-Based ELPAC and Alternative ELPAC Assessments						

*** Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.**

6100 Department of Education - Continued

Assoc Info Sys Analyst (Spec)	-	-	-	-	-	73
Educ Programs Consultant	-	-	-	-	-	87
Personnel Funding for Data Collection and Reporting Requirements for the District of Choice Program						
Staff Info Sys Analyst (Spec)	-	-	-	-	-	77
Personnel Funding for Educational Equity Compliance Reviews (AB 699)						
Assoc Govtl Program Analyst	-	-	-	-	-	67
Personnel Funding for High School Equivalency Exam Fee Waiver Backfill						
Educ Programs Consultant	-	-	-	-	-	146
Personnel Funding for Special Education Litigation Unit						
Educ Administrator I	-	-	-	-	-	96
Educ Programs Consultant	-	-	-	-	-	260
Office Techn (Typing)	-	-	-	-	-	41
Personnel Funding for State Preschool Expansion						
Educ Programs Consultant	-	-	-	-	-	173
Personnel Funding for Universal Meal Service Support (SB 138)						
Assoc Govtl Program Analyst	-	-	-	-	-	67
Personnel Funding for the Information Security and Privacy Office						
Sys Software Spec III (Tech)	-	-	-	-	-	102
Personnel Funding to Support District Reorganization Workload						
Fld Rep - School Administration (Spec)	-	-	-	-	-	85
Personnel Funding to Support Subsidized County Child Care Pilot Programs						
Assoc Govtl Program Analyst	-	-	-	-	-	134
Assoc Info Sys Analyst (Spec)	-	-	-	-	-	72
Educ Programs Consultant	-	-	-	-	-	87
Staff Programmer Analyst (Spec)	-	-	-	-	-	79
Personnel Funding to Support a Centralized Uniform Complaint Procedures Process and Database						
Educ Programs Consultant	-	-	-	-	-	87
Staff Svcs Mgr I	-	-	-	-	-	76
Sexual Health Education Backfill						
Educ Programs Consultant	-	-	-	-	-	173
TOTALS, WORKLOAD AND ADMINISTRATIVE ADJUSTMENTS	**-**	**-**	**-**	**$-**	**$-**	**$2,542**
Totals, Adjustments	**-33.9**	**-28.0**	**-26.0**	**$113**	**$1,934**	**$11,281**
TOTALS, SALARIES AND WAGES	**2,215.8**	**2,217.2**	**2,217.2**	**$159,453**	**$157,164**	**$165,701**

INFRASTRUCTURE OVERVIEW

The State Special Schools Division has six facilities under its jurisdiction: three residential schools and three diagnostic centers. These facilities comprise a total of approximately 1,042,000 gross square feet on 167.29 acres.

The residential schools serve students ranging in age from 3 to 22. They include Schools for the Deaf in Riverside and Fremont and a School for the Blind in Fremont. The California Schools for the Deaf provide comprehensive educational programs composed of academic, extracurricular, and residential activities for students. The California School for the Blind is a statewide residential campus that provides intensive, disability-specific educational services for pupils who are blind, visually impaired, or deaf-blind. The diagnostic centers are regionally located in Fresno, Fremont, and Los Angeles; the centers address the unique educational needs of California's most difficult to serve special education students.

*** Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.**

6100 Department of Education - Continued

SUMMARY OF PROJECTS

	State Building Program Expenditures	2016-17*	2017-18*	2018-19*
5230	**CAPITAL OUTLAY Projects**			
0000409	New Gym and Pool Center	-	2,156	-
	Construction	-	2,156	-
0000720	Fremont School for the Deaf: Middle School Activity Center	266	1,483	-
	Preliminary Plans	70	-	-
	Working Drawings	196	-	-
	Construction	-	1,483	-
TOTALS, EXPENDITURES, ALL PROJECTS		**$266**	**$3,639**	**$-**

FUNDING		**2016-17***	**2017-18***	**2018-19***
0001	General Fund	$266	$1,483	$-
0660	Public Buildings Construction Fund	-	2,156	-
TOTALS, EXPENDITURES, ALL FUNDS		**$266**	**$3,639**	**$-**

DETAIL OF APPROPRIATIONS AND ADJUSTMENTS

3 CAPITAL OUTLAY	**2016-17***	**2017-18***	**2018-19***
0001 General Fund			
APPROPRIATIONS			
301 Budget Act appropriation	$1,749	-	-
Past Year Adjustments	196	-	-
Prior Year Balances Available:			
Item 6100-301-0001, Budget Act of 2016 as reappropriated by Item 6100-492, Budget Act 2017	-	1,483	-
Totals Available	**$1,945**	**$1,483**	**-**
Balance available in subsequent years	-1,679	-	-
TOTALS, EXPENDITURES	**$266**	**$1,483**	**-**
0660 Public Buildings Construction Fund			
APPROPRIATIONS			
0000409 - Riverside: New Gymnasium and Pool Center (per AB 109, Chapter 249, Statutes of 2017) - C	-	$2,156	-
TOTALS, EXPENDITURES	**-**	**$2,156**	**-**
Total Expenditures, All Funds, (Capital Outlay)	**$266**	**$3,639**	**$0**

*** Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.**

EXHIBIT B

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Director
Office for Civil Rights
Washington, D.C. 20201

June 21, 2016

SENT VIA U.S. MAIL AND ELECTRONIC MAIL

Catherine W. Short, Esq.
Vice President of Legal Affairs
Life Legal Defense Foundation
P.O. Box 2105
Napa, CA 94558

Matthew S. Bowman, Esq., Senior Legal Counsel
Casey Mattox, Esq., Senior Legal Counsel
Alliance Defending Freedom
440 1st Street NW, Suite 600
Washington, D.C. 20001

James F. Sweeney, Esq.
Law Offices of James F. Sweeney
P.O. Box 320130
San Francisco, CA 94132

Michelle (Shelley) Rouillard, Director
California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Re: OCR Transaction Numbers: 14-193604, 15-193782, & 15-195665

Dear Ms. Short, Mr. Bowman, Mr. Mattox, Mr. Sweeney, and Ms. Rouillard:

The Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) has concluded its investigation of allegations that the California Department of Managed Health Care (CDMHC) engaged in discrimination under the Weldon Amendment[1] by issuing letters to several health insurers directing them to amend their plan documents to remove coverage exclusions and limitations regarding elective abortions. OCR received three complaints challenging the CDMHC letter, filed on behalf of a religious organization, churches and a

[1] Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Sec. 507(d) (Dec. 18, 2015).

church-run school, and employees of a religiously-affiliated university. The following sets forth the results of our investigation of these complaints.

Background

On August 22, 2014, the Director of CDMHC notified seven California health insurance plans[2] that it had come to CDMHC's attention that each of them had issued insurance contracts that limited or excluded coverage for termination of pregnancies. CDMHC regulates health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 (Act), Cal. Health & Safety Code Sections 1340-1399.864, and its letter directed each health insurer to ensure that its health plans complied with the Act's requirement to cover legal abortions. CDMHC required the insurers to amend plan documents to remove coverage exclusions and limitations for "voluntary" or "elective" abortions and any limitations on coverage to only "therapeutic" or "medically necessary" abortions and to file revised documents within 90 days. A footnote in the letter stated that "no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion."

Implementing regulations of the Federal Health Care Provider Conscience Laws designate OCR as the office to receive complaints alleging discrimination under the Weldon Amendment. 45 C.F.R. § 88.2. OCR investigated each of the three complaints it received about the CDMHC letter, including requesting, receiving, and analyzing a written response to the complaints from CDMHC; collecting additional information from the complainants; interviewing each of the seven health insurers contacted by CDMHC, some on several occasions; and engaging in follow-up conversations with CDMHC.

OCR's investigation found that each of the insurers that received the CDMHC letter had, at the time it received the letter, included coverage for voluntary abortions in plans that it offered; upon receipt of the letter, each amended its plan documents by CDMHC's deadline to eliminate the subject exclusions from any plans that contained them. None of the insurers asserted any objection to offering coverage for voluntary abortion services and none identified any religious or moral objection that it had to such coverage.

OCR's investigation also found that Blue Cross of California (dba Anthem Blue Cross) subsequently sought and received from CDMHC an exemption to allow it to offer a plan excluding elective abortion services for religious employers as defined under California law. Cal. Health & Safety Code Section 1367.25(c)(1). As a result, CDMHC has demonstrated its willingness to authorize insurers to offer products that exclude coverage for elective abortion to such religious employers.

[2] The seven health insurance plans were Aetna Health of California, Inc.; Blue Cross of California, dba Anthem Blue Cross; California Physicians' Service, dba Blue Shield of California; GEMCare Health Plan, Inc., dba ERD, Inc., Physicians Choice by GEMCare Health Plan; Health Net of California, Inc.; Kaiser Foundation Health Plan, Inc., dba Kaiser Foundation, Permanente Medical Care Program; and United Healthcare of California. OCR understands that GEMCare is no longer participating in the commercial insurance marketplace.

The Weldon Amendment

The Weldon Amendment provides:

> (d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.
>
> (2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.[3]

The amendment was passed to protect health care entities covered by the amendment from discrimination where those entities object to abortion on religious or moral grounds. *See State of California v. Lockyer*, 450 F.3d 436, 441 (9th Cir. 2006) ("Congress passed the Weldon Amendment precisely to keep doctors who have moral qualms about performing abortions from being put to the hard choice of acting in conformity with their beliefs or risking imprisonment or loss of professional livelihood").

The amendment applies only to health care entities as defined therein. As the primary sponsor of the amendment, Representative Weldon himself made clear in discussing its scope:

> This provision is intended to protect the decisions of physicians, nurses, clinics, hospitals, medical centers, and even health insurance providers from being forced by the government to provide, refer, or pay for abortions. . . . It explicitly clarifies existing law to state that a health care entity includes a hospital, a health professional, a provider-sponsored organization, a health maintenance organization, a health insurance plan or any other kind of health care facility. It goes on further to state that existing law protects health care entities from discrimination based on three kinds of participation in abortion: performing, training and referring.[4]

Representative Weldon further stated that the health care entities that are protected are those that "choose not to provide abortion services."[5] In making clear that the amendment protects those who object to the provision of abortions, he stated, "[t]he Hyde-Weldon amendment . . . simply states you cannot force the unwilling" to participate in elective abortions. "The amendment does not apply to willing abortion providers."[6]

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[3] Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Sec. 507(d) (Dec. 18, 2015).
[4] 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004).
[5] *Id.*
[6] 151 Cong. Rec. H177 (Statement of Rep. Weldon) (Jan. 25, 2005).

Representative Weldon also made clear that the health care entities protected under the amendment are those that have objections based on religious or moral grounds:

> [The Weldon Amendment] is a continuation of the Hyde policy of conscience protection. . . . The right of conscience is fundamental to our American freedoms. We should guarantee this freedom by protecting all health care providers from being forced to perform, refer, or pay for elective abortions.[7]

Findings

CDMHC is an agency and instrumentality of the State, and thus an entity to which the terms of the Weldon Amendment apply. The State of California receives federal funding under the Appropriations Act that includes the Weldon Amendment.[8] The seven health insurers to which CDMHC sent the August 22, 2014 letter meet the definition of "health care entity" in the Weldon Amendment, as each is a "health insurance plan." Based on the facts provided to OCR, none of the complainants meets the definition of a "health care entity" under the Weldon Amendment.

By its plain terms, the Weldon Amendment's protections extend only to health care entities and not to individuals who are patients of, or institutions or individuals that are insured by, such entities. In addition, its author, Representative Weldon, made clear both that the amendment protects only those covered health care entities that object to the provision of abortions and that its basic purpose is to protect those entities whose objections are made on religious or moral grounds.

Here, none of the seven insurers that received the CDMHC letter – the entities that are covered under the Weldon Amendment – objected to providing coverage for abortions. All modified their plan documents to cover voluntary abortion in response to the CDMHC letter, and none has indicated to OCR that it has a religious or moral objection to abortion or to providing coverage for abortion in the products it offers. Indeed, as noted above, at the time CDMHC sent the letter, all of the insurers offered plans that covered abortion, demonstrating that they have no religious or moral objection to that procedure. As a result, there is no health care entity protected under the statute that has asserted religious or moral objections to abortion and therefore there is no covered entity that has been subject to discrimination within the meaning of the Weldon Amendment.[9]

We further note that the approach described above avoids a potentially unconstitutional application of the amendment. A finding that CDMHC has violated the Weldon Amendment might require the government to rescind all funds appropriated under the Appropriations Act to

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[7] 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004).
[8] Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Sec. 507(d) (Dec. 18, 2015).
[9] We reiterate that to the extent that entities whose religious beliefs are not protected under the Weldon Amendment nonetheless object to CDMHC's letter, CDMHC has demonstrated its willingness to authorize insurers to offer products that exclude coverage for elective abortion to entities that qualify as religious employers under California law. *See* discussion of Anthem Blue Cross *supra*. Some employers may also, of course, decide to self-insure; self-insured plans are not subject to the CDMHC policy.

the State of California – including funds provided to the State not only by HHS but also by the Departments of Education and Labor, as well as other agencies. HHS' Office of General Counsel, after consulting with the Department of Justice, has advised that such a rescission would raise substantial questions about the constitutionality of the Weldon Amendment. Specifically, in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), the Supreme Court ruled that Congress could not condition a State's preexisting Medicaid funding on the State's compliance with an Affordable Care Act requirement to expand the program to include all low-income adults. The Court reasoned that this threat to terminate significant independent grants was so coercive as to deprive States of any meaningful choice whether to accept the condition attached to receipt of federal funds. Following accepted canons of statutory construction, OCR's approach, which is consistent with the views of the primary sponsor of the amendment, avoids this potentially unconstitutional application of the statute. *See Gomez v. United States*, 490 U.S. 858, 864 (1989).

Accordingly, OCR is closing its investigation of these complaints without further action.

Advisements

The determinations in this letter are not intended, nor should they be construed, to cover any issues regarding CDMHC's compliance with the Weldon Amendment that are not specifically addressed in this letter. It neither covers issues or authorities not specifically addressed herein nor precludes future determinations about compliance that are based on subsequent investigations.

The complainant has the right not to be intimidated, threatened, or coerced by a covered entity or other person because he or she has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing held in connection with a complaint. Please take all necessary steps to ensure that no adverse action is taken against the complainants or any other individual for the filing of this complaint, providing information to OCR, or otherwise participating in this investigation.

Under the Freedom of Information Act, it may be necessary to release this document and related correspondence and records upon request. In the event OCR receives such a request, we will seek to protect, to the extent provided by law, personal information which, if released, would constitute an unwarranted invasion of privacy.

Sincerely,

Jocelyn Samuels
Director, Office for Civil Rights

cc: Gabriel Ravel
Deputy Director, General Counsel
California Department of Managed Health Care

EXHIBIT C

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF THE SECRETARY**

Voice - (800) 368-1019 TDD - (800) 537-7697 Fax - (202) 619-3818
http://www.hhs.gov/ocr/

Office for Civil Rights
200 Independence Ave., SW
Washington, DC 20201

VIA U.S. MAIL AND ELECTRONIC MAIL (Xavier.Becerra@doj.ca.gov)

January 18, 2019

Xavier Becerra, Esq.
California Attorney General
California Department of Justice
P.O. Box 944255
Sacramento, CA 94244

Notice of Violation – OCR Transaction Numbers 16-224756 and 18-292848

Dear Attorney General Becerra:

This letter notifies you that the U.S. Department of Health & Human Services ("HHS") Office for Civil Rights ("OCR") has completed investigations of the complaints filed by Sacramento Life Center (OCR Transaction Number 16-224756),[1] and LivingWell Medical Clinic, Inc., Pregnancy Center of the North Coast, Inc., and Confidence Pregnancy Center, Inc. (OCR Transaction Number 18-292848)[2] (collectively, the "Complainants"). The Complainants allege that the State of California ("California") engaged in impermissible discrimination when it enacted the Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act (the "FACT Act"),[3] subjecting Complainants to potential fines if they refused to provide certain notices or refer for or make arrangements for abortion.

Under part 88 of 45 C.F.R., OCR is authorized to receive and handle complaints based on potential violations of the Weldon Amendment, the Church Amendments,[4] and the Coats-Snowe Amendment. OCR investigated the Complainants' allegations under the Weldon and Coats-Snowe Amendments by conducting clarifying interviews, reviewing documents, and propounding data requests to California. OCR also reviewed relevant pleadings, briefs, and court decisions from Complainants' Federal court litigation, as well as other relevant Federal court litigation. Based on its investigations, OCR has determined that California violated the Weldon Amendment[5] and the Coats-Snowe Amendment.[6]

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[1] Letter from James F. Sweeney, Attorney, to Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Nov. 4, 2015) (on file with HHS OCR).
[2] Letter from Francis J. Manion & Geoffrey R. Surtees, Attorneys, Am. Ctr. for Law & Justice, to Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Jan. 10, 2018) (on file with HHS OCR).
[3] Cal. Health & Safety Code Ann. §§ 123470 *et seq.*
[4] 42 U.S.C. § 300a-7. OCR closes these complaints without making any findings under these complaints as to whether the FACT Act violates the Church Amendments.
[5] *E.g.*, Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018).
[6] 42 U.S.C. § 238n.

BACKGROUND OF THE COMPLAINTS

1. Sacramento Life Center[7]

On November 4, 2015, Sacramento Life Center filed a complaint with OCR asserting that California discriminated against Sacramento Life Center in violation of the Weldon Amendment because it subjected Sacramento Life Center to potential fines for refusing to post the FACT Act's required notice in direct conflict with its convictions about abortion. This complaint with OCR was designated OCR Transaction Number 16-224756.

Sacramento Life Center is a non-profit, pro-life pregnancy resource center that is under the supervision of a medical director. It provides medical and other services, consistent with its convictions, that support pregnant mothers and the lives of their unborn children.[8] According to Sacramento Life Center's Complaint:

> The mission of the Sacramento Life Center is to offer compassion, support, resources, and free medical care to women and couples facing unplanned or unsupported pregnancies, by providing them with realistic, high quality options other than abortion. In addition to being a social service agency, it is also a state-licensed medical clinic committed to ensuring all women and teen girls have access to free, or low cost, medical care. The Sacramento Life Center is a private, non-denominational, non-profit charitable organization that serves everyone regardless of financial standing, ethnic background, or religion. It is opposed to abortion and has, for the past forty years, worked tirelessly to offer women in crisis pregnancies abortion alternatives and compassionate care.[9]

Sacramento Life Center provides abortion alternatives through staff and volunteers that include nurses, a sonogram technician, and a licensed physician.[10]

Sacramento Life Center meets the definition of a "licensed covered facility" under the FACT Act. It is "a facility licensed under Section 1204 or an intermittent clinic operating under a primary care clinic pursuant to subdivision (h) of Section 1206, whose primary purpose is providing family planning or pregnancy-related services;"[11] it "offers obstetric ultrasounds, obstetric sonograms, or prenatal care to pregnant women;"[12] it "offers pregnancy testing or

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[7] According to the plain text of the statutes, the Weldon and Coats-Snowe Amendments do not necessarily require the assertion of a religious or moral objection to abortion or abortion referrals. However, this Notice of Violation describes the Complainants, their beliefs, and their allegations, as well as the procedural background of their lawsuits where germane to OCR's completed investigations.

[8] OCR telephonic interview with Marie Leatherby, Exec. Dir., Sacramento Life Ctr. (Apr. 24, 2018) (on file with HHS OCR).

[9] Letter from James F. Sweeney, Attorney, to Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Nov. 4, 2015) (on file with HHS OCR).

[10] OCR telephonic interview with Marie Leatherby, Exec. Dir., Sacramento Life Ctr. (Apr. 24, 2018) (on file with HHS OCR).

[11] Cal. Health & Safety Code Ann. § 123471(a).

[12] *Id.* at § 123471(a)(1).

pregnancy diagnosis;"[13] it "advertises or solicits patrons with offers to provide prenatal sonography, pregnancy tests, or pregnancy options counseling;"[14] and it "has staff or volunteers who collect health information from clients."[15] Sacramento Life Center does not meet any of the FACT Act's exceptions.[16]

Because Sacramento Life Center meets the definition of a "licensed covered facility" under the FACT Act, it would be required to post notices stating that the state of California provides free or low-cost family planning services and abortion, and providing contact information on how to obtain such family planning services and abortion for qualifying members of the public.[17]

2. LivingWell Medical Clinic, Inc., Pregnancy Center of the North Coast, Inc., and Confidence Pregnancy Center, Inc.

On January 10, 2018, LivingWell Medical Clinic, Inc. ("LivingWell"); Pregnancy Center of the North Coast, Inc. ("North Coast"); and Confidence Pregnancy Center, Inc. ("Confidence") filed a complaint with OCR asserting that California discriminated against them in violation of both the Weldon and Coats-Snowe Amendments, because California subjected them to potential fines for refusing to post the FACT Act's required notice in direct conflict with their convictions about abortion. This complaint with OCR was designated OCR Transaction Number 18-292848.

LivingWell, North Coast, and Confidence are three non-profit, faith-based pregnancy resource centers that offer pregnancy-related care and counseling to pregnant mothers free of charge and consistent with their religious beliefs.[18] Because of those religious beliefs, LivingWell, North Coast, and Confidence will not perform, counsel for, refer for, or provide education about procedures that end human life through abortion or abortion-inducing drugs.[19]

According to the Complaint from LivingWell, North Coast, and Confidence, all three pregnancy resource centers "operate licensed clinics that provide services to women seeking help with unplanned pregnancies. Each of the Complainants, for religious reasons, objects to posting or distributing the State's dictated message, because they view it as requiring them to approve of

[13] *Id.* at § 123471(a)(3).
[14] *Id.* at § 123471(a)(4).
[15] *Id.* at § 123471(a)(6).
[16] *Id.* at § 123471(c).
[17] Cal. Health & Safety Code Ann. § 123472(a)(1); *see also Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2371 (2018) (under the FACT Act, "licensed clinics must provide a government-drafted script about the availability of state-sponsored services, as well as contact information for how to obtain them").
[18] OCR telephonic interview with Christine Morris, Exec. Dir., Confidence Pregnancy Ctr., Inc. (May 22, 2018) (on file with HHS OCR); OCR telephonic interview with Cindy Broese Van Groenou, Exec. Dir., Pregnancy Ctr. of the North Coast, Inc. (June 7, 2018) (on file with HHS OCR); OCR telephonic interview with Cathy Seapy, Chief Exec. Officer, LivingWell Med. Clinic, Inc. (June 12, 2018) (on file with HHS OCR).
[19] *Supra* note 18.

and refer for abortions."[20] LivingWell, North Coast, and Confidence provide abortion alternatives through staff and volunteers that include nurses, sonogram technicians, and licensed physicians.[21]

For the same reasons that Sacramento Life Center qualifies as a "licensed covered facility," LivingWell, North Coast, and Confidence also meet the definition of a "licensed covered facility" under the FACT Act. Nor do LivingWell, North Coast, or Confidence meet any of the FACT Act's exceptions.[22]

Accordingly, all three pregnancy resource centers would be required to post notices stating that the State of California provides free or low-cost family planning services and abortion and providing contact information to members of the public. [23]

PROCEDURAL BACKGROUND

On September 9, 2015, the California legislature passed the FACT Act, which was signed into law by Governor Jerry Brown on October 9, 2015, and went into effect on January 1, 2016.

On October 27, 2015, LivingWell, North Coast, and Confidence filed for injunctive relief against California in U.S. District Court for the Northern District of California, alleging that the FACT Act required them to post a government-dictated message they did not wish to communicate in violation of the First Amendment to the U.S. Constitution, among other grounds.[24]

On December 18, 2015, the District Court denied LivingWell, North Coast, and Confidence's motion for a preliminary injunction, as well as a stay of the FACT Act pending appeal.[25] LivingWell, North Coast, and Confidence appealed to the Ninth Circuit Court of Appeals, which affirmed the District Court on October 14, 2016.[26] LivingWell, North Coast, and Confidence appealed to the U.S. Supreme Court.

OCR conducted an investigation following receipt of the complaints from Sacramento Life Center, LivingWell, North Coast, and Confidence. As part of OCR's investigations, OCR conducted interviews with representatives from each Complainant and submitted detailed data requests to California requesting information on the FACT Act, California's interpretation of the FACT Act, and California's enforcement of the FACT Act.[27]

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[20] Letter from Francis J. Manion & Geoffrey R. Surtees, Attorneys, Am. Ctr. for Law & Justice, to Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Jan. 10, 2018) (on file with HHS OCR).
[21] OCR telephonic interview with Christine Morris, Exec. Dir., Confidence Pregnancy Ctr., Inc. (May 22, 2018) (on file with HHS OCR); OCR telephonic interview with Cindy Broese Van Groenou, Exec. Dir., Pregnancy Ctr. of the North Coast, Inc. (June 7, 2018) (on file with HHS OCR); OCR telephonic interview with Cathy Seapy, Chief Exec. Officer, LivingWell Med. Clinic, Inc. (June 12, 2018) (on file with HHS OCR).
[22] Cal. Health & Safety Code Ann. § 123471(c).
[23] *Id.* at § 123472(a)(1).
[24] *LivingWell Med. Clinic, Inc. v. Harris,* No. 15-CV-04939, 2015 WL 13187682 (N.D. Cal. 2015).
[25] *Id.*
[26] *LivingWell Med. Clinic, Inc. v. Harris,* 669 Fed. Appx. 493 (9th Cir. 2016).
[27] Letter from Molly Wlodarczyk, Senior Investigator, Pacific Region, Office for Civil Rights, U.S. Dep't of Health & Human Servs., to Cal. Gov. Edmund G. Brown, Jr., Cal. Attorney Gen. Xavier Becerra, and Cal. Sec'y of Health

On June 26, 2018, the Supreme Court issued its opinion in *National Institute of Family and Life Advocates v. Becerra,* 138 S. Ct. 2361 (2018) (*"NIFLA"*), in which it held that the plaintiffs in that case were likely to prevail on the merits of their claim that the FACT Act violated their First Amendment right of free speech.[28] The Supreme Court found that the FACT Act requires pregnancy resource centers like Complainants to "provide a government-drafted script about the availability of state-sponsored services, as well as contact information for how to obtain them. One of those services is abortion—the very practice that [Complainants] are devoted to opposing."[29]

The Supreme Court further stated in *NIFLA* that, with respect to "licensed covered facilities," the FACT Act is a content based regulation that compels speech, is "wildly underinclusive," and in no way relates to the services provided by entities covered by the law.[30]

With respect to "unlicensed covered facilities," the Supreme Court stated that the FACT Act targets pro-life pregnancy resource centers and imposes an unduly burdensome notice requirement that will chill their protected speech.[31]

On June 28, 2018, the Supreme Court granted LivingWell, North Coast, and Confidence's petition for writ of certiorari, vacated the Ninth Circuit Court of Appeals' judgement, and remanded the case for further consideration in light of *NIFLA*.[32] The Ninth Circuit subsequently reversed in part, vacated in part, and remanded the case back to the District Court for further consideration in light of *NIFLA* on August 28, 2018.[33]

Following the Supreme Court's *NIFLA* decision protecting pro-life pregnancy resource centers from coerced speech, OCR requested additional information from California regarding its intentions to enforce the FACT Act.[34] The California Attorney General's office responded on August 14, 2018, by stating, "[G]iven the status of pending litigation regarding the Act, this office has no plans to enforce the Act against any facility."[35]

& Human Servs. Agency Diane S. Dooley Sept. 29, 2017) (on file with HHS OCR); Letter from Luis E. Perez, Deputy Dir., Conscience & Religious Freedom Div., Office for Civil Rights, U.S. Dep't of Health & Human Servs., to Cal. Attorney Gen. Xavier Becerra (July 17, 2018) (on file with HHS OCR); and Letter from Luis E. Perez, Deputy Dir., Conscience & Religious Freedom Div., Office for Civil Rights, U.S. Dep't of Health & Human Servs., to Cal. Gov. Edmund G. Brown, Jr., Cal. Attorney Gen. Xavier Becerra, and Cal. Sec'y of Health & Human Servs. Agency Diane S. Dooley (July 26, 2018) (on file with HHS OCR).

[28] 138 S. Ct. 2361, 2378 (2018).

[29] *Id.* at 2371.

[30] *Id.* at 2367.

[31] *Id.* at 2377.

[32] *LivingWell Med. Clinic, Inc. v. Becerra,* 138 S. Ct. 2701 (Mem) (2018).

[33] *LivingWell Med. Clinic, Inc. v. Becerra,* 901 F.3d 1168 (9th Cir. 2018).

[34] Letter from Luis E. Perez, Deputy Dir., Conscience & Religious Freedom Div., Office for Civil Rights, U.S. Dep't of Health & Human Servs., to Cal. Attorney Gen. Xavier Becerra (July 17, 2018) (on file with HHS OCR); and Letter from Luis E. Perez, Deputy Dir., Conscience & Religious Freedom Div., Office for Civil Rights, U.S. Dep't of Health & Human Servs., to Cal. Gov. Edmund G. Brown, Jr., Cal. Attorney Gen. Xavier Becerra, and Cal. Sec'y of Health & Human Servs. Agency Diane S. Dooley (July 26, 2018) (on file with HHS OCR).

[35] Letters from Jose A. Zelidon-Zepeda, Deputy Attorney Gen., to Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Aug. 14, 2018 & Aug. 24, 2018) (on file with HHS OCR).

On October 26, 2018, pursuant to the parties' stipulated judgment, the U.S. District Court for the Southern District of California entered a permanent injunction in favor of the plaintiffs and against California concerning the FACT Act.[36] The court order permanently enjoins California from enforcing the FACT Act and does not limit is application to the named plaintiffs. Thus, the injunction also protects Sacramento Life Center, LivingWell, North Coast, Confidence, and all similarly-situated pregnancy resource centers in California, both licensed and unlicensed.

JURISDICTION AND OCR'S INVESTIGATION

As a recipient of Federal funds from HHS that are subject to the Weldon and Coats-Snowe Amendments, California is subject to the terms of the Weldon and Coats-Snowe Amendments. The Weldon Amendment states, in relevant part:

> None of the funds made available in this Act may be made available to a . . . State or local government, if such . . . government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.[37]

The Coats-Snowe Amendment states, in relevant part:

> The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that—(1) the entity refuses to … perform [induced] abortions, or to provide referrals for … such abortions, [or] (2) the entity refuses to make arrangements for any of the activities specified in paragraph (1).[38]

Throughout the FACT Act's introduction, passage, and enactment into law, California has received, and continues to receive, Federal financial assistance made available in the annual Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act. Based on the plain language of the Weldon and Coats-Snowe Amendments, California is prohibited from discriminating against a health care entity on the basis that the entity does not "refer for abortions" or make arrangements for abortion.[39]

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[36] Order RE: Permanent Injunction at 2, *Nat'l Inst. of Family & Life Advocates v. Becerra,* No. 3:15-cv-02277 (S.D. Cal., Oct. 26, 2018).

[37] Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018). The Weldon Amendment defines "health care entity" as including (and, thus, not limited to) "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." *Id.* at § 507(d)(2).

[38] 42 U.S.C. § 238n. The Coats-Snowe Amendment defines "health care entity" as including (and, thus, not limited to) "an individual physician, a postgraduate training program, and a participant in a program of training in the health professions." *Id.* at § 238n(c)(2).

[39] Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018); 42 U.S.C. § 238n(a)(1) & (2).

FINDINGS AND ANALYSIS[40]

1. California's FACT Act Requires Pro-Life Pregnancy Resource Centers that Meet the Definition of a "Licensed Covered Facility" to Post State-Mandated Notices Referring Their Clients for Abortion

The FACT Act requires all pregnancy resource centers that meet the definition of a "licensed covered facility" to publicly post the following notice:

> California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women. To determine whether you qualify, contact the county social services office at [insert the telephone number].[41]

The FACT Act dictates, among other things, the notice's location, timing of presentation, medium, and the number of languages it must be stated in.[42] As set forth above, each Complainant satisfies the FACT Act's definition of a "licensed covered facility," and is therefore subject to the notice requirement.

In *NIFLA*, the Supreme Court said the following about the FACT Act's notice requirements for pregnancy resource centers that meet the definition of a "licensed covered facility":

> This notice must be posted in the waiting room, printed and distributed to all clients, or provided digitally at check-in. §123472(a)(2). The notice must be in English and any additional languages identified by state law. §123472(a). In some counties, that means the notice must be spelled out in 13 different languages. See State of Cal., Dept. of Health Care Services, Frequency of Threshold Language Speakers in the MediCal Population by County for Jan. 2015, pp. 4–5 (Sept. 2016) (identifying the required languages for Los Angeles County as English, Spanish, Armenian, Mandarin, Cantonese, Korean, Vietnamese, Farsi, Tagalog, Russian, Cambodian, Other Chinese, and Arabic).[43]

2. California's FACT Act Requires Pro-Life Pregnancy Resource Centers that Meet the Definition of an "Unlicensed Covered Facility" to Post State-Mandated Notices

The FACT Act also requires all pregnancy resource centers that meet the definition of an "unlicensed covered facility" to publicly post the following notice:

> This facility is not licensed as a medical facility by the State of California and has

[40] The findings in this letter are not intended, nor should they be construed, to cover any matters not specifically addressed.
[41] Cal. Health & Safety Code Ann. § 123472(a)(1).
[42] *Id.* at § 123472. *See also Nat'l Inst. of Family & Life Advocates*, 138 S. Ct. at 2369.
[43] *Nat'l Inst. of Family & Life Advocates*, 138 S. Ct. at 2369.

> no licensed medical provider who provides or directly supervises the provision of services.[44]

Like the notice requirement for a "licensed covered facility," the FACT Act dictates the placement, dimensions, and language(s) of the notice requirement for an "unlicensed covered facility." In its *NIFLA* decision, the Supreme Court summarized the mandate's requirements accordingly:

> This notice must be provided on site and in all advertising materials. §§123472(b)(2), (3). Onsite, the notice must be posted 'conspicuously' at the entrance of the facility and in at least one waiting area. §123472(b)(2). It must be 'at least 8.5 inches by 11 inches and written in no less than 48-point type.' Ibid. In advertisements, the notice must be in the same size or larger font than the surrounding text, or otherwise set off in a way that draws attention to it. §123472(b)(3).
>
> Like the licensed notice, the unlicensed notice must be in English and any additional languages specified by state law. §123471(b). Its stated purpose is to ensure 'that pregnant women in California know when they are getting medical care from licensed professionals.' Cal. Legis. Serv., §1(e).
>
> As California conceded at oral argument, a billboard for an unlicensed facility that says 'Choose Life' would have to surround that two-word statement with a 29-word statement from the government, in as many as 13 different languages.[45]

3. Failure to Post the State-Mandated Notice Subjects a Pro-Life Pregnancy Resource Center to the Threat of Financial Penalties, Litigation by California's State and Local Governmental Authorities, and Associated Costs and Attorney Fees

A violation of the FACT Act called for a civil fine of $500 for a first offense and $1,000 for each subsequent offense. Either the California Attorney General, a city attorney, or a county counsel were authorized to bring an action to enforce the FACT Act.[46]

4. The FACT Act Provides Broad Exemptions from its Mandates and Penalties – But not for Pro-Life Pregnancy Resource Centers

The U.S. Supreme Court deemed the underinclusive nature of the FACT Act to be tantamount to targeting pro-life pregnancy resource centers based upon their views regarding abortion:

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[44] Cal. Health & Safety Code Ann. § 123472(b)(1).
[45] *Nat'l Inst. of Family & Life Advocates,* 138 S. Ct. at 2370, 2378.
[46] Cal. Health & Safety Code Ann. § 123473(a). *Cf. Hobby Lobby v. Burwell,* 134 S. Ct. 2751, 2779 (2014) (holding that a threatened imposition of a penalty unlawfully burdened plaintiffs' religious freedom).

> The California State Legislature enacted the FACT Act to regulate crisis pregnancy centers. Crisis pregnancy centers—according to a report commissioned by the California State Assembly …—are 'pro-life (largely Christian belief-based) organizations that offer a limited range of free pregnancy options, counseling, and other services to individuals that visit a center.'
>
> '[U]nfortunately,' the author of the FACT Act stated, 'there are nearly 200 licensed and unlicensed' crisis pregnancy centers in California. These centers 'aim to discourage and prevent women from seeking abortions. The author of the FACT Act observed that crisis pregnancy centers 'are commonly affiliated with, or run by organizations whose stated goal' is to oppose abortion…. [47]

According to the Supreme Court in *NIFLA*, the FACT Act's suspicious triggering thresholds and exceptions belie the State's purported goal of increasing public awareness of the unlicensed status of pregnancy related facilities:

> The unlicensed notice imposes a government-scripted, speaker-based disclosure requirement that is wholly disconnected from California's informational interest. . . . And it covers a curiously narrow subset of speakers. . . . a facility that advertises and provides pregnancy tests is covered by the unlicensed notice, but a facility across the street that advertises and provides nonprescription contraceptives is excluded—even though the latter is no less likely to make women think it is licensed.[48]

Justice Kennedy's concurring opinion also described how California targeted pro-life pregnancy resource centers for disfavor:

> It does appear that viewpoint discrimination is inherent in the design and structure of this Act. This law is a paradigmatic example of the serious threat presented when government seeks to impose its own message in the place of individual speech, thought, and expression. For here the State requires primarily pro-life pregnancy centers to promote the State's own preferred message advertising abortions. This compels individuals to contradict their most deeply held beliefs, beliefs grounded in basic philosophical, ethical, or religious precepts, or all of these.[49]

5. <u>The FACT Act Violated the Weldon and Coats-Snowe Amendments</u>

California's enactment of the FACT Act violates the Weldon and Coats-Snowe Amendments by discriminating against health care entities that object to referring for, or making arrangements for, abortion.

The Supreme Court held in *NIFLA* that the FACT Act deprives pro-life pregnancy resource

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[47] *Nat'l Inst. of Family & Life Advocates,* 138 S.Ct. at 2368-2370.
[48] *Id.* at 2378.
[49] *Id.* at 2379 (Kennedy, J., concurring) (explaining why California's FACT Act likely violates the First Amendment).

centers of their First Amendment rights because the FACT Act impermissibly compels speech. The FACT Act forces pro-life pregnancy resource centers "to promote the State's own preferred message advertising abortions."[50] By targeting those who will not promote its message, California engaged in discrimination prohibited by the Supreme Court and forbidden by the Weldon and Coats-Snowe Amendments.

Under the Weldon Amendment, a covered state or local government has a duty to refrain from subjecting "any . . . health care entity to discrimination on the basis that the health care entity does not . . . refer for abortions."[51] The same is true under the Coats-Snowe Amendment: a covered state or local government has a duty to refrain from subjecting "any health care entity to discrimination on the basis that … the entity refuses to … provide referrals … for abortion … [or] make arrangements for [abortion]."[52]

The Weldon and Coats-Snowe Amendments both define "health care entity" in an illustrative, non-exhaustive fashion. Pursuant to the Weldon Amendment, "the term 'health care entity' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."[53] Pursuant to the Coats-Snowe Amendment, "The term 'health care entity' includes an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions."[54] Accordingly, the "licensed covered facilities," as defined by the FACT Act, qualify as "health care entities" under Weldon and Coats-Snowe, and are therefore subject to the Amendments' protections. While OCR does not, at this time, make a determination as to whether every entity that is designated as an "unlicensed covered facility" under the FACT Act would constitute a "health care entity" under either the Weldon or Coats-Snowe Amendments, OCR finds that at least those "unlicensed covered facilities" that provide obstetric ultrasounds/sonograms and prenatal care qualify as "health care entities" under the Weldon Amendment and are subject to that Amendment's protections.

California subjected pro-life pregnancy resource centers that meet the definition of a "licensed covered facility" and at least some that meet the definition of an "unlicensed covered facility" to an untenable choice that violates the Weldon and/or Coats-Snowe Amendments: violate the FACT Act and face financial penalties, lawsuits, attorney fees, costs, and fines, or violate their protected right to be free from discrimination on the basis that they will not refer for or make arrangements for abortions.

This ultimatum facially violates the Weldon Amendment and Coats-Snowe Amendment as to entities designated as "licensed covered facilities" by requiring that they refer for abortions against their will. The ultimatum also violates the Weldon Amendment as applied to those

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[50] *Nat'l Inst. of Family & Life Advocates*, 138 S. Ct. at 2379 (Kennedy, J., concurring).
[51] *E.g.*, Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018).
[52] 42 U.S.C. § 238n.
[53] *E.g.*, Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. at 764; 42 U.S.C. § 238n.
[54] 42 U.S.C. § 238n(c)(2).

"unlicensed covered facilities" that qualify as health care entities under the Weldon Amendment, because the FACT Act subjects such facilities to discrimination by targeting them for burdensome and unnecessary notice requirements because they do not refer for abortion.[55]

CONCLUSION AND REMEDY

For all the above reasons, OCR finds that California's FACT Act violates the Weldon and Coats-Snowe Amendments. OCR has determined that the FACT Act's provisions facially violate the Weldon and Coats-Snowe Amendments with respect to entities designated as "licensed covered facilities" under the FACT Act and, as applied, violate the Weldon Amendment with respect to certain entities designated as "unlicensed covered facilities." Therefore, the FACT Act cannot be enforced under the Weldon and Coats-Snowe Amendments.

OCR took into account California's representation that the State of California will not enforce the challenged provisions of the FACT Act against any facility, including Complainants.[56] Ordinarily, OCR would require California's assurances be made binding as to complainants and all similarly situated parties through a voluntary resolution agreement; however, in light of the District Court's entering of a permanent injunction against any enforcement of the FACT Act against any covered entities (both licensed and unlicensed),[57] a voluntary resolution agreement is not necessary as California's adherence to the court's permanent injunction is a sufficient remedy to the violations found by OCR in this Notice.

OCR is therefore closing these complaints as satisfactorily resolved. However, if California were to violate the terms of the injunction it would be subject to a reopening of the complaints and further enforcement action by OCR.

OCR reminds the State of California to take all necessary steps to ensure that no adverse action is taken against the Complainants or any other health care entities discriminated against, or any other individual, for the filing of these complaints, providing information to OCR, or otherwise participating in this investigation. OCR's closing of these complaints does not preclude future investigations based on new complaints or changed circumstances.

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[55] *Nat'l Inst. of Family & Life Advocates,* 138 S. Ct. at 2378 ("The unlicensed notice imposes a government-scripted, speaker-based disclosure requirement that is wholly disconnected from California's informational interest. . . . And it covers a curiously narrow subset of speakers. While the licensed notice applies to facilities that provide 'family planning' services and 'contraception or contraceptive methods,' § 123471(a), the California Legislature dropped these triggering conditions for the unlicensed notice.").

[56] Letters from Jose A. Zelidon-Zepeda, Deputy Attorney Gen., to Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Aug. 14, 2018 & Aug. 24, 2018) (on file with HHS OCR).

[57] Order RE: Permanent Injunction at 2, *Nat'l Inst. of Family & Life Advocates v. Becerra,* No. 3:15-cv-02277 (S.D. Cal., Oct. 26, 2018).

Sincerely,

/s/

Roger T. Severino
Director
Office for Civil Rights

EXHIBIT D

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CONSCIENTIOUS OBJECTION

Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses

Wendy Chavkin [a,b,c,*], Liddy Leitman [a], Kate Polin [a]; for Global Doctors for Choice

[a] *Global Doctors for Choice, New York, USA*
[b] *College of Physicians and Surgeons, Columbia University, New York, USA*
[c] *Mailman School of Public Health, Columbia University, New York, USA*

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ABSTRACT

Background: Global Doctors for Choice—a transnational network of physician advocates for reproductive health and rights—began exploring the phenomenon of conscience-based refusal of reproductive healthcare as a result of increasing reports of harms worldwide. The present White Paper examines the prevalence and impact of such refusal and reviews policy efforts to balance individual conscience, autonomy in reproductive decision making, safeguards for health, and professional medical integrity.

Objectives and search strategy: The White Paper draws on medical, public health, legal, ethical, and social science literature published between 1998 and 2013 in English, French, German, Italian, Portuguese, and Spanish. Estimates of prevalence are difficult to obtain, as there is no consensus about criteria for refuser status and no standardized definition of the practice, and the studies have sampling and other methodologic limitations. The White Paper reviews these data and offers logical frameworks to represent the possible health and health system consequences of conscience-based refusal to provide abortion; assisted reproductive technologies; contraception; treatment in cases of maternal health risk and inevitable pregnancy loss; and prenatal diagnosis. It concludes by categorizing legal, regulatory, and other policy responses to the practice.

Conclusions: Empirical evidence is essential for varied political actors as they respond with policies or regulations to the competing concerns at stake. Further research and training in diverse geopolitical settings are required. With dual commitments toward their own conscience and their obligations to patients' health and rights, providers and professional medical/public health societies must lead attempts to respond to conscience-based refusal and to safeguard reproductive health, medical integrity, and women's lives.

1. Introduction

How can societies find the proper balance between women's rights to receive the reproductive healthcare they need and healthcare providers' rights to exercise their conscience? Global Doctors for Choice (GDC)—a transnational network of physician advocates for reproductive health and rights (www.globaldoctorsforchoice.org)—began exploring the phenomenon of conscience-based refusal of reproductive healthcare in response to increasing reports of harms worldwide. The present White Paper addresses the varied interests and needs at stake when clinicians claim conscientious objector status when providing certain elements of reproductive healthcare. (While GDC represents physicians, in the present White Paper we use the terms providers or clinicians to also address refusal of care by nurses, midwives, and pharmacists.) As the focus is on health, we examine data on the prevalence of refusal; lay out the potential consequences for the health of patients and the impact on other health providers and health systems; and report on legal, regulatory, and professional responses. Human rights are intertwined with health, and we draw upon human rights frameworks and decisions throughout. We also refer to bedrock bioethical principles that undergird the practice of medicine in general, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care that is urgently needed. Others have underscored the consequences of negotiating conscientious objection in healthcare in terms of secular/religious tension. Our contribution, which complements all of this previous work, is to provide the medical and public health perspectives and the evidence. We focus on the rights of the provider who conscientiously objects, together with that provider's professional obligations; the rights of the women who need healthcare and the consequences of refusal for their health; and the impact on the health system as a whole.

Conscientious objection is the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs [1]. This originated as opposition to mandatory military service but has increasingly been

* Corresponding author: Wendy Chavkin, 60 Haven Avenue B-2, New York, NY 10032, USA. Tel.: +1 646 649 9903; fax: +1 646 366 1897.
E-mail address: wendy@globaldoctorsforchoice.org; wc9@columbia.edu (W. Chavkin).

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raised in a wide variety of contested contexts such as education, capital punishment, driver's license requirements, marriage licenses for same-sex couples, and medicine and healthcare. While health providers have claimed conscientious objection to a variety of medical treatments (e.g. end-of-life palliative care and stem cell treatment), the present White Paper addresses conscientious objection to providing certain components of reproductive healthcare. (The terms conscientious objection and conscience-based refusal of care are used interchangeably throughout.) Refusal to provide this care has affected a wide swath of diagnostic procedures and treatments, including abortion and postabortion care; components of assisted reproductive technologies (ART) relating to embryo manipulation or selection; contraceptive services, including emergency contraception (EC); treatment in cases of unavoidable pregnancy loss or maternal illness during pregnancy; and prenatal diagnosis (PND).

Efforts have been made to balance the rights of objecting providers and other health personnel with those of patients. International and regional human rights conventions such as the Convention on the Elimination of All Forms of Discrimination against Women [2], the International Covenant on Civil and Political Rights (ICCPR) [1], the American Convention on Human Rights [3], and the European Convention for the Protection of Human Rights and Fundamental Freedoms [4], as well as UN treaty-monitoring bodies [5,6], have recognized both the right to have access to quality, affordable, and acceptable sexual and reproductive healthcare services and/or the right to freedom of religion, conscience, and thought. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa recognizes the right to be free from discrimination based on religion and acknowledges the right to health, especially reproductive health, as a key human right [7]. These instruments negotiate these apparently competing rights by stipulating that individuals have a right to belief but that the freedom to manifest one's religion or beliefs can be limited in order to protect the rights of others.

The ICCPR, a central pillar of human rights that gives legal force to the 1948 UN Universal Declaration of Human Rights, states in Article 18(1) that [1]:

> Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

Article 18(3), however, states that [1]:

> Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

International professional associations such as the World Medical Association (WMA) [8] and FIGO [9]—as well as national medical and nursing societies and groups such as the American Congress of Obstetricians and Gynecologists (ACOG) [10]; Grupo Médico por el Derecho a Decidir/GDC Colombia [11]; and the Royal College of Nursing, Australia [12]—have similarly agreed that the provider's right to conscientiously refuse to provide certain services must be secondary to his or her first duty, which is to the patient. They specify that this right to refuse must be bounded by obligations to ensure that the patient's rights to information and services are not infringed.

Conscience-based refusal of care appears to be widespread in many parts of the world. Although rigorous studies are few, estimates range from 10% of OB/GYNs refusing to provide abortions reported in a UK study [13] to almost 70% of gynecologists who registered as conscientious objectors to abortion with the Italian Ministry of Health [14]. While the impact of the loss of providers may be immediate and most obvious in countries in which maternal death rates from pregnancy, delivery, and illegal abortion are high and represent major public health concerns, consequences at individual and systemic levels have also been reported in resource-rich settings. At the individual level, decreased access to health services brought about by conscientious objection has a disproportionate impact on those living in precarious circumstances, or at otherwise heightened risk, and aggravates inequities in health status. Indeed, too many women, men, and adolescents lack access to essential reproductive healthcare services because they live in countries with restrictive laws, scant health resources, too few providers and slots to train more, and limited infrastructure for healthcare and means to reach care (e.g. roads and transport). The inadequate number of providers is further depleted by the "brain drain" when trained personnel leave their home countries for more comfortable, technically fulfilling, and lucrative careers in wealthier lands [15]. Access to reproductive healthcare is additionally compromised when gynecologists, anesthesiologists, generalists, nurses, midwives, and pharmacists cite conscientious objection as grounds for refusing to provide specific elements of care.

The level of resources allocated by the health system greatly influences the impact caused by the loss of providers due to conscience-based refusal of care. In resource-constrained settings, where there are too few providers for population need, it is logical to assume the following chain of events: further reductions in available personnel lead to greater pressure on those remaining providers; more women present with complications due to decreased access to timely services; and complications require specialized services such as maternal/neonatal intensive care and more highly trained staff, in addition to incurring higher costs. The increased demand for specialized services and staffing burdens and diverts the human and infrastructural resources available for other priority health conditions. However, it is difficult to disentangle the impact of conscientious objection when it is one of many barriers to reproductive healthcare. It is conceptually and pragmatically complicated to sort the contribution to constrained access to reproductive care attributable to conscientious objectors from that due to limited resources, restrictive laws, or other barriers.

What are the criteria for establishing objector status and who is eligible to do so? In the military context, conscientious objector applicants must satisfy numerous procedural requirements and must provide evidence that their beliefs are sincere, deeply held, and consistent [16]. These requirements aim to parse genuine objectors from those who conflate conscientious objection with political or personal opinion. For example, the true conscientious objector to military involvement would refuse to fight in any war, whereas the latter describes someone who disagrees with a particular war but who would be willing to participate in a different, "just" war. Study findings and anecdotal reports from many countries suggest that some clinicians claim conscientious objection for reasons other than deeply held religious or ethical convictions. For example, some physicians in Brazil who described themselves as objectors were, nonetheless, willing to obtain or provide abortions for their immediate family members [17]. A Polish study described clinicians, such as those referred to as the White Coat Underground, who claim conscientious objection status in their public sector jobs but provide the same services in their fee-paying private practices [18]. Other investigations indicate that some claim objector status because they seek to avoid being associated with stigmatized services, rather than because they truly conscientiously object [19].

Moreover, some religiously affiliated healthcare *institutions* claim objector status and compel their employees to refuse to provide

legally permissible care [20,21]. The right to conscience is generally understood to belong to an individual, not to an institution, as claims of conscience are considered a way to maintain an individual's moral or religious integrity. Some disagree, however, and argue that a hospital's mission is analogous to a conscience–identity resembling that of an individual, and "warrant[s] substantial deference" [22]. Others dispute this on the grounds that healthcare institutions are licensed by states, often receive public financing, and may be the sole providers of healthcare services in communities. Wicclair and Charo both argue that, since a license bestows certain rights and privileges on an institution [22–24], "[W]hen licensees accept and enjoy these rights and privileges, they incur reciprocal obligations, including obligations to protect patients from harm, promote their health, and respect their autonomy" [22].

There are also disputes as to whether obligations and rights vary if a provider works in the public or private sector. Public sector providers are employees of the state and have obligations to serve the public for the greater good, providing the highest "standard of care," as codified in the laws and policies of the state [22]. The Institute of Medicine in the USA defines standard of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" and identifies safety, effectiveness, patient centeredness, and timeliness as key components [25]. WHO adds the concepts of equitability, accessibility, and efficiency to the list of essential components of quality of care [26]. There are legal precedents limiting the scope of conscientious objection for professionals who operate as state actors [23]. Some argue that such limitations can be extended to those who provide health services in the private sector because, as state licensure grants these professions a monopoly on a public service, the professions have a collective obligation to patients to provide non-discriminatory access to all lawful services [23,27]. However, it is more difficult to identify conscience-based refusal of care in the private sector because clinicians typically have discretion over the services they choose to offer, although the same professional obligations of providing patients with accurate information and referral pertain.

An alternative framing is provided by the concept of *conscientious commitment* to acknowledge those providers whose conscience motivates them to deliver reproductive health services and who place priority on patient care over adherence to religious doctrines or religious self-interest [28,29]. Dickens and Cook articulate that conscientious commitment "inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health" [28]. They assert that, because provision of care can be conscience based, full respect for conscience requires accommodation of both objection to participation and commitment to performance of services such that the latter group of providers also have the right to not suffer discrimination on the basis of their convictions [28]. This principle is articulated by FIGO [9]; according to the FIGO "Resolution on Conscientious Objection," "Practitioners have a right to respect for their conscientious convictions in respect both not to undertake and to undertake the delivery of lawful procedures" [30].

We begin the present White Paper with a review of the limited data regarding the prevalence of conscience-based refusal of care and objectors' motivations. Descriptive prevalence data are needed in order to assess the distribution and scope of this phenomenon and it is necessary to understand the concerns of those who refuse in order to design respectful and effective responses. We review the data; point out the methodologic, geographic, and other limitations; and specify some questions requiring further investigation. Next, we explore the consequences of conscientious objection for patients and for health systems. Ideally, we would evaluate empirical evidence on the impact of conscience-based refusal on delay in obtaining care for patients and their families, society, healthcare providers, and health systems. As such research has not been conducted, we schematically delineate the logical sequence of events if care is refused.

We then look at responses to conscience-based refusal of care by transnational bodies, governments, health sector and other employers, and professional associations. These responses include establishment of criteria for obtaining objector status, required disclosure to patients, registration of objector status, mandatory referral to willing providers, and provision of emergency care. We draw upon analyses performed by others to categorize the different models used: legislative, constitutional, case law, regulatory, employment requirements, and professional standards of care. Finally, we provide recommendations for further research and for ways in which medical and public health organizations could contribute to the development and implementation of policies to manage conscientious objection.

The present White Paper draws upon medical, public health, legal, ethical, and social science literature of the past 15 years in English, French, German, Italian, Portuguese, and Spanish available in 2013. It is intended to be a state-of-the-art compendium useful for health and other policymakers negotiating the balance of an individual provider's rights to "conscience" with the systemic obligation to provide care and it will need updating as further evidence and policy experiences accrue. It is intended to highlight the importance of the medical and public health perspectives, employ a human rights framework for provision of reproductive health services, and emphasize the use of scientific evidence in policy deliberations about competing rights and obligations.

2. Review of the evidence

2.1. Methods

We reviewed data regarding the prevalence of conscientious objection and the motivations of objectors in order to assess the distribution and scope of the phenomenon and to have an empirical basis for designing respectful and effective responses. However, estimates of prevalence are difficult to obtain; there is no consensus about criteria for objector status and, thus, no standardized definition of the practice. Moreover, it is difficult to assess whether findings in some studies reflect intention or actual behavior. The few countries that require registration provide the most solid evidence of prevalence.

A systematic review could not be performed because the data are limited in a variety of ways (which we describe), making most of them ineligible for inclusion in such a process. We searched systematically for data from quantitative, qualitative, and ethnographic studies and found that many have non-representative or small samples, low response rates, and other methodologic limitations that limit their generalizability. Indeed, the studies reviewed are not comparable methodologically or topically. The majority focus on conscience-based refusal of abortion-related care and only a few examine refusal of emergency or other contraception, PND, or other elements of care. Some examine provider attitudes and practices related to abortion in general, while others investigate these in terms of the specific circumstances for which people seek the service: for example, financial reasons, sex selection, failed contraception, rape/incest, fetal anomaly, and maternal life endangerment. Some rely on closed-ended electronic or mail surveys, while others employ in-depth interviews. Most focus on physicians; fewer study nurses, midwives, or pharmacists.

These investigations are also limited geographically because more were conducted in higher-income than lower-income countries. Because of both greater resources and more liberalized reproductive health laws and policies, many higher-income coun-

tries offer a greater range of legal services and, consequently, more opportunities for objection. Assessment of the impact of conscience-based refusal of care in resource-constrained settings presents additional challenges because high costs and lack of skilled providers may dwarf this and other factors that impede access. Acknowledging that conscientious objection to reproductive healthcare has yet to be rigorously studied, we included all studies we were able to locate within the past 15 years, and present the cross-cutting themes as topics for future systematic investigation.

2.2. Prevalence and attitudes

The sturdiest estimates of prevalence come from a limited sample of those few places that require objectors to register as such or to provide written notification. 70% of OB/GYNs and 50% of anesthesiologists have registered with the Italian Ministry of Health as objectors to abortion [31]. While Norway and Slovenia require some form of registration, neither has reported prevalence data [32–34]. Other estimates of prevalence derive from surveys with varied sampling strategies and response rates. In a random sample of OB/GYN trainees in the UK, almost one-third objected to abortion [35]. 14% of physicians of varied specialties surveyed in Hong Kong reported themselves to be objectors [36]. 17% of licensed Nevada pharmacists surveyed objected to dispensing mifepristone and 8% objected to EC [37]. A report from Austria describes many regions without providers and a report from Portugal indicates that approximately 80% of gynecologists there refuse to perform legal abortions [38–40].

Other studies have investigated opinions about abortion and intention to provide services. A convenience sample of Spanish medical and nursing students indicated that most support access to abortion and intend to provide it [41]. A survey of medical, nursing, and physician assistant students at a US university indicated that more than two-thirds support abortion yet only one-third intend to provide, with the nursing and physician assistant students evincing the strongest interest in doing so [42]. The 8 traditional healers interviewed in South Africa were opposed to abortion [43], and an ethnographic study of Senegalese OB/GYNs, midwives, and nurses reported that one-third thought the highly restrictive law there should permit abortion for rape/incest, although very few were willing to provide services (unpublished data).

Some studies indicate that a subset of providers claim to be conscientious objectors when, in fact, their objection is not absolute. Rather, it reflects opinions about patient characteristics or reasons for seeking a particular service. For example, a stratified random sample of US physicians revealed that half refuse contraception and abortion to adolescents without parental consent, although the law stipulates otherwise [44]. A survey of members of the US professional society of pediatric emergency room physicians indicated that the majority supported prescription of EC to adolescents but only a minority had done so [45]. A study of the postabortion care program in Senegal, intended to reduce morbidity and mortality due to complications from unsafe abortion, found that some providers nonetheless delayed care for women they suspected of having had an induced abortion (unpublished data).

Willingness to provide abortions varies by clinical context and reason for abortion, as demonstrated by a stratified random sample of OB/GYN members of the American Medical Association (AMA) [46]. A survey of family medicine residents in the USA assessing prevalence of moral objection to 14 legally available medical procedures revealed that 52% supported performing abortion for failed contraception [47]. Despite opposition to voluntary abortion, more than three-quarters of OB/GYNs working in public hospitals in the Buenos Aires area from 1998 to 1999 supported abortion for maternal health threat, severe fetal anomaly, and rape/incest [48]. While 10% of a random sample of consultant OB/GYNs in the UK described themselves as objectors, most of this group supported abortion for severe fetal anomaly [13].

Other inconsistencies regarding refusal of care derived from the provider's familiarity with a patient, experience of stigmatization, or opportunism. A Brazilian study reported that Brazilian gynecologists were more likely to support abortion for themselves or a family member than for patients [17]. Physicians in Poland and Brazil reported reluctance to perform legally permissible abortions because of a hostile political atmosphere rather than because of conscience-based objection. The authors also noted that conscientious objection in the public sphere allowed doctors to funnel patients to private practices for higher fees [19].

Not surprisingly, higher levels of self-described religiosity were associated with higher levels of disapproval and objection regarding the provision of certain procedures [49]. Additionally, a random sample of UK general practitioners (GPs) [50], a study of Idaho licensed nurses [51], a study of OB/GYNs in a New York hospital [52], and a cross-sectional survey of OB/GYNs and midwives in Sweden [53] found self-reported religiosity to be associated with reluctance to perform abortion. A study of Texas pharmacists found the same association regarding refusal to prescribe EC [54].

Higher acceptance of these contested service components and lower rates of objection were associated with higher levels of training and experience in a survey of medical students and physicians in Cameroon and in a qualitative study of OB/GYN clinicians in Senegal [55,56]. Similar patterns prevailed in a survey of Norwegian medical students [57] and among pharmacists and OB/GYNs in the USA [45].

Clinicians' refusal to provide elements of ART and PND also varied, at times motivated by concerns about their own lack of competence with these procedures. And, while the majority of Danish OB/GYNs and nurses (87%) in a non-random sample supported abortion and ART, 69% opposed selective reduction [49]. A random sample of OB/GYNs from the UK indicated that 18% would not agree to provide a patient with PND [13].

Several studies report institutional-level implications consequent to refusal of care. Physicians and nurse managers in hospitals in Massachusetts said that nurse objection limited the ability to schedule procedures and caused delays for patients [58]. Half of a stratified random sample of US OB/GYNs practicing primarily at religiously affiliated hospitals reported conflicts with the hospital regarding clinical practice; 5% reported these to center on treatment of ectopic pregnancy [59]. 52% of a non-random sample of regional consultant OB/GYNs in the UK said that insufficient numbers of junior doctors are being trained to provide abortions owing to opting out and conscientious objection [35]. A 2011 South African report states that more than half of facilities designated to provide abortion do not do so, partly because of conscientious objection, resulting in the persistence of widespread unsafe abortion, morbidity, and mortality [60]. A non-random sample of Polish physicians reported that institutional, rather than individual, objection was common [19]. Similar observations have been made about Slovakian hospitals [61].

A few investigations have explored clinician attitudes toward regulation of conscience-based refusal of reproductive healthcare. Two studies from the USA indicate that majorities of family medicine physicians in Wisconsin and a random sample of US physicians believe physicians should disclose objector status to patients [44,47]. A survey of UK consultants revealed that half want the authority to include abortion provision in job descriptions for OB/GYN posts, and more than one-third think objectors should be required to state their reasons [35]. Interviews with a purposive sample of Irish physicians revealed mixed opinions about the obligation of objectors to refer to other willing providers, as well as awareness that women traveled abroad for abortions and related services that were denied at home [62].

While the reviewed literature indicates widespread occurrence of conscientious objection to providing some elements of reproductive healthcare, it does not offer a rigorously obtained evidentiary basis from which to map the global landscape. Assessment of the prevalence of conscientious objection requires ascertainment of the number objecting (numerator) and the total count of the relevant population of providers comprising the denominator (e.g. the number of OB/GYNs claiming conscientious objection to providing EC and the total population of OB/GYNs). Registration of objectors, as required by the Italian Ministry of Health, provides such data. Professional societies could also systematically gather data by surveying members on their practices related to conscience-based refusal of care or by including such self-identification on standard mandatory forms. Academic institutions or other research organizations could conduct formal studies or add questions on conscience-based refusal of care to ongoing general surveys of clinicians.

Aside from prevalence, there are a host of key questions. Further research on motivations of objectors is required in order to better understand reasons other than conscience-based objection that may lead to refusal of care. As the studies reviewed indicate, these factors may include desire to avoid stigma, to avoid burdensome administrative processes, and to earn more money by providing services in private practice rather than in public facilities; knowledge gaps in professional training; and lack of access to necessary supplies or equipment. Qualitative studies would best probe these complicated motivations.

What is the impact of conscience-based refusal of care? In the next section, we outline systemic and biologically plausible sequences of events when specified care components are refused. Research is needed to see whether these hold true and have health consequences for women and practical consequences for other clinicians and the health system as a whole. Research could illuminate women's experiences when refused care—their understanding, access to safe and unsafe alternatives, emotional response, and course of action. Investigations on the clinician side could further explore the experiences of those who do provide services after others have refused to do so. Each of these questions is likely to have context-specific answers, so research should take place in varied geopolitical settings, and the contextual nature of the findings must be made clear.

Do clinicians consider conscientious objection to be problematic? What kinds of constraints on provider behavior do clinicians consider appropriate or realistic? When enacted, have such policies or regulations been implemented? Have those implemented effectively met their purported objectives? What mechanisms of regulation do women consider reasonable? Do they perceive conscience-based refusal of care as a significant barrier to reproductive health services? Could enhanced training and updated medical and nursing school curricula devoted to reproductive health address the lack of clinical skills that contributes to refusal of care? Could further education clarify which services are permitted by law, and under which circumstances, and thus reassure clinicians sufficiently such that they provide care? Empirical evidence is essential as varied political actors try to respond to these competing concerns with policies or regulations.

3. Consequences of refusal of reproductive healthcare for women and for health systems

We lay out the potential implications of conscience-based refusal of care for patients and for health systems in 5 areas of reproductive healthcare—abortion and postabortion care, ART, contraception, treatment for maternal health risk and unavoidable pregnancy loss, and PND. Because we lack empirical data to explore the impact of conscience-based refusal of care on patients and health systems, we build logical models delineating plausible consequences if a particular component of care is refused. We provide visual schemata to represent these pathways and we use data and examples of refusal from around the world to ground them.

We attempt to isolate the impact of conscientious objection for each of the 5 reproductive health components, although we recognize the difficulties of identifying the contributions attributable to other barriers to access. These include limited resources, inadequate infrastructure, failure to implement policies, sociocultural practices, and inadequate understanding of the relevant law by providers and patients alike.

We start from the premise that refusal of care leads to fewer clinicians providing specific services, thereby constraining access to these services. We posit that those who continue to provide these contested services may face stigma and/or become overburdened. We specify plausible health outcomes for patients, as well as the consequences of refusal for families, communities, health systems, and providers.

3.1. Conscience-based refusal of abortion-related services

The availability of safe and legal abortion services varies greatly by setting. Nearly all countries in the world allow legal abortion in certain cases (e.g. to save the life of the woman, in cases of rape, and in cases of severe fetal anomaly). Few countries prohibit abortion in all circumstances. While some among these allow the criminal law defense of necessity to permit life-saving abortions, Chile, El Salvador, Malta, and Nicaragua restrict even this recourse. Other countries with restrictive laws are not explicit or clear about those circumstances in which abortion is allowed [63].

In many countries, particularly in low-resource areas, access to legal services is compromised by lack of resources for health services, lack of health information, inadequate understanding of the law, and societal stigma associated with abortion [64].

There is substantial evidence that countries that provide greater access to safe, legal abortion services have negligible rates of unsafe abortion [65]. Conversely, nearly all of the world's unsafe abortions occur in restrictive legal settings. Where access to legal abortion services is restricted, women seek services under unsafe circumstances. Approximately 21.6 million of the world's annual 46 million induced abortions are unsafe, with nearly all of these (98%) occurring in resource-limited countries [65,66]. In low-income countries, more than half of abortions performed (56%) are unsafe, compared with 6% in high-income areas [66]. Nearly one-quarter (more than 5 million) of these result in serious medical complications that require hospital-based treatment [67,68]; 47,000 women die each year because of unsafe abortion and an additional unknown number of women experience complications from unsafe abortions but do not seek care [68]. While the international health community has sought to mitigate the high rates of maternal morbidity and mortality caused by unsafe abortion through postabortion care programs [56], the implementation and effectiveness of these have been undermined by conscience-based refusal of care [24,56,69].

We posit that conscience-based refusal of care will have less of an impact at the population level in countries with available safe, legal abortion services than in those where access is restricted. Women living in settings in which legal abortion is widely available and who experience provider refusal will be more likely to find other willing providers offering safe, legal services than women in settings in which abortion is more highly restricted. We ground our model (Fig. 1) in the following examples: (1) in South Africa, widespread conscientious objection limits the numbers of willing providers and, thus, access to safe care, and the number of unsafe abortions has not decreased since the legalization of abortion in

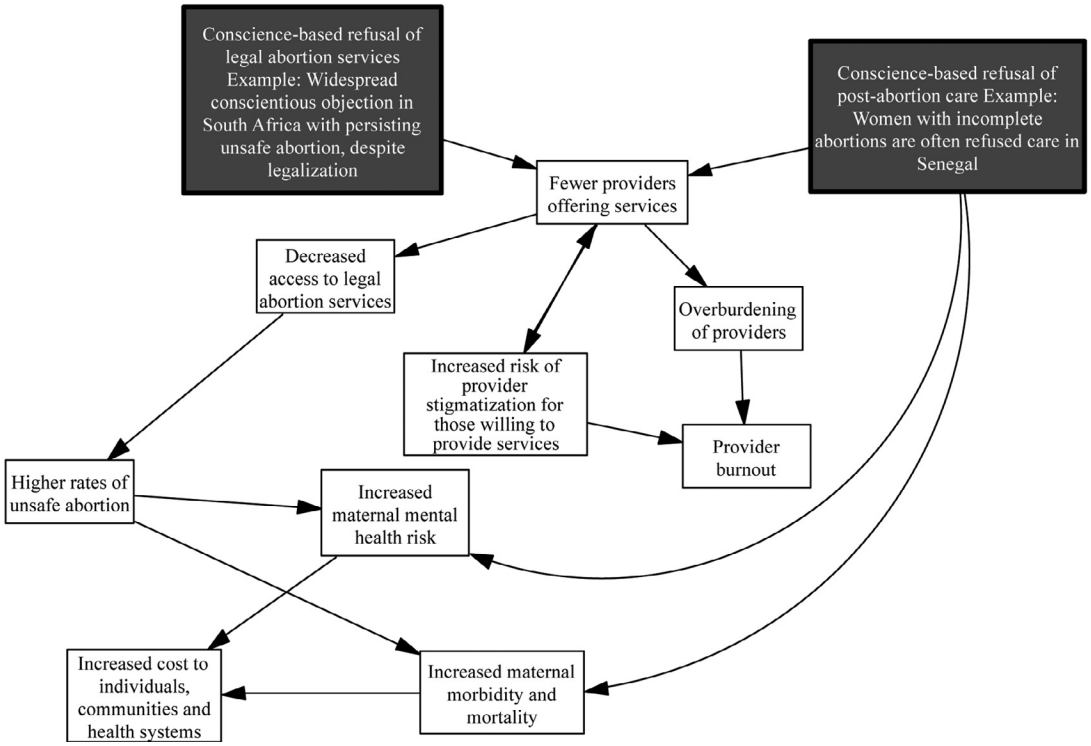

Fig. 1. Consequences of refusal of abortion-related services.

1996 [70,71]; (2) although Senegal's postabortion care program is meant to mitigate the grave consequences of unsafe abortion, conscientious objection is, nevertheless, often invoked when abortion is suspected of being induced rather than spontaneous [56] (unpublished data).

3.2. Conscience-based refusal of components of ART

Infertility is a global public health issue affecting approximately 8%–15% of couples [72,73], or 50–80 million people [74], worldwide. Although the majority of those affected reside in low-resource countries [72,73], the use of ART is much more likely in high-resource countries.

Access to specific ART varies by socioeconomic status and geographic location, between and within countries. In high-resource countries, the cost of treatment varies greatly depending on the healthcare system and the availability of government subsidy [75]. For example, in 2006, the price of a standard in vitro fertilization (IVF) cycle ranged from US $3956 in Japan to $12,513 in the USA [76]. After government subsidization in Australia, the cost of IVF averaged 6% of an individual's annual disposable income; it was 50% without subsidization in the USA [77]. In low-income countries, despite high rates of infertility, there are few resources available for ART, and costs are generally prohibitive for the majority of the population. Because these economic and infrastructural factors drive lack of access to ART in low-income countries, we posit that denial of services owing to conscience-based refusal of care is not a major contributing factor to limited access in these settings. Therefore, for the model (Fig. 2), we primarily examine the consequences of conscientious objection to components of ART in middle- to high-income countries. At times, regulations and policies regarding ART stem from empirically based concerns, grounded in medical evidence, about health outcomes for women and their offspring or health system priorities. Our focus, however, is on those instances in which some physicians practice according to moral or religious beliefs, even when these contradict best medical practices. In some Latin American countries, despite the medical evidence that maternal and fetal outcomes are markedly superior when fewer embryos are implanted, the objection to embryo selection/reduction and cryopreservation promoted by the Catholic Church has reportedly led many physicians to avoid these [78]. Anecdotal reports from Argentina describe ART physicians' avoidance of cryopreservation and embryo selection/reduction following the self-appointment of a lawyer and member of Opus Dei as legal guardian for cryopreserved embryos [78,79]. The only example that illustrates the implications of denial of preimplantation genetic diagnosis (PGD) refers to a legal ban, rather than conscience-based refusal of care. Nonetheless, we use it to describe the potential consequences when such care is denied. In 2004, Italy passed a law banning PGD, cryopreservation, and gamete donation [80]. This ban compelled a couple who were both carriers of the gene for β-thalassemia to wait to undergo amniocentesis and then to have a second-trimester abortion rather than allow the abnormality to be detected prior to implantation [80] (Fig. 2).

3.3. Conscience-based refusal of contraceptive services

The availability of the range of contraceptive methods varies by setting, as does prevalence of use [81]. In general, contraceptive use is correlated with level of income. In 2011, 61.3% of women aged 15–49 years, married or in a union, in middle–upper-income countries were using modern methods, compared with 25% in the lowest-resource countries [81,82]. Within countries, access to and use of methods also vary. For example, according to the 2003 Demographic and Health Survey of Kenya (a cross-sectional study of a nationally representative sample), women in the richest quintile were reported to have significantly higher odds for using long-term contraceptive methods (intrauterine device, sterilization, implants) than women in the poorest quintile [82].

The legal status of particular contraceptive methods also varies by setting. In Honduras, Congress passed a bill banning EC, which has not yet been enacted into law [83]. Even when contraception is legal, lack of basic resources allocated by government programs may compromise availability of particular methods. High manufacturing

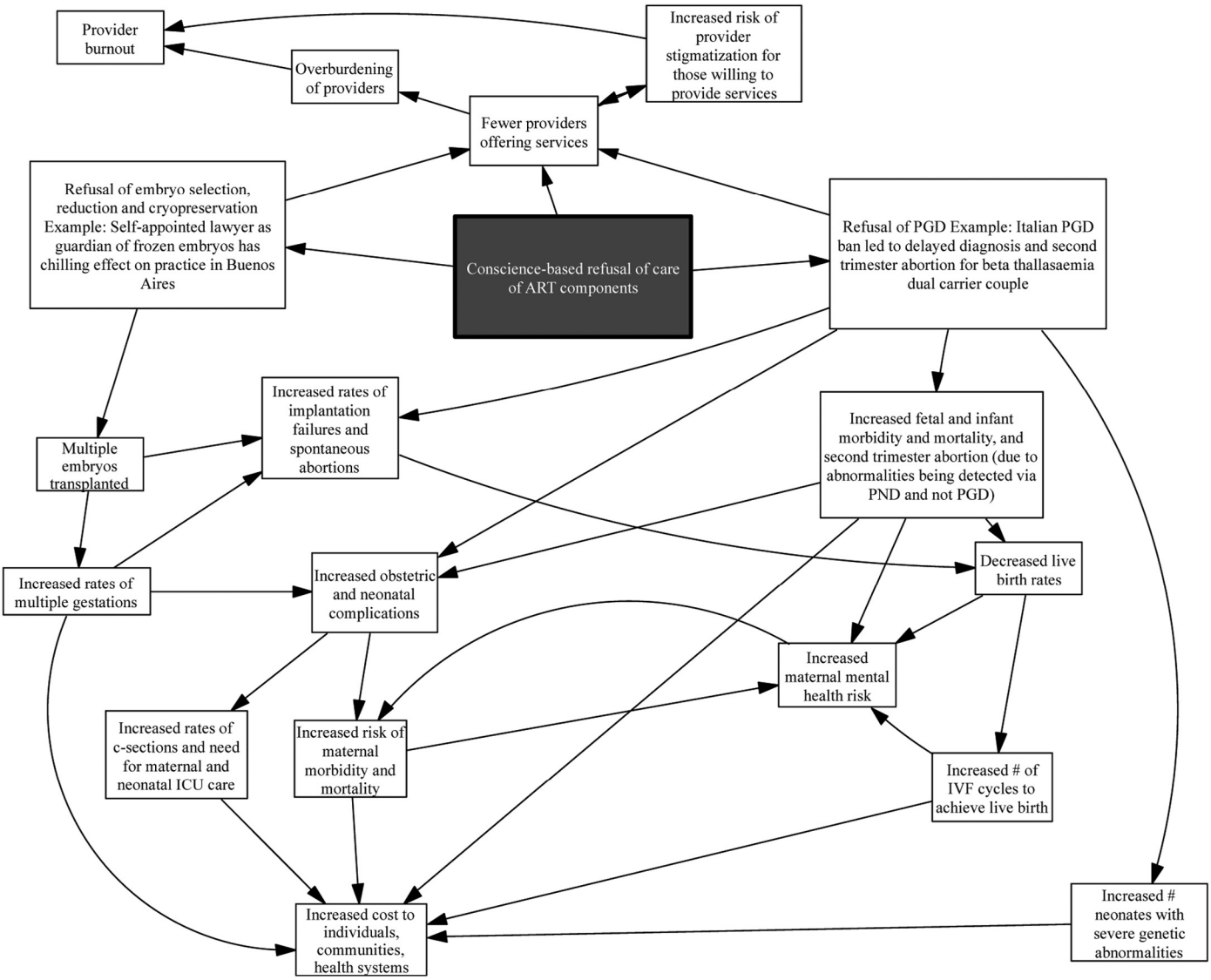

Fig. 2. Consequences of refusal of components of assisted reproductive technologies.

costs or steep prices can also undermine access [84]. In other cases, individual health providers opt not to provide contraception to all or to certain groups of women. Some providers refuse to provide specific methods such as EC or sterilization. In Poland, there is widespread refusal to provide contraceptive services (J. Mishtal, personal communication, April 2012). In Oklahoma, a rape victim was denied EC by a doctor [85], and in Germany a rape victim was denied EC by 2 Catholic hospitals in 2012 [86]. In Fig. 3, we delineate potential implications of conscience-based refusal of contraceptive services.

3.4. Conscience-based refusal of care in cases of risk to maternal health and unavoidable pregnancy loss

In some circumstances, pregnancy can exacerbate a serious maternal illness or maternal illness may require treatment hazardous to a fetus. In these cases, women require access to life-saving treatment, which may include abortion. Yet women have been denied appropriate treatment. Women seeking completion of inevitable pregnancy loss due to ectopic pregnancy or spontaneous abortion have also been denied necessary care.

It is beyond the scope of the present White Paper to define the full range of conditions that may be exacerbated by pregnancy and jeopardize the health of the pregnant woman. However, the incidence of ectopic pregnancy ranges from 1% to 16% [87–90], and 10%–20% of all clinically recognized pregnancies end in spontaneous abortion [90]. Often, refusal of care in circumstances of maternal health risk occurs in the context of highly restrictive abortion laws. We refer to 3 cases from around the world (Fig. 4) to highlight this phenomenon in our model. In Ireland in 2012, Savita Halappanavar, 31, presented at a Galway hospital with ruptured membranes early in the second trimester. She was refused completion of the inevitable spontaneous abortion, developed sepsis, and subsequently died [91]. *Z*'s daughter, a young Polish woman, was diagnosed with ulcerative colitis while she was pregnant [92]. She was repeatedly denied medical treatment; physicians stated that they would not conduct procedures or tests that might result in fetal harm or termination of the pregnancy [92]. She developed sepsis, experienced fetal demise, and died. The only example that illustrates the implications of denial of treatment for ectopic pregnancy derives from legal bans, rather than from an example of conscience-based refusal of care. In El Salvador, a total prohibition on abortion has led to physician refusal to treat ectopic pregnancy [93]; in Nicaragua, the abortion ban results in delay of treatment for ectopic pregnancies, despite law and medical guidelines mandating the contrary [94] (Fig. 4).

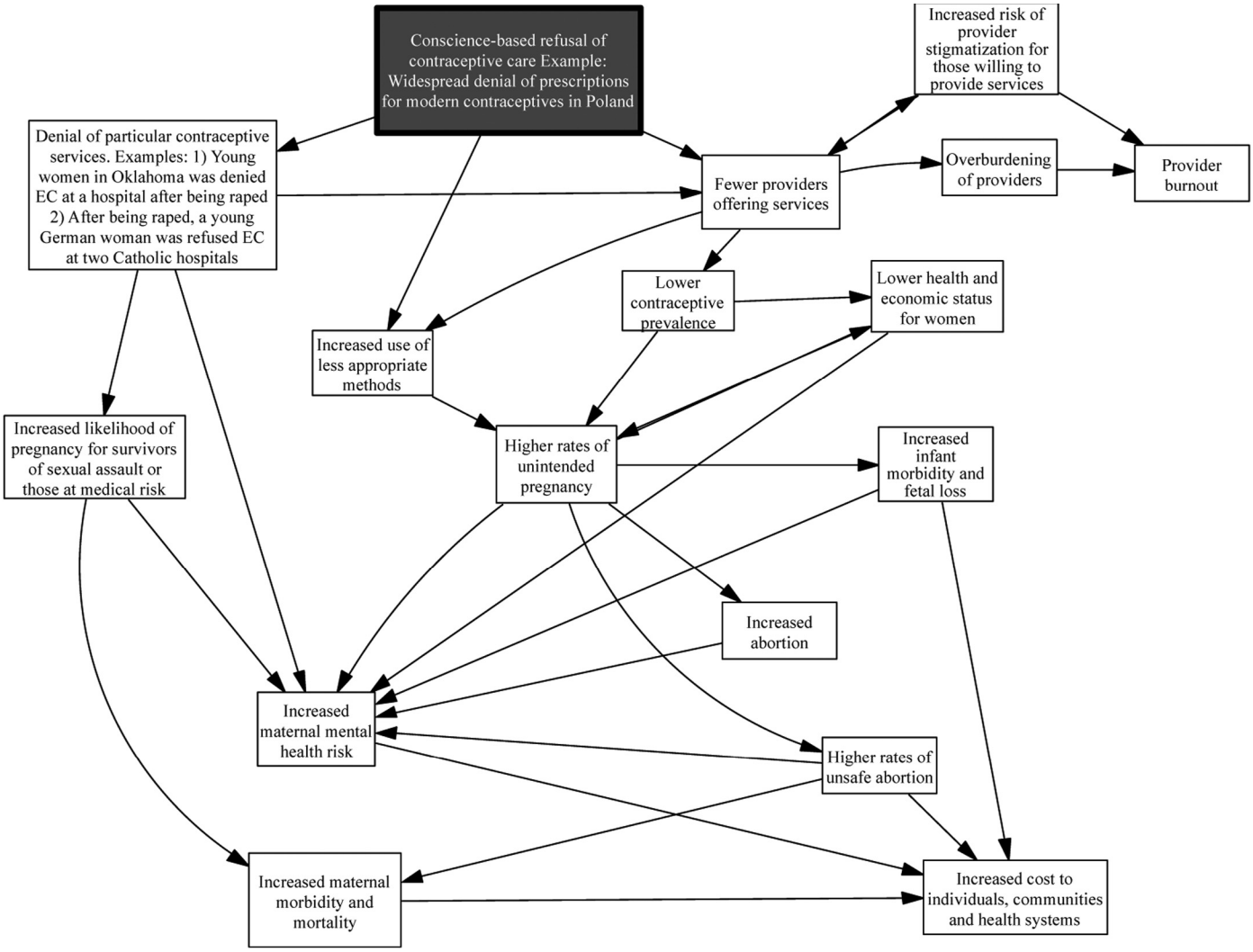

Fig. 3. Consequences of refusal of contraceptive services.

3.5. Conscience-based refusal of PND

The availability of PND varies greatly by setting—with those in middle–upper-income countries having access to testing for a variety of genetic conditions and structural anomalies, and fewer having access to a more limited series of testing in low-income countries. Access to PND provides women with information so that they can make decisions and/or preparations when severe or lethal fetal anomalies are detected. Outcomes for affected neonates vary by country resource level; PND enables physicians to plan for the level of care needed during delivery and in the neonatal period. With PND, families are also afforded the time to secure the necessary emotional and financial resources to prepare for the birth of a child with special needs [95,96]. In settings in which there are fewer resources available for PND, conscientious objection further restricts women's access to services. Figure 5 presents pathways and implications of provider conscience-based refusal to provide PND services. Because most data on access to PND are from high-resource countries, we must project what would happen in lower-income countries. We use the example of *R.R.*, a Polish woman who was repeatedly refused diagnostic tests to assess fetal status after ultrasound detection of a nuchal hygroma [97] (Fig. 5).

4. Policy responses to manage conscience-based refusal of reproductive healthcare

Here, we review various policy interventions related to conscience-based refusal of care. Initially, we look at the context established by human rights standards or human rights bodies wherein freedom of conscience is enshrined. The UN Committee on Economic, Social and Cultural Rights (CESCR); the UN Committee on the Elimination of Discrimination against Women (CEDAW); and the UN Human Rights Committee have commented on the need to balance providers' rights to conscience with women's rights to have access to legal health services [98–104]. CEDAW asserts that "it is discriminatory for a country to refuse to legally provide for the performance of certain reproductive health services for women" and that, if healthcare providers refuse to provide services on the basis of conscientious objection, "measures should be introduced to ensure that women are referred to alternative health providers" [99]. CESCR has called on Poland to take measures to ensure that women enjoy their rights to sexual and reproductive health, including by "enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection" [104].

The international medical and public health communities, including FIGO in its Ethical Guidelines on Conscientious Objection (2005) [9] and WHO in its updated Safe Abortion Guidelines (2012) [105], have agreed on principles related to the management of

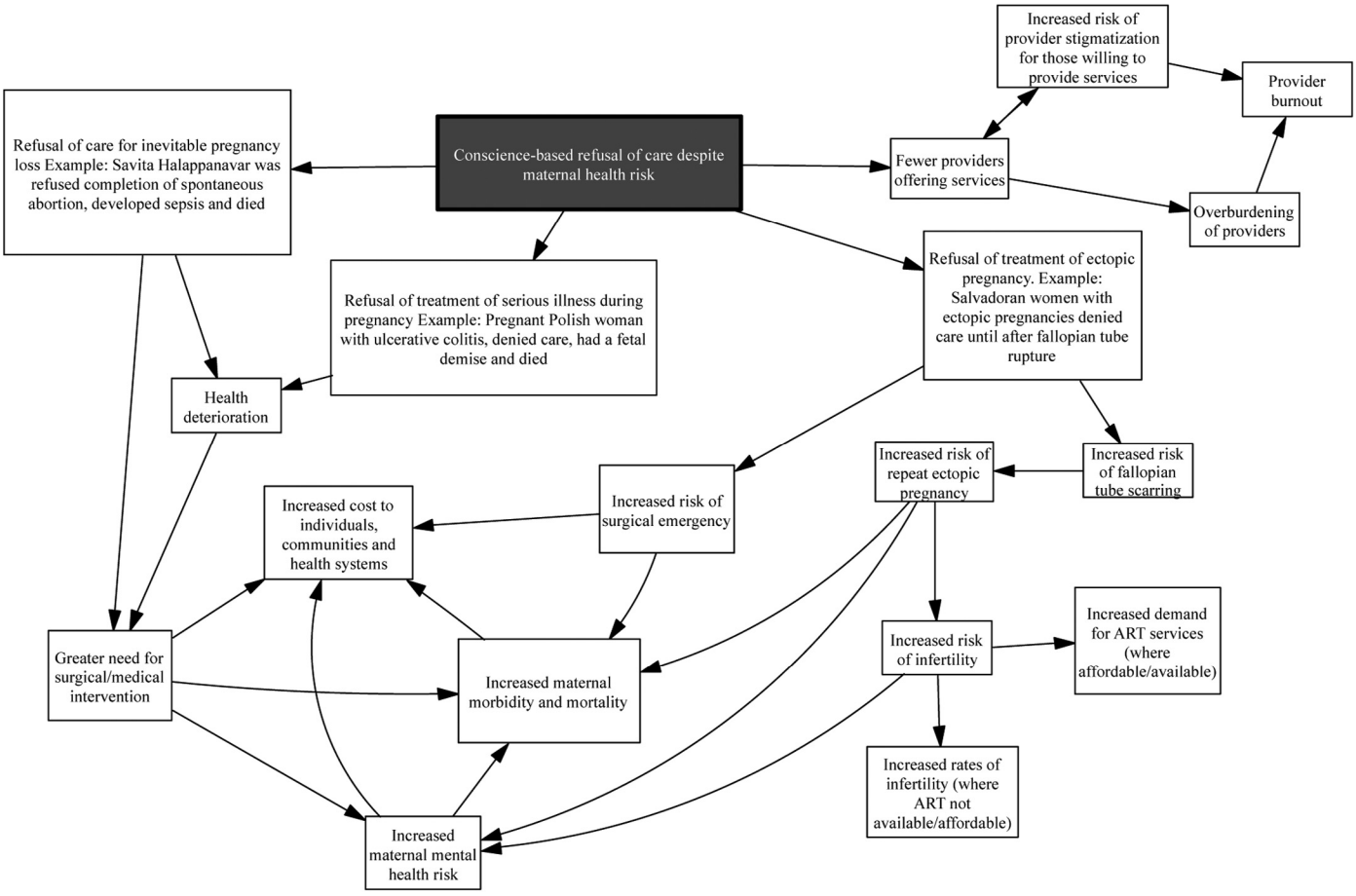

Fig. 4. Consequences of refusal of care in cases of risk to maternal health and unavoidable pregnancy loss.

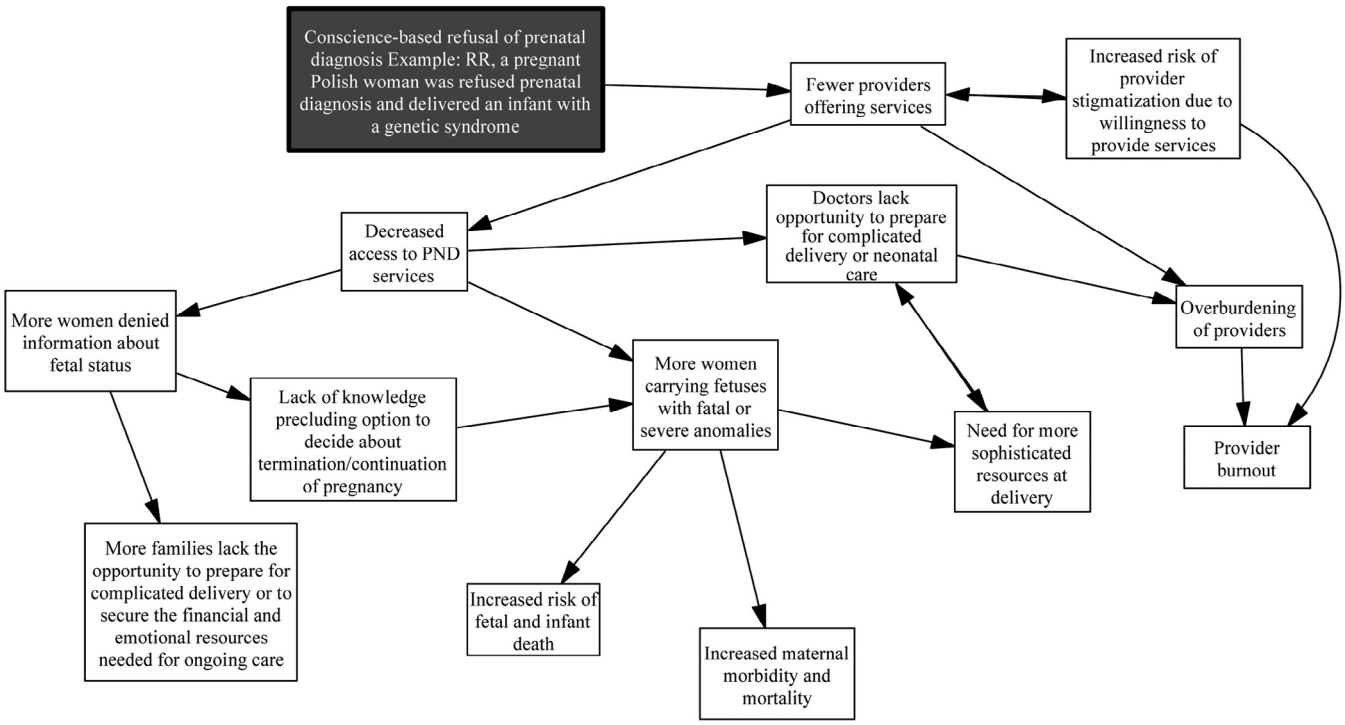

Fig. 5. Consequences of refusal of prenatal diagnosis.

conscientious objection to reproductive healthcare provision. While these are non-binding recommendations, they do assert professional standards of care. These include the following:

- Providers have a right to conscientious objection and not to suffer discrimination on the basis of their beliefs.
- The primary conscientious duty of healthcare providers is to

treat, or provide benefit and prevent harm to patients; conscientious objection is secondary to this primary duty.

Moreover, the following safeguards must be in place in order to ensure access to services without discrimination or undue delays:

- Providers have a professional duty to follow scientifically and professionally determined definitions of reproductive health services, and not to misrepresent them on the basis of personal beliefs.
- Patients have the right to be referred to practitioners who do not object for procedures medically indicated for their care.
- Healthcare providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, including those that providers object to on grounds of conscience.
- Providers must provide timely care to their patients when referral to other providers is not possible and delay would jeopardize patients' health.
- In emergency situations, providers must provide the medically indicated care, regardless of their own personal objections.

These statements support both sides of the tension: the right of patients to have access to appropriate medical care and the right of providers to object, for reasons of conscience, to providing particular forms of care. They underscore the professional obligation of healthcare providers to ensure timely access to care, through provision of accurate information, referral, and emergency care. At the transnational level, human rights consensus documents have asserted that institutions and individuals are similarly bound by their obligations to operate according to the bedrock principles that underpin the practice of medicine, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care in emergency situations.

At the country level, however, there is no agreement as to whether institutions can claim objector status. For example, Spain [106], Colombia [107], and South Africa [108] have laws stating that refusal to perform abortions is always an individual, not an institutional, decision. Conversely, Argentinian law [109,110] gives private institutions the ability to object and requires private health centers to register as conscientious objectors with local health authorities. In Uruguay, the Ethical Code does not require the institution employing a conscientious objector to provide referral services, although a newly proposed bill would require such referral [111,112]. In the USA, the question of institutional rights and obligations is hotly debated and the situation is complicated and unresolved. Currently, federal law forbids agencies receiving federal funding from discriminating against any healthcare entity that refuses to provide abortion services [113]. Yet other federal law requires institutions providing services for low-income people to maintain an adequate network of providers and to guarantee that individuals receive services without additional out-of-pocket cost [114].

International and regional human rights bodies, governments, courts, and health professional associations have developed various responses to address conscience-based refusal of care. These responses differ as to whose rights they protect: the rights of a woman to have access to legal services or the rights of a provider to object based on reasons of conscience. They might also have different emphases or targets. Some focus on ensuring an adequate number of providers for a certain service, some concentrate on ensuring that women receive timely referrals to non-objecting practitioners, and some seek to establish criteria for designation as an objector. For example, Norway established a comprehensive regulatory and oversight framework on conscientious objection to abortion, which includes ensuring the availability of providers [33,115]. In Colombia, the Constitutional Court affirmed that conscientious objection must be grounded in true religious conviction, rather than in a personal judgment of "rightness" [116].

Some of these responses are legally binding through national constitutional provisions, legislation, or case law. The European Court of Human Rights (ECHR), whose rulings are legally binding for member nations, clarified the obligation of states to organize the practice of conscience-based refusal of care to ensure that patients have access to legal services, specifically to abortion [97]. Professional associations and employers have developed other interventions, including job requirements and non-binding recommendations. In Germany, for example, a Bavarian High Administrative Court decision [117], upheld by the Federal Administrative Court [118], ruled that it was permissible for a municipality to include ability and willingness to perform abortions as a job criterion. In Norway, employers can refuse to hire objectors and employment advertisements may require performance of abortion as a condition for employment [112]. In Sweden, Bulgaria, Czech Republic, Finland, and Iceland, healthcare providers are not legally permitted to conscientiously object to providing abortion services [38]. Some require referral to non-objecting providers. For example, in the recent *P. and S. v. Poland* case, the ECHR emphasized the need for referrals to be put in writing and included in patients' medical records [119]. In Argentina [110] and France [120], legislation requires doctors who conscientiously object to refer patients to non-objecting practitioners. Similar laws exist in Victoria, Australia [121], Colombia [116,122,123], Italy [124], and Norway [115]. Professional and medical associations around the world recommend that objectors refer patients to non-objecting colleagues. ACOG in the USA [125] and El Sindicato Médico in Uruguay [126] recommend that objectors refer patients to other practitioners. The British Medical Association (BMA) specifies that practitioners cannot claim exemption from giving advice or performing preparatory steps (including referral) where the request for an abortion meets legal requirements [127]. The WMA asserts that, if a physician must refuse a certain service on the basis of conscience, s/he may do so after ensuring the continuity of medical care by a qualified colleague [128]. FIGO maintains that patients are entitled to referral to practitioners who do not object [9].

Pharmacists' associations in the USA and UK have made similar recommendations. The American Society of Health-System Pharmacists asserts that pharmacists and other pharmacy employees have the right not to participate in therapies they consider to be morally objectionable but they must make referrals in an objective manner [129]; the AMA guidelines state that patients have the right to receive an immediate referral to another dispensing pharmacy if a pharmacist invokes conscientious objection [130]. In the UK, pharmacists must also have in place the means to make a referral to another relevant professional within an appropriate time frame [131].

Some jurisdictions mandate registration of objectors or require objectors to provide advance written notice to employers or government bodies. In Spain, for example, the law requires that conscientious objection must be expressed in advance and in written form to the health institution and the government [106]. Italian law also requires healthcare personnel to declare their conscientious objection to abortion to the medical director of the hospital or nursing home in which they are employed and to the provincial medical officer no later than 1 month after date of commencement of employment [124]. Victoria, Australia [118]; Colombia [123]; Norway [115]; Madagascar [132]; and Argentina [109] have similar laws. In Norway, the administrative head of a health institution must inform the county municipality of the number of different categories of health personnel who are exempted on grounds of conscience [115]. Argentinian law [109] gives private institutions the ability to object, requiring these

institutions to register as conscientious objectors with local health authorities and to guarantee care by referring women to other centers. Argentinian law also states that an individual objector cannot provide services in a private health center that s/he objects to the provision of in the public health system [110]. Regulation in Canada requires pharmacists to ensure that employers know about their conscientious objector status and to prearrange access to an alternative source for treatment, medication, or procedure [133]. The Code of Ethics for nurses in Australia also requires disclosure to employers [134]. In Northern Ireland, a guidance document by the Department of Health, Social Services and Public Safety asserts that an objecting provider "should have in place arrangements with practice colleagues, another GP practice, or a Health Social Care Trust to whom the woman can be referred" for advice or assessment for termination of pregnancy [135].

Other measures require disclosure to patients about providers' status as objectors. For example, the law in the state of Victoria, Australia, requires objectors to inform the woman and refer her to a willing provider [121]. In Argentina, the Technical Guide for Comprehensive Legal Abortion Care 2010 [109] requires that all women be informed of the conscientious objections of medical, treating, and/or support staff at first visit. Portugal's medical ethical guidelines encourage doctors to communicate their objection to patients [136].

The right to receive information in healthcare, including reproductive health information, is enshrined in international law. For example, the ECHR determined that denial of services essential to making an informed decision regarding abortion can constitute a violation of the right to be free from inhuman and degrading treatment [97]. At the national level, laws have mandated disclosure of health information to patients. For example, according to the South African abortion law, providers, including objectors, must ensure that pregnant women are aware of their legal rights to abortion [108]. In Spain, women are entitled to receive information about their pregnancies (including prenatal testing results) from all providers, including those registered as objectors [106]. In the UK, objectors are legally required to disclose their conscientious objector status to patients, to tell them they have the right to see another doctor, and to provide them with sufficient information to enable them to exercise that right [137–139].

Professional guidelines have also addressed disclosure of health information. In Argentina, any delaying tactics, provision of false information, or reluctance to carry out treatment by health professionals and authorities of hospitals is subject to administrative, civil, and/or criminal actions [109]. FIGO asserts that the ethical responsibility of OB/GYNs to prevent harm requires them to provide patients with timely access to medical services, including giving them information about the medically indicated options for their care [9].

Some require the provision of services in cases of emergency. For example, legislation in Victoria, Australia [121]; Mexico City [140]; Slovenia [141]; and the UK [138] stipulates that physicians may not refuse to provide services in cases of emergency and when urgent termination is required. US case law determined that a private hospital with a tradition of providing emergency care was still obliged to treat anyone relying on it even after its merger with a Catholic institution. This sets the standard for continuity of access after mergers of 2 hospitals with conflicting philosophies [142]. Also, ACOG urges clinicians to provide medically indicated care in emergency situations [125]. In Argentina, technical guidelines from the Ministry of Health stipulate that institutions must provide termination of pregnancy through another provider at the institution within 5 days or immediately if the situation is urgent [109]. In the UK, medical standards also prohibit conscience-based refusal of care in cases of emergency for nurses and midwives [143].

Other measures address the required provision of services when referral to an alternative provider is not possible. In Norway, for example, a doctor is not legally allowed to refuse care unless a patient has such reasonable access [115]. FIGO recommends that "practitioners must provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well being, such as by patients experiencing unwanted pregnancy" [9].

Some interventions obligate the state to ensure services. In Colombia, for example, the health system is responsible for providing an adequate number of providers, and institutions must provide services even if individuals conscientiously object [107]. The law on voluntary sterilization and vasectomies in Argentina obligates health centers to ensure the immediate availability of alternative services when a provider has objected [144]. In Spain, the government will pay for transportation to an alternative willing public health facility [106]. Italian law requires healthcare institutions to ensure that women have access to abortion; regional healthcare entities are obliged to supervise and ensure such access, which may include transferring healthcare personnel [125]. In Mexico City, the public health code was amended to reinforce the duty of healthcare facilities to make abortion accessible, including their responsibility to limit the scope of conscientious objection [140].

Some measures specify which service providers are eligible to refuse and when they are allowed to do so. In the UK, for example, auxiliary staff are not entitled to conscientiously object [145,146]. According to the BMA guidelines, refusal to participate in paperwork or administration connected with abortion procedures lies outside the terms of the conscientious objection clause [127]. In Spain, only health professionals directly involved in termination of pregnancy have the right to object, and they must provide care to the woman before and after termination of pregnancy [106]. Similarly, doctors in Italy are legally required to assist before and after an abortion procedure even if they opt out of the procedure itself [124]. Also, medical guidelines in Argentina encourage practitioners to aid before and after legal abortion procedures even if they are invoking conscientious objection to participation in the procedure itself [109]. During the Bush administration, the US Department of Health and Human Services extended regulatory "conscience protections" to any individual peripherally participating in a health service [147]. This regulation was contested vigorously and retracted almost fully in February 2011 [148,149].

In Table 1, we lay out some benefits and limitations of policy responses to conscientious objection in order to provide varied actors with a menu of possibilities. As criteria are developed for invoking refusal, it is essential to address the questions of who is eligible to object, and to the provision of which services. We have added the categories of "data" and "standardization" as parameters in the table in recognition of the scant evidence available and the resulting inability to methodically assess the scope and efficacy of interventions. Selection of the various options delineated below will be influenced by the specific sociopolitical and economic context.

5. Conclusion

Refusal to provide certain components of reproductive healthcare because of moral or religious objection is widespread and seems to be increasing globally. Because lack of access to reproductive healthcare is a recognized route toward adverse health outcomes and inequalities, exacerbation of this through further depletion of clinicians constitutes a grave global health and rights concern. The limited evidence available indicates that objection occurs least when the law, public discourse, provider custom, and clinical experience all normalize the provision of the full range of reproductive healthcare services and promote women's autonomy. While data on both the prevalence of conscience-based refusal of

Table 1
Benefits and limitations of policy interventions

Option	Health system needs	Timely access to care	Balancing rights and obligations	Developing criteria for refusers	Standardization	Data needs
Referral to willing and accessible providers	Enables system planning for service delivery	Expedites patients' access to services	Upholds patients' rights to health-related information; providers' obligations to provide information and make refusal transparent; individual conscience	Establishes obligations of those claiming objector status while acknowledging legitimacy of objection	Policies and procedures for disclosure and referral standardized throughout health system	Provides indirect data on patients' encounters with refusal
Registration of objectors/written notice to employers	Informs on prevalence of objection, enabling system planning for service delivery	Leads to more timely access to care for women who can avoid seeking care from known objectors	Acknowledges provider right to object while informing patients. Requirement of formal documentation acknowledges health system stake in such knowledge	Delineates the specific instances in which objection is permitted, and by whom; formal notification of employers makes explicit the criteria for designation as an objector	Ensures that requirements for designation as objector are standardized throughout the health system	Registries provide data on prevalence by type of provider as well as component of care refused
Required disclosure of objector status to patients	Enables women to avoid unproductive visits to objectors and delayed care, promoting smoother functioning of system	Women go directly to willing provider	Acknowledges provider right to object while upholding patients' rights to autonomy and health-related information	Defines obligations of objectors	Standardizes information provided to patients	N/A
Required information to patients about available health options	Informed patients are better able to make decisions and to locate the services that they need	Facilitates patient access to appropriate care	Upholds patients' rights to obtain health-related information; underscores providers' obligations to provide accurate information and to inform about legally available options; asserts health system's commitment to science and to patients' rights	Limits scope of objection by specifying components of care individuals obligated to provide	Standardizes information to patients about health system's range of available services	N/A
Mandated provision of services in urgent situations or when no alternative exists	Facilitates planning for provision of emergency care and for associated policies, procedures, and oversight; ensures that medical sequelae of denial or delay of care are minimized	Provides critical care in a timely fashion	Obligations of the provider to operate in the best interests of patients and to provide appropriate care take precedence over the individual clinician's right to object	Sets limits on the scope of refusal to protect patients in emergency situations	Ensures that objectors adhere to contractual obligations to provide essential and/or life-saving care	Contributes to the ability to track urgent cases and to plan service provision needs
Willingness to provide and proficiency as criteria for employment	Underscores employers' needs to ensure sufficient number of providers to meet demand for specific services	Staff competency and willingness enable ready and timely access to appropriate care	Health systems' needs to employ proficient and willing providers to respond to the health needs of the community trump provider rights to object; providers free to adhere to conscience by choosing other employment	Limits objection because only those willing and trained are eligible for employment	Standardizes such requirements in job postings throughout health system	Tracks the number of proficient and willing candidates seeking employment
Medical certification contingent upon proficiency in specific services	Improves health system-level planning for service delivery by assuring that providers are proficient in needed services	Availability of trained providers facilitates timely access to care	Establishes that objectors have the right to choose other specialties, but not to refuse essential components of a specialty; ensures patient rights to receive appropriate services from providers designated as specialists; defines and safeguards professional standards	Clarifies that specialist objectors must be trained and ready to provide care in emergency situations or when other options not available	Specialty certification guarantees mastery of a set of skills and compliance with explicit obligations	Tracks number of providers certified and, therefore, proficient, thus facilitating planning
Medical society guidelines delineating expected standards of care	Recommends that priority go to patient receipt of care and to prevention of shortages of willing and qualified providers; guidelines may lack mechanisms for implementation	Recommends policies and procedures to ensure timely access to care but may lack force	Delineates the rights and obligations of providers and the rights of patients	Suggests criteria for designation as objector and associated obligations	Asserts standards of care	N/A

care and the consequences for women's health and health system function are inadequate, they indicate that refusal is unevenly distributed; that it may have the most severe impact in those parts of the world least able to sustain further personnel shortages; and that it also affects women in more privileged circumstances.

The present White Paper has laid out the available data and outlined research questions for further management of conscience-based refusal of care. It presents logical chains of consequences when refusal compromises access to specific components of reproductive healthcare and categorizes efforts to balance the claims of objectors with the claims of both those seeking healthcare and the systems obligated to provide these services. We highlight the claims of those whose conscience compels them to provide such care, despite hardship. As our emphasis is on medicine and science, we close by considering ways for medical professional and public health societies to develop and implement policies to manage conscientious objection.

One recommendation is to standardize a definition of the practice and to develop eligibility criteria for designation as an objector. Such designation would have accompanying obligations, such as disclosure to employers and patients, and duties to refer, to impart accurate information, and to provide urgently needed care. Importantly, professional organizational voices can uphold conformity with standards of care as the priority professional commitment of clinicians, thus eliminating refusal as an option for the care of ectopic pregnancy, inevitable spontaneous abortion, rape, and maternal illness. In sum, medical and public health professional organizations can establish a clinical standard of care for conscientious objection, to which clinicians could be held accountable by patients, medical societies, and health and legal systems.

There are additional avenues for professional organizations to explore in upholding standards. Clinical specialty boards might condition certification upon demonstration of proficiency in specific services. Clinical educators could ensure that trainees and members are educated about relevant laws and clinical protocols/procedures. Health systems may consider willingness to provide needed services and proficiency as criteria for employment. These last are noteworthy because they also move us from locating the issue at the individual level to consideration of obligations at the professional and health system levels.

These issues are neither simple nor one-sided. Conscience and integrity are critically important to individuals. Societies have the complicated task of honoring the rights of dissenters while also limiting their impact on other individuals and on communities. Although conscientious objection is only one of many barriers to reproductive healthcare, it is one that medical societies are well positioned to address because providers are at the nexus of health and rights concerns. They have the unique vantage point of caring simultaneously about their own conscience and about their obligations to patients' health and rights and to the highest standards of evidence-based care. The present White Paper has disentangled the range of implications for women's health and rights, health systems, and objecting and committed providers. Thus, it equips clinicians and their professional organizations to contribute a distinct medical voice, complementary to those of lawyers, ethicists, and others. We urge medical and public health societies to assert leadership in forging policies to balance these competing interests and to safeguard reproductive health, medical integrity, and women's lives.

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Conflict of interest

The authors have no conflicts of interest.

References

[1] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* March 23, 1976).
[2] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* December 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 *(entered into force* September 3, 1981).
[3] Organization of American States. American Convention on Human Rights, *"Pact of San Jose", Costa Rica*. November 22, 1969. http://www.unhcr.org/refworld/docid/3ae6b36510.html. Accessed February 10, 2013.
[4] Council of Europe. European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14. November 4, 1950, ETS 5. http://www.unhcr.org/refworld/docid/3ae6b3b04.html. Accessed February 10, 2013.
[5] UN Committee on Economic, Social and Cultural Rights (CESCR). General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). August 11, 2000, E/C.12/2000/4. http://www.refworld.org/docid/4538838d0.html. Accessed May 7, 2013.
[6] L.C. v. Peru, Communication No. 1153/2003, Human Rights Committee, para. 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).
[7] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, *adopted* July 11, 2003, 2nd African Union Assembly, Maputo, Mozambique (*entered into force* 2005).
[8] World Medical Association. Declaration of Helsinki—Ethical Principles for Medical Research Involving Human Subjects. Adopted 1964. http://www.wma.net/en/30publications/10policies/b3/. Accessed June 15, 2013.
[9] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Ethical guidelines on conscientious objection. FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Int J Gynecol Obstet 2006;92(3):333–4.
[10] American College of Obstetricians and Gynecologists (ACOG). ACOG Committee Opinion, Committee on Ethics. The Limits of Conscientious Refusal in Reproductive Health Care. Number 385, November 2007 (*reaffirmed* 2010). http://www.acog.org/Resources%20And%20Publications/Committee%20Opinions/Committee%20on%20Ethics/The%20Limits%20of%20Conscientious%20Refusal%20in%20Reproductive%20Medicine.aspx. Accessed March 22, 2013.
[11] González Vélez AC. Refusal of Care due to Conscientious Objection. Grupo Médico por el Derecho a Decidir. Global Doctors for Choice/Colombia 2012. http://globaldoctorsforchoice.org/wp-content/uploads/Negaci%C3%B3n-de-servicios-por-razones-de-conciencia.pdf. Accessed October 23, 2013.
[12] Royal College of Nursing, Australia. Position Statement. Conscientious Objection. http://www.rcna.org.au/wcm/RCNA/Policy/Position_statements/rcna/policy/position_statements_guidelines_and_communiques.aspx. Accessed March 22, 2013.
[13] Green JM. Obstetricians' views on prenatal diagnosis and termination of pregnancy: 1980 compared with 1993. British J Obstet Gynaecol 1995;102(3):228–32.
[14] Zampas C, Andion-Ibaniez X. Conscientious objection to sexual and reproductive health services: international human rights standards and European law and practice. Eur J Health Law 2012;19:231–56.
[15] Dodani S, LaPorte R. Brain drain from developing countries: how can brain drain be converted into wisdom gain? J R Soc Med 2005;98(11):487–91.
[16] United States Department of Defense Regulations. DoD Directive 1300.6: Conscientious Objectors. http://www.dtic.mil/whs/directives/corres/pdf/130006p.pdf. Published May 31, 2007. Accessed October 23, 2013.
[17] Faundes A, Duarte GA, Neto JA, de Sousa MH. The closer you are, the better you understand: the reaction of Brazilian obstetrician-gynaecologists to unwanted pregnancy. RHM 2004;12(24 Suppl):47–56.
[18] Mishtal J. Contradictions of Democratization: The Politics of Reproductive Rights and Policies in Postsocialist Poland. Dissertation submitted to the Faculty of the Graduate School of the University of Colorado in partial fulfillment of the requirement for the degree of Doctor of Philosopy. Department of Anthropology. 2006. http://federa.org.pl/dokumenty_pdf/prawareprodukcyjne/Mishtal%20dissertation.pdf. Accessed June 17, 2013.
[19] De Zordo S, Mishtal J. Physicians and abortion: Provision, political participation and conflicts on the ground—The cases of Brazil and Poland. Women's Health Issues 2011;21(Suppl 3):S32-6.
[20] MergerWatch. Religious Restrictions: Refusals to Provide Care. http://www.mergerwatch.org/refusals/. Accessed August 17, 2012.
[21] Shelton DL. Chicago Tribune News. Appeals court sides with pharmacists in emergency contraceptives care. http://articles.chicagotribune.com/2012-09-22/news/ct-met-emergency-contraceptives-20120922_1_emergency-contraceptives-conscience-act-pharmacists. Published September 22, 2012. Accessed March 22, 2013.

[22] Wicclair MR. Refusals by hospitals and emergency contraception. Cambridge Quarterly of Healthcare Ethics 2011;20(1):130–8.
[23] Charo RA. American Constitution Society for Law and Policy, Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience. The Journal of the ACS Issue Groups 2007: 119–35. https://media.law.wisc.edu/m/yzdkn/charo_-_health_care_provider_refusals_-_feb_2007_-_advance_vol_1.pdf.
[24] Wicclair MR. Conscientious Objection in Health Care. Cambridge: Cambridge University Press; 2011.
[25] Institute of Medicine. Shaping the Future of Health. Crossing the Quality Chasm: A New Health System for the 21st Century. http://www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf. Published 2001. Accessed May 8, 2013.
[26] WHO. Quality of Care: A Process for Making Strategic Choices in Health Systems. Geneva: WHO; 2006. http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf.
[27] Endres v. Indiana State Police, 349 F.3d 922 (7th Cir. 2003) (cert. denied, 541 U.S. 989 (2004)), *cited in* Charo RA. American Constitution Society for Law and Policy, Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience. The Journal of the ACS Issue Groups 2007: 119–35. https://media.law.wisc.edu/m/yzdkn/charo_-_health_care_provider_refusals_-_feb_2007_-_advance_vol_1.pdf.
[28] Dickens BM, Cook RJ. Conscientious commitment to women's health. Int J Gynecol Obstet 2011;113:163–6.
[29] Harris L. Recognizing Conscience in Abortion Provision. N Engl J Med 2012;367(11):981–3.
[30] FIGO. Resolution on Conscientious Objection. http://www.figo.org/projects/conscientious. Published 2005. Accessed June 1, 2013.
[31] Republic of Italy. Ministry of Health. Report of the Ministry of Health on the Performance of the Law Containing Rules for the Social Care of Maternity and Voluntary Interruption of Pregnancy: 2006-2007 (2008).
[32] The Act (13 June 1995 no. 50), concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978 no. 5, at 14 (Norway).
[33] Health Services Act, Art. 56, Official Gazette of the Republic of Slovenia (Slovenia).
[34] The Abortion Act, Act No. 595/1974, as amended through Act No. 998/2007 (Sweden).
[35] Roe J, Francome C, Bush M. Recruitment and training of British obstetrician-gynaecologists for abortion provision: conscientious objection versus opting out. RHM 1999;7(14):97–105.
[36] Lo SS, Kok WM, Fan SY. Emergency contraception: knowledge, attitude and prescription practice among doctors in different specialties in Hong Kong. J Obstet Gynaecol Research 2009;35(4):767–74.
[37] Davidson LA, Pettis CT, Cook DM, Klugman CM. Religion and conscientious objection: a survey of pharmacists' willingness to dispense medications. Soc Sci Med 2010;71(1):161–5.
[38] Heino A, Gissler M, Apter D, Fiala C. Conscientious objection and induced abortion in Europe. Euro J Contracept Reprod Health Care 2013;18:231–3.
[39] Austrian Ministry of Health. Austrian Women's Health Report 2010/2011. Vienna: Ministry of Health; 2011.
[40] Oliveira da Silva M. Reflections on the legalisation of abortion in Portugal. Eur J Contracept Reprod Health Care 2009;14:245–8.
[41] Rodríguez-Calvo MS, Martínez-Silva IM, Concheiro L, Muñoz-Barús JI. University students' attitudes towards Voluntary Interruption of Pregnancy. Legal Medicine 2012;14(4):209–13.
[42] Guttmacher Institute. Attitudes and intentions of future health care providers toward abortion provision. Perspectives Sexual Reprod Health 2004;36(2):58–63.
[43] Rakhudu MA, Mmelesi AMM, Myburgh CPH, Poggenpoel M. Exploration of the views of traditional healers regarding the termination of pregnancy (TOP) law. Curationis 2006;29(3):56–60.
[44] Curlin FA, Lawrence RE, Chin MH, Lantos JD. Religion, conscience, and controversial clinical practices. N Engl J Med 2007;356(6):593–600.
[45] Goyal M, Zhao H, Mollen C. Exploring emergency contraception knowledge, prescription practices, and barriers to prescription for adolescents in the emergency department. Pediatrics 2009;123(3):765–70.
[46] Harris LH, Cooper A, Rasinski KA, Curlin FA, Lyerly AD. Obstetrician–gynecologists' objections to and willingness to help patients obtain an abortion. Obstet Gynecol 2011;118(4):905–12.
[47] Frank JE. Conscientious refusal in family medicine residency training. Family Medicine 2011;43(5):330–3.
[48] Gogna M, Romero M, Ramos S, Petracci M, Szulik D. Abortion in a restrictive legal context: the views of obstetrician-gynaecologists in Buenos Aires, Argentina. RHM 2002;10(19):128–37.
[49] de la Fuente Fonnest I, Sondergaard F, Fonnest G, Vedsted-Jacobsen A. Attitudes among health care professionals on the ethics of assisted reproductive technologies and legal abortion. Acta Obstet Gynecol Scand 2000;79(1):49–53.
[50] Marie Stopes International. General practitioners: attitudes to abortion 2007. http://www.mariestopes.org.uk/documents/GP%20attitudes%20to%20abortion%202007.pdf. Published 2007. Accessed June 17, 2013.
[51] Davis S, Schrader V, Belcheir MJ. Influencers of ethical beliefs and the impact on moral distress and conscientious objection. Nurs Ethics 2012;19(6):738–49.
[52] Aiyer AN, Steinman A, Ho GY. Influence of physician attitudes on willingness to perform abortion. Obstet Gynecol 1999;93(4):576–80.
[53] Hammarstedt M, Jacobsson L, Wulff M, Lalos A. Views of midwives and gynecologists on legal abortion—a population-based study. Acta Obstet Gynecol Scand 2005;84(1):58–64.
[54] Griggs SK, Brown CM. Texas community pharmacists' willingness to participate in pharmacist-initiated emergency contraception. JAPhA 2007;47(1):48–57.
[55] Wonkam A, Hurst SA. Acceptance of abortion by doctors and medical students in Cameroon. Lancet 2007;369(9578):1999.
[56] Suh S. Abortion Politics without Borders: The Implementation and Practice of Post-Abortion Care in Senegal. SSRN 2013. http://ssrn.com/abstract=2250193. Published April 13, 2013.
[57] Hagen GH, Hage CO, Magelssen M, Nortvedt P. Attitudes of medical students towards abortion. Tidsskr Nor Laegeforen 2011;131(18):1768–71.
[58] Kade K, Kumar D, Polis C, Schaffer K. Effect of nurses' attitudes on hospital-based abortion procedures in Massachusetts. Contraception 2004;69(1):59–62.
[59] Stulberg DB, Dude AM, Dahlquist I, Curlin FA. Obstetrician-gynecologists, religious institutions, and conflicts regarding patient-care policies. Am J Obstet Gynecol 2012;207(1):73 e1–5.
[60] Guttmacher Institute. Making Abortion Services Accessible in The Wake of Legal Reforms: A Framework And Six Case Studies. http://www.guttmacher.org/pubs/abortion-services-laws.pdf. Published 2012. Accessed June 15, 2013.
[61] International Planned Parenthood Federation. Abortion, Legislation in Europe. http://www.ippfen.org/NR/rdonlyres/ED17CA78-43A8-4A49-ABE7-64A836C0413E/0/Abortionlegislation_May2012corr.pdf. Updated May 2012. Accessed May 8, 2013.
[62] Mishtal J. Quiet Contestations of Irish Abortion Law: Reproductive Health Politics in Flux. In: Penny Light T, Stettner S, eds. The History and Politics of Abortion. Toronto: University of Toronto Press; 2014 (in press).
[63] Center for Reproductive Rights. The World's Abortion Laws Map 2013 and Update. http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_Factsheet_2013.pdf and http://worldabortionlaws.com/. Published 2013. Accessed June 15, 2013.
[64] Cohen SA. Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide. Guttmacher Policy Review 2009;12(4).
[65] Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, et al. Unsafe abortion: the preventable pandemic. Lancet 2006;368(9550):1908–19.
[66] Guttmacher Institute. In Brief: Fact Sheet. Facts on Induced Abortion Worldwide. http://www.guttmacher.org/pubs/fb_IAW.html. Published 2012. Accessed June 17, 2013.
[67] Singh S. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. Lancet 2006;369(9550):1887–92.
[68] Guttmacher Institute. Media Kit. Worldwide Abortion: Legality, Incidence and Safety. http://www.guttmacher.org/media/presskits/abortion-WW/statsandfacts.html. Accessed June 15, 2013.
[69] Ipas. Report on successes in achieving UN Global Strategy for Women's and Children's Health–September 2012. http://www.who.int/woman_child_accountability/ierg/reports/2012_10S_Ipas_submission_forIERGreport_1May2012.pdf. Published 2012. Accessed June 15, 2013.
[70] Sangonet. Unsafe Abortion in South Africa: A Preventable Pandemic. http://www.ngopulse.org/blogs/unsafe-abortion-south-africa-preventable-pandemic. Published July 2012. Accessed May 8, 2013.
[71] Republic of South Africa. Saving Mothers: Short. http://www.doh.gov.za/docs/reports/2012/savingmothersshort.pdf. Published 2012.
[72] Poongothai J. Genetics of human male infertility. Singapore Med J 2009;50(4):337.
[73] WHO. Mother or nothing: The agony of fertility. Bull World Health Organ 2010;88(12):877–953.
[74] WHO. Genomic Resource Centre. Gender and Genetics. Assisted Reproductive Technologies (ARTs). http://www.who.int/genomics/gender/en/index6.html.who.int/genomics/gender/en/index6.html. Accessed October 23, 2013.
[75] Inhorn M. Global infertility and the globalization of new reproductive technologies: illustrations from Egypt. Soc Sci Med 2003;56(9):1837–51.
[76] Chambers GM, Sullivan EA, Ishihara O, Chapman MG, Adamson GD. The economic impact of assisted reproductive technology: a review of selected developed countries. Fertil Steril 2009;91(6):2281–94.
[77] Chambers GM. The costs and consequences of assisted reproductive technology: an economic perspective. Hum Reprod Update 2010;6(6):603–13.
[78] Chavkin W. The Old Meets the New: Religion and assisted reproductive technologies. Development 2006;49(4):78–83.
[79] Giubellino G. I Would Not Freeze My Children. Clarín. http://edant.clarin.com/diario/2005/07/26/sociedad/s-03101.htm. Published July 26, 2005.
[80] Turone, F. Italian court upholds couple's demands for preimplantation genetic diagnosis. BMJ 2007;335(7622):687.

[81] United Nations. Department of Economic and Social Affairs. Population Division. World Contraceptive Use 2011, Wall Chart, Front Side. http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm. Accessed May 8, 2013.

[82] Creanga AA, Gillespie D, Karklins S, Tsui AO. Low use of contraception among poor women in Africa: an equity issue. Bull World Health Organ 2011;89(4):258–66.

[83] Center for Reproductive Rights. Over 700,000 Petitioners Demand Honduran Congress Reject Law Criminalizing Emergency Contraception. http://reproductiverights.org/en/press-room/over-700000-petitioners-demand-honduran-congress-reject-law-criminalizing-emergency-contr. Published May 16, 2012.

[84] WHO. Emergency Contraception Pills. . . Too Expensive? http://www.who.int/reproductivehealth/topics/family_planning/ec/en/index.html. Accessed October 23, 2013.

[85] Pieklo J. Care2. Oklahoma Rape Victim Turned Away from Hospital. http://www.care2.com/causes/oklahoma-rape-victim-turned-away-from-hospital.html. Published 2012. Accessed June 15, 2013.

[86] Spiegel Online. Cologne Archbishop Meisner approves "morning after" pill for rape victims. http://www.spiegel.de/panorama/gesellschaft/koelner-erzbischof-meisner-billigt-pille-danach-fuer-vergewaltigungsopfer-a-880814.html. Published January 31, 2013. Accessed June 15, 2013.

[87] Murray H, Baakdah H, Bardell T, Tulandi T. Diagnosis and treatment of ectopic pregnancy. CMAJ 2005;173(8):905.

[88] Togas T. Incidence, risk factors, and pathology of ectopic pregnancy. http://www.uptodate.com/contents/incidence-risk-factors-and-pathology-of-ectopic-pregnancy. Accessed February 23, 2012.

[89] Sivalingam VN, Duncan WC, Kirk E, Shephard LA, Home AW. Diagnosis and management of ectopic pregnancy. J Fam Plann Reprod Health Care 2011;37(4):231–40.

[90] American Pregnancy Association. Promoting Pregnancy Wellness. Miscarriage. http://americanpregnancy.org/pregnancycomplications/miscarriage.html. Accessed February 23, 2012.

[91] Berer M. Termination of pregnancy as emergency obstetric care: the interpretation of Catholic health policy and the consequences for pregnant women: An analysis of the death of Savita Halappanavar in Ireland and similar cases. RHM 2013;21(41):9–17.

[92] Case of Z v. Poland. Application no. 46132/08. Judgment (Merits and Just Satisfaction). http://hudoc.echr.coe.int/sites/eng-press/pages/search.aspx?i=001-114521#{"itemid":["001-114521"]}. Published 2012. Accessed June 15, 2013.

[93] Harvard University. David Rockefeller Center for Latin American Studies. Remobilization, Demobilization, and Incarceration: Women and Abortion in Post-war El Salvador. http://www.drclas.harvard.edu/node/853. Accessed October 23, 2013.

[94] Mollmann M. Over Their Dead Bodies—Denial of Access to Emergency Obstetric Care and Therapeutic Abortion in Nicaragua. Human Rights Watch 2007;19(2)(B). http://womenshealthnews.blogspot.com/2006/04/women-of-el-salvador.html. Published 2009. Accessed June 8, 2013.

[95] Skotko B. Mothers of children with Down syndrome reflect on their postnatal support. Pediatrics 2005;115(1):64–77.

[96] Hoehn KS, Wernovsky G, Rychik J, Tian ZY, Donaghue D, Gaynor JW, et al. Parental decision-making in congenital heart disease. Cardiol Young 2004;14(2004):309–14.

[97] R.R. v. Poland, No. 27617/04 ECHR. (2011).

[98] UN Human Rights Committee. General Comment 22, Article 18: The Right to Freedom of Thought, Conscience and Religion. A/48/40 vol. I (1993), para. 11.2.

[99] UN Committee on the Elimination of Discrimination against Women. General Recommendation 24: Article 12 of the Convention (women and health) (20th Sess., 1999), para.11. http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24. Accessed February 23, 2012.

[100] UN Committee on the Elimination of Discrimination against Women. Concluding Observations, Croatia, UN Doc. A/53/38 (1998), paras. 109, 117.

[101] UN Committee on the Elimination of Discrimination against Women. Concluding Observations. Italy. UN Doc. A/52/38 Rev.1, Part II (1997), paras. 353, 360.

[102] UN Committee on the Elimination of Discrimination against Women. Concluding Observations. South Africa. UN Doc. A/53/38/Rev.1 (1998), para. 113.

[103] UN. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover—Mission to Poland, 20 May 2010, UN Doc. A/HRC/14/20/Add.3.

[104] CESCR Committee. Concluding Observations. Poland. UN Doc. E/C.12/POL/CO/5 (2009), para. 28.

[105] WHO. Safe abortion: technical and policy guidance for health systems. Second edition. http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf. Published 2012. Accessed June 8, 2013.

[106] Ley Orgánica 2/2010, de 3 de marzo, de Salud Sexual y Reproductiva y de la Interrupción Voluntaria del Embarazo. [Law of Sexual and Reproductive Health and Abortion] (2010), Arts.17(4) and 14(a) (Spain).

[107] Law C-355 of 2006 (Colombia).

[108] Choice of Termination of Pregnancy Act 1996 (South Africa).

[109] Regulation to National Law No. 25.673, Art.10 (Argentina). Ministerio de Salud de la Nación [National Health Ministry]. Guía Técnicapara la Atención Integral de los Abortos No Punibles [Technical Guide for Comprehensive Care for Legal Abortions] (2010) (Argentina).

[110] National Law No. 26.130, Art.6 (Argentina).

[111] Codigo de Ética Medica [Ethical Medical Code], Chapter 5. (Uruguay). http://www.smu.org.uy/elsmu/institucion/documentos/doc/cem.html#cap5. Accessed February 23, 2013.

[112] Vique AB, Cabrera OA, Lugo FG, Hevia M. Women and Health in Uruguay. The Uruguayan Executive Veto for the Decriminalization of Abortion: Deconstructing the fundamentals. Notebooks: Contributions to the debate on health, citizenship and right. 2010; Epoca 1 (1). http://www.archivos.hacelosvaler.org/Cuaderno%201%20Final.pdf. Published 2010. Accessed February 23, 2012.

[113] Public Health Service Act (1973) (United States).

[114] Sonfeld A. Guttmacher Institute. Delineating the Obligations That Come with Conscientious Refusal: A Question of Balance. Guttmacher Policy Review 2009;12(30). http://www.guttmacher.org/pubs/gpr/12/3/gpr120306.html.

[115] Regulations for the Implementation of the Act dated 13 June 1995 no. 50 concerning Termination of 31 Pregnancy, with Amendments in the Act dated 16 June 1978, no. 66, §20 (Norway).

[116] Constitutional Court Decision, T-209 of 2008 (Colombia). http://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=30206. Published February 28, 2008.

[117] Judgment of the Bavarian Higher Administrative Court of 03/07/1990, BayVGH DVB1. 1990, 880-82 41 (Federal Republic of Germany).

[118] Judgment of the Federal Administrative Court of 12/13/1991, BVerwGE 89, 260-70 (Federal Republic of Germany).

[119] P. and S. v. Poland, Application no. 57375/08, Decision, October 30, 2012. http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-114098#{%22itemid%22:[%22001-114098%22]}. Accessed February 23, 2012.

[120] Code de la Sante Publique, arts. L2212-8, R4127-18 32 (France).

[121] Abortion Law Reform Act, Sec. 8 (Australia, Victoria).

[122] Constitutional Court Decision, T-388 of 2009 (Colombia).

[123] Colombia. Ministry of Social Protection. Governmental Decree 4444 of 2006, article 6. http://www.womenslinkworldwide.org/pdf_programs/es_prog_rr_col_legaldocs_decreto4444.pdf. Accessed July 19, 2012.

[124] Law No. 194 of 22 May 1978 on the social protection of motherhood and the voluntary termination of pregnancy, Gazz. Uff., Part I, 22 May 1978, No. 140, 3642-46 (Italy). http://www.columbia.edu/itc/history/degrazia/courseworks/legge_194.pdf. Accessed February 23, 2012.

[125] American Congress of Obstetricians and Gynecologists. ACOG Committee Opinion. The Limits of Conscientious Refusal in Reproductive Medicine 2007; Opinion Number 385. http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/The_Limits_of_Conscientious_Refusal_in_Reproductive_Medicine. Accessed August 27, 2013.

[126] El Sindicato Médico del Uruguay [Medical Association of Uruguay]. Chap 5, Art. 37 (Uruguay). http://www.smu.org.uy/publicaciones/libros/laetica/cem.htm#cap5. Accessed August 20, 2013.

[127] British Medical Association. Ethics Department. The Law and Ethics of Abortion: BMA Views. November 2007.

[128] World Medical Association. World Medical Association Declaration on Therapeutic Abortion. http://www.wma.net/e/policy/a1.htm. Published 2006.

[129] American Society of Health-System Pharmacists, Council on Legal and Public Affairs. ASHP Statement: Pharmacist's Right of Conscience and Patient's Right of Access to Therapy (0610). 2010.

[130] Anderson RM, Bishop LJ, Darragh M, Gray H, Nolen A, Poland SC, et al. National Reference Center for Bioethics Literature. The Joseph and Rose Kennedy Institute of Ethics. Pharmacists and Conscientious Objection. http://bioethics.georgetown.edu/publications/scopenotes/sn46.pdf. Accessed August 27, 2013.

[131] General Pharmaceutical Council. Standards of conduct, ethics and performance. July 2012.

[132] Decree No. 98-945 of 4 December 1998, setting forth the Code of Medical Ethics (Madagascar).

[133] National Association of Pharmacy Regulatory Authorities. Model Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons. http://www.nbpharmacists.ca/LinkClick.aspx?fileticket=wcx0ugUqRRE%3D&tabid=261&mid=695. Published 1999.

[134] Code of Ethics for Nurses in Australia, developed under the auspices of Australian Nursing and Midwifery Council, Royal College of Nursing, Australia, Australian Nursing Federation. 2008.

[135] Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland, 16 July 2008, the Department of Health, Social Services and Public Safety.

[136] Codigo Deontologico da Ordem dos Medicos [Code of Ethics of the Association of Doctors] (2008), Art. 37 (Portugal); 39 Lei No. [Law No.] 16/2007 de 17 de abril, Exclusão da ilicitudenos casos de interrupção voluntária da gravidez [Exclusion of cases of voluntary interruption of pregnancy] 40 (Portugal).

[137] Health Service Guidance HSG (94)39 (US).
[138] Abortion Act 1967 (England) (Section 4(1) of the 1967 Act permits that "no person shall be under any duty, whether by contractor by any statutory or other legal requirement, to participate in any treatment … to which he has a conscientious objection." This does not apply to emergency procedures.).
[139] Enright and another v. Kwun and Another, [2003] E.W.H.C. 1000 (Q.B.).
[140] Decree reforming Articles 145 and 148 of the new Penal Code of Mexico City and adding Articles 16 bis 6 and 16 bis 7 to the Health Law of Mexico City, reported in Official Gazette of Mexico City, 14, no. 7, 24 January 2004, pp. 6-7 (Mexico).
[141] Health Services Act, Art. 56, Official Gazette of the Rep. of Slovenia 36, No. 9, enacted 1992 (Slovenia).
[142] Wilmington General Hospital v. Manlove, 174 A2d 135 (Del SC 1961) (US).
[143] Nursing and Midwifery Council, The Code of Conduct, Professional standards for nurses and midwives (UK).
[144] National Law on Medical Practice, Dentistry, and Auxiliary Practices, Law 17.132 (Argentina).
[145] Janaway v. Salford Health Authority, 1988 (UK).
[146] Brahams D. Conscientious Objection and Referral Letter for Abortion. Lancet 1988;331(8590):893.
[147] 73 Fed. Reg. 78071 (December 19, 2008). 45 CFR Part 88 (2008).
[148] Galston WA, Rogers M. Brookings Institute. Governance Studies at Brookings. Health Care Providers' Consciences and Patients' Needs: The Quest for Balance. http://www.brookings.edu/~/media/research/files/papers/2012/2/23%20health%20care%20galston%20rogers/0223_health_care_galston_rogers.pdf. Published February 23, 2012.
[149] Office of the Secretary of Health and Human Services. Final Rule, Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws. http://www.gpo.gov/fdsys/pkg/FR-2011-02-23/pdf/2011-3993.pdf. Published February 23, 2011.

EXHIBIT E

May 2011: National poll shows majority support healthcare conscience rights, conscience law

Highlights of *the polling company, inc.* Phone Survey of the American Public

On May 3, 2011, the Christian Medical Association and the Freedom2Care coalition released the results of a nationwide, scientific poll conducted April 29-May 1, 2011 by the polling company™, inc./ WomanTrend. Survey of 1000 American Adults, Field Dates: April 29-May 1, 2011, Margin of Error=±3.1.

1. **77%** of American adults surveyed said it is either "very" or "somewhat" important to them that "that healthcare professionals in the U.S. are **not forced to participate** in procedures or practices to which they have **moral objections**." **16%** said it is not important.

ALL		*PRO-CHOICE* (n=465)	*PRO-LIFE* (n=461)
77%	Total **important** (net)	68%	85%
52%	Very important	42%	64%
25%	Somewhat important	26%	21%
16%	Total **not important** (net)	24%	8%
8%	Not too important	11%	5%
8%	Not at all important	13%	3%
8%	Do not know/depends	8%	6%
1%	Refused	*	

2. **50%** of American adults surveyed "strongly" or "somewhat" support "a **law** under which federal agencies and other government bodies that receive federal funds could **not discriminate** against hospitals and health care professionals who **decline to participate in abortions**." **35%** opposed.

ALL		*PRO-CHOICE* (n=465)	*PRO-LIFE* (n=461)
50%	Total **support** (net)	45%	58%
29%	Strongly support	20%	40%
21%	Somewhat support	25%	18%
35%	Total **oppose** (net)	43%	32%
14%	Somewhat oppose	20%	10%
21%	Strongly oppose	23%	22%
7%	It depends/need more info.	7%	5%
7%	Do not know	6%	5%
1%	Refused	1%	1%

April, 2009: Two National Polls[1] Reveal Broad Support for Conscience Rights in Health Care

Highlights of *the polling company, inc.* Phone Survey of the American Public

39% Democrat • 33% Republican • 22% Independent

1. **88%** of American adults surveyed said it is either "very" or "somewhat" **important to them that they share a similar set of morals as their doctors**, nurses, and other healthcare providers.
2. **87%** of American adults surveyed believed it is important to "make sure that healthcare professionals in America are **not forced to participate** in procedures and practices to which they have moral objections."
3. Support for the conscience protection regulation (rule finalized Dec. 2008):
   - **63% support conscience protection regulation**
   - 28% oppose conscience protection regulation
4. Support for Obama administration proposal to eliminate the new conscience protection regulation:
   - 30% support Obama administration proposal
   - **62% oppose Obama administration proposal**
5. Likelihood of voting for current Member of Congress who supported eliminating the conscience rule:
   - 25% more likely to vote for Member who supported eliminating rule
   - **54% less likely to vote for Member who supported eliminating rule**
6. "In 2004 the Hyde-Weldon Amendment was passed. It ruled that taxpayer funds must not be used by governments and government-funded programs to discriminate against hospitals, health insurance plans, and healthcare professionals who decline to participate in abortions. Do you support or oppose this law?"
   - **58% support Hyde-Weldon Amendment**
   - 31% oppose Hyde-Weldon Amendment

Highlights of Online Survey of Faith-Based Professionals

2,865 faith-based healthcare professionals

1. **Over nine of ten** (91%) faith-based physicians agreed, "I would **rather stop practicing medicine** altogether than be forced to violate my conscience."
2. **32%** of faith-based healthcare professionals report having "been **pressured to refer a patient** for a procedure to which [they] had moral, ethical, or religious objections."
3. **39%** of faith-based healthcare professionals have "experienced pressure from or **discrimination by faculty** or administrators based on [their] moral, ethical, or religious beliefs"
4. **20%** of faith-based medical students say they are "**not pursuing a career in Obstetrics or Gynecology**" because of perceived discrimination and coercion in that field.

[1] Results of both 2009 surveys released April 8. On behalf of the Christian Medical Association, the polling companyTM, inc./ WomanTrend conducted a nationwide survey of 800 American adults. Field Dates: March 23 -25, 2009. The overall margin of error for the survey is ± 3.5% at a 95% confidence interval. The polling companyTM, inc./ WomanTrend also conducted an online survey of members of faith-based organizations, fielded March 31, 2009 to April 3, 2009. It was completed by 2,298 members of the Christian Medical Association, 400 members of the Catholic Medical Association, 69 members of the Fellowship of Christian Physicians Assistants, 206 members of the Christian Pharmacists Fellowship International, and 8 members of Nurses Christian Fellowship. http://www.freedom2care.org/learn/page/surveys

April 2009 Phone Survey of the American Public

Americans of all characteristics and politics seek shared values with healthcare professionals.

Fully 88% of American adults surveyed said it is either "very" or "somewhat" important to them that they enjoy a similar set of morals as their doctors, nurses, and other healthcare providers. Intensity was strong, as 63% described this as "very" important while at the other end of the spectrum, just 6% said it is "not at all important," a ratio of more than 10-to-1.

Voters will punish politicians who fail to defend healthcare providers' conscience rights.

Finally, when asked how they would view their Member of Congress if he or she voted against conscience protection rights, 54% indicated they would be less likely to back their United States Representative. In fact, 36% said they would be much less likely, a figure three times greater than the 11 % who said they would be much more likely. Furthermore, 43% of respondents who said they voted for President Obama indicated that they would be less inclined to back a Member of Congress if he or she opposed conscience protection rights.

Healthcare providers' conscience protections are viewed as an inalienable right.

A sizable 87% of American adults surveyed believed it is important to "make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections." 65% of respondents considered it very essential. Also joining with these majorities were 95% of respondents who self-identified as "pro-life," 78% who considered themselves "pro-choice," 94% who voted for Senator McCain in November 2008 and 80% who cast a ballot for (now) President Obama.

Americans oppose forcing healthcare providers to act against their consciences...

A majority (57%) of American adults opposed regulations "that require medical professionals to perform or provide procedures to which they have moral or ethical objections." In contrast, 38% favored such rules. A full 40% strongly objected to the rules while just 19% strongly backed them. A majority of conservative Republicans (69%), moderate Republicans (69%), and conservative Democrats (59%), as well as the plurality of liberal/moderate Democrats (49%), joining together to reject policies to that require doctors and nurses to act against their personal moral code or value set.

...Support laws that protect them from doing so...

Without any names or political parties being mentioned, support for the new conscience protection rule outpaced opposition by a margin of more than 2-to-1 (63% vs. 28%). Intensity favored the rule, with 42% strongly backing it and 19% strongly rejecting it. Endorsements for the rule spanned demographic and political spectra, with majorities in all cohorts offering their support. In fact, even 56% of adults who said they voted for President Obama last fall and 60% of respondents who self-identified as "pro-choice" said they favor this two-month old conscience protection rule.

... And oppose any efforts to remove such rules.

Opposition to revocation of the conscience protection rule outpaced support by a margin of more than 2- to-1 (62% vs. 30%). Intensity favored retention of the rule (44% strongly opposing rescission versus 17% strongly supporting it). There was consistent demographic alignment and cohesiveness across political lines, as 52% of self-identified Democrats, 67% of self-identified Independents, and 73% of self- identified Republicans, as well as 50% of liberals, 65% of moderates, and 69% of conservatives also opposed nullification. A narrow majority (53%) of people who considered themselves to be "pro-choice" opposed rescission. Notably, a small number

(7%) were ambivalent or undecided, saying they did not know or lacked the information to render an opinion one way or the other.

Online Survey of Faith-Based Medical Professionals

1. Medical access will suffer if doctors are forced to act against their moral and ethical codes.

In the survey of 2,865 members of faith-based organizations, doctors and other medical professionals voiced their concerns that serious consequences could occur if doctors are forced to participate in or perform practices to which they have moral or ethical objections. Nearly three-quarters (74%) believed that elimination of the conscience protection could result in "fewer doctors practicing medicine," 66% predicted "decreased access to healthcare providers, services, and/or facilities for patients in low-income areas," 64% surmised "decreased access to healthcare providers, services, and/or facilities for patients in rural areas," and 58% hypothesized "fewer hospitals providing services."

Asked how rescission of the rule would affect them personally, 82% said it was either "very" or "somewhat" likely that they personally would limit the scope of their practice of medicine. This was true of 81% of medical professionals who practice in rural areas and 86% who work full-time serving poor and medically-underserved populations.

The conscience protection rule is fundamental and necessary in the medical profession.

Fully 97% of members who participated in the survey supported the two-month-old conscience protection clause and 96% objected to rescission of the rule. 91% of physicians agreed, "I would rather stop practicing medicine altogether than be forced to violate my conscience." The Department of Health and Human Services has asked whether the objectives of the conscience protection rule can be achieved "through non-regulatory means, such as outreach and education." Nearly nine-in-ten (87%) members surveyed – those who are on the ground, in hospitals and clinics across the country – felt "outreach and education" alone were insufficient to accomplish the goal. Ninety-two percent declared the codification of conscience protection to be necessary (83% "very" and 9% "somewhat") based on their knowledge of "discrimination in healthcare on the basis of conscience, religious, and moral values."

Discrimination is widespread in education and professional practice.

Asked to assess their educational experiences:

- 39% have "experienced pressure from or discrimination by faculty or administrators based on [their] moral, ethical, or religious beliefs"
- 33% have "considered not pursuing a career in a particular medical specialty because of attitudes prevalent in that specialty that is not considered tolerant of [their] moral, ethical or religious beliefs."
- 23% have "experienced discrimination during the medical school or residency application and interview process because of [their] moral, ethical or religious beliefs."

Asked to assess their professional experiences:

- 32% have "been pressured to refer a patient for a procedure to which [they] had moral, ethical, or religious objections."
- 26% have "been pressured to write a prescription for a medication to which [they] had moral, ethical, or religious objections."
- 17% have "been pressured to participate in training for a procedure to which [they] had moral, ethical, or religious objections."
- 12% have "been pressured to perform a procedure to which [they] had moral, ethical, or religious objections."

Discrimination is forcing faith-based medical students to shun careers in Obstetrics and Gynecology.

- 20% of students surveyed agreed with the statement, "I am **not pursuing a career in Obstetrics or Gynecology** mainly because I do not want to be forced to compromise my moral, ethical, or religious beliefs by being required to perform or participate in certain procedures or provide certain medications."
- **96%** of medical students support (90% "Strongly Support") the conscience protection regulation.
- 32% of medical students say they "have experienced pressure from or **discrimination by faculty** or administrators based on your moral, ethical, or religious beliefs."

EXHIBIT F

TO: Interested Parties

FROM: Kellyanne Conway, President & CEO
the polling company™, inc./WomanTrend

DATE: April 8, 2009

RE: Key Findings on Conscience Rights Polling

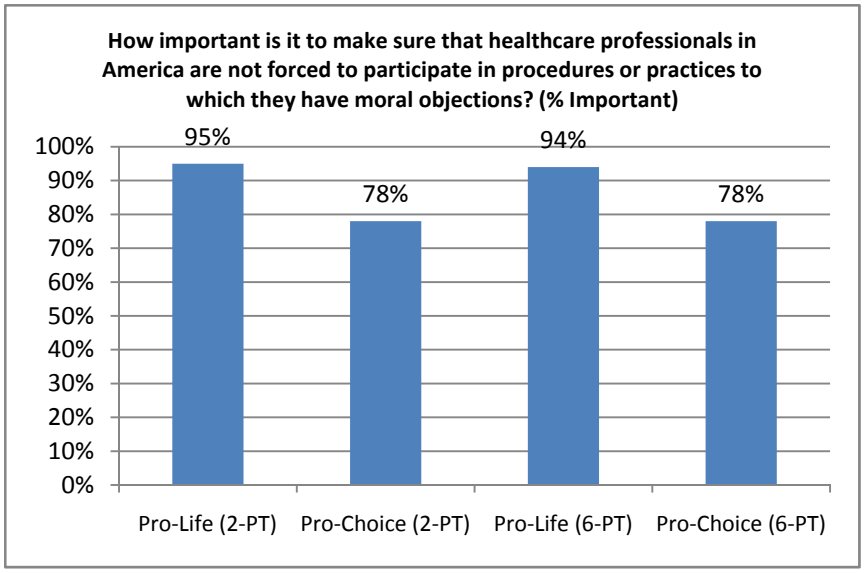
On behalf of the Christian Medical & Dental Association (CMDA), the polling company™, inc./ WomanTrend *conducted a nationwide survey of 800 American adults and an online survey of members of faith-based medical organizations. Full statements of methodology can be found at the conclusion of this document.*

Americans of All Demographic Characteristics and Political Stripes Seek a Shared a Set of Values with their Healthcare Providers.

Fully 88% of American adults surveyed said it is either "very" or "somewhat" important to them that they enjoy a similar set of morals as their doctors, nurses, and other healthcare providers. Intensity was strong, as 63% described this as "very" important while at the other end of the spectrum, just 6% said it is "not at all important," a ratio of more than 10-to-1.

Healthcare Providers' Conscience Protections Viewed as an Inalienable Right

A sizable 87% of American adults surveyed believed it is important to ***"make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections."*** Support for this protection garnered considerable intensity as well, with 65% of respondents considering it very essential. Majorities of men, women, and adults of all ages, races, regions, and political affiliations considered it critical to defend the rights of healthcare providers to refuse to perform certain procedures on moral grounds. Also joining with these majorities were 95% of respondents who self-identified as "pro-life," 78% who considered themselves "pro-choice," 94% who voted for Senator McCain in November 2008 and 80% who cast a ballot for (now) President Obama.



Americans Oppose The *Principle* of Forcing Healthcare Providers to Act Against Their Consciences...

A majority (57%) of American adults opposed regulations ***"that require medical professionals to perform or provide procedures to which they have moral or ethical objections."*** In contrast, 38% favored such rules. The potency of opposition was twice that of the supporters: 40% strongly objected to the laws while just 19% strongly backed them. Politically, a majority of conservative Republicans (69%), moderate Republicans (69%), and conservative Democrats (59%), as well as the plurality of liberal/moderate Democrats (49%), joining together to reject policies to that require doctors and nurses to act against their personal moral code or value set.

…Support Laws That Protect Them From Doing So…
Without any names or political parties being mentioned, respondents were provided with a short description of the new conscience protection law and its recent inception: ***"Just two months ago, a federal law known as 'conscience protection' went into effect after reports of doctors being discriminated against for declining to perform abortions. It protects doctors and other medical professionals who work at institutions that receive federal money from performing medical procedures to which they object on moral or religious grounds."***

After hearing this short description, support for this new law outpaced opposition by a margin of more than 2-to-1 (63% vs. 28%). Intensity favored the law, with 42% strongly backing it and 19% strongly rejecting it. Endorsements for the rule spanned demographic and political spectra, with majorities in all cohorts offering their support. **In fact, even 56% of adults who said they voted for President Obama last fall and 60% of respondents who self-identified as "pro-choice" said they favor this two-month old conscience protection rule.**

… And Oppose Any Efforts to Remove Such Laws.
Next, respondents were asked to react to the proposed rescission of the conscience protection law: *"Earlier this month, officials from the U.S. Department of Health and Human Services introduced a rule change that would effectively eliminate the two-month-old conscience protection. This could mean that doctors and other medical professionals could be coerced to participate in medical procedures to which they object on moral or religious grounds."*

Opposition to revocation of the conscience protection law outpaced support by a margin of more than 2-to-1 (62% vs. 30%). As was the case in the previous question, intensity favored retention of the law (44% strongly opposing rescission versus 17% strongly supporting it). Again, there was consistent demographic alignment, as a majority of men, women, and adults of all ages, races, incomes, regions, and geographic types stood together to reject removal of the law. And, there was cohesiveness across political lines, as 52% of self-identified Democrats, 67% of self-identified Independents, and 73% of self-identified Republicans, as well as 50% of liberals, 65% of moderates, and 69% of conservatives also opposed nullification. A narrow majority (53%) of people who considered themselves to be "pro-choice" opposed rescission. Notably, a small number (7%) were ambivalent or undecided, saying they did not know or lacked the information to render an opinion one way or the other.

Rescission of Conscience Protection Viewed by a Majority as Government Insinuating Itself into the Patient-Physician Relationship.
When asked whether rescission of the rule and a resulting forced participation of doctors in abortions is a sign of more, less, or the right amount of government involvement in medicine, the majority (58%) said it exemplified excessive participation. Just 18% thought it reflected the ideal role and 11% believed it was still too minimal.

The Political Currency Calculus: Voters Will Punish Politicians Who Fail to Defend Healthcare Providers' Rights to Refuse to Violate Their Conscience in the Name of Medicine.
Finally, when asked how they would view their Member of Congress if he or she voted ***against*** conscience protection rights, 54% indicated they would be less likely to back their United States Representative. In fact, 36% said they would be *much less likely*, a figure three times greater than the 11% who said they would be *much more likely*. Furthermore, 43% of respondents who said they voted for President Obama indicated that they would be less inclined to back a Member of Congress if he or she opposed conscience protection rights.

Rescission of Conscience Protections May be a Priority for Obama Administration, but not for his Constituents.

When presented with a list of 13 areas for the sitting Congress and current President to address and allowed to select multiple answers, only 10% of American adults preferred that Washington devote its time and energy to abortion policy. In fact, the issue of abortion was ranked 9th out of 13 among the issues offered to survey respondents. Moreover, adults desirous of action on abortion policy were six times more likely to be "pro-life" than "pro-choice" (19% vs. 3%). In contrast, no less than 68% of any demographic or political cohort studied said that President Obama and Congressional leaders should focus on the economy and jobs.

Real Effects Likely to Be Felt in Medical Community If Doctors Forced to Act Against Their Moral and Ethical Codes

In the survey of 2,865 members of faith-based organizations, doctors and other medical professionals voiced their concerns that serious consequences could occur if doctors are forced to participate in or perform practices to which they have moral or ethical objections. Nearly three-quarters (74%) believed that elimination of the conscience protection could result in "fewer doctors practicing medicine," 66% predicted "decreased access to healthcare providers, services, and/or facilities for patients in low-income areas," 64% surmised "decreased access to healthcare providers, services, and/or facilities for patients in rural areas," and 58% hypothesized "fewer hospitals providing services."

When asked how rescission of the conscience rule would affect them personally, fully 82% said it was either "very" or "somewhat" likely that they personally would limit the scope of their practice of medicine. This was true of 81% of medical professionals who practice mainly in rural areas and 86% who work full-time in serving poor and medically-underserved populations.

Conscience Protection Rule Fundamental and Necessary in the Medical Profession, According to Members of the Christian Medical & Dental Association, the Catholic Medical Association, and the Christian Pharmacists Fellowship International

Fully 97% of members who participated in the survey supported the two-month-old conscience protection clause and 96% objected to rescission of the rule.

The Department of Health and Human Services has asked whether the objectives of the conscience protection law can be achieved "through non-regulatory means, such as outreach and education." Nearly nine-in-ten (87%) members surveyed – those who are on the ground, in hospitals and clinics across the country – felt "outreach and education" alone were insufficient to accomplish the goal.

Ninety-two percent declared the codification of conscience protection to be necessary (83% "very" and 9% "somewhat") based on their knowledge of "discrimination in healthcare on the basis of conscience, religious, and moral values." Many respondents held this opinion due in part to their own personal experience. When asked to assess their educational experiences:

- 39% have "experience pressure from or discrimination by faculty or administrators based on [their] moral, ethical, or religious beliefs"
- 33% have "considered not pursuing a career in a particular medical specialty because of attitudes prevalent in that specialty that is not considered tolerant of [their] moral, ethical or religious beliefs."
- 23% have "experienced discrimination during the medical school or residency application and interview process because of [their] moral, ethical or religious beliefs."

And, when asked to assess their professional experiences:

- 32% have "been pressured to refer a patient for a procedure to which [they] had moral, ethical, or religious objections
- 26% have "been pressured to write a prescription for a medication to which [they] had moral, ethical, or religious objections
- 17% have "been pressured to participate in training for a procedure to which [they] had moral, ethical, or religious objections."
- 12% have "been pressured to perform a procedure to which you had moral, ethical, or religious objections."

STATEMENT OF METHODOLOGY

Nationwide Survey of Adults:
On behalf of the **Christian Medical & Dental Association,** the polling company™, inc./ WomanTrend conducted a nationwide survey of 800 American Adults (18+). The survey contained one screener question, 10 substantive questions, and 13 demographic inquiries. All substantive questions were closed-ended in nature.

The survey was fielded March 23-25, 2009 at a Computer-Assisted Telephone Interviewing (CATI) facility using live callers. The sample was drawn utilizing Random Digit Dial, a computer dialing technique that ensures that every household in the nation with a landline telephone has an equal chance of being called. Each respondent was screened to ensure he or she was 18 years of age.

Sampling controls were used to ensure that a proportional and representative number of people were interviewed from such demographic groups as age, race and ethnicity, and region according to the most recent figures available from the U.S. Census Bureau and voter registration and turnout figures. After data collection, weighting was used to ensure that the sample reflected the current population. This is a common and industry-accepted practice. Age, race, and gender were allowed four points of flexibility in pre-set quotas while three points of flexibility was permitted on region.

The overall margin of error for the survey is ± 3.5% at a 95% confidence interval, meaning that in 19 out of 20 cases, the data obtained would not differ by any more than 3.5 percentage points in either direction if the survey were repeated multiple times employing this methodology and sampling method. Margins of error for subgroups are higher.

Online Survey of Members of Faith-Based Medical Organizations:
On behalf of the **Christian Medical & Dental Association,** the polling company™, inc./ WomanTrend conducted an online survey of members of faith-based organizations. The Catholic Medical Association and Christian Pharmacists Fellowship International also invited their members to participate.

The survey was fielded March 31, 2009 to April 3, 2009 and was completed by 2,865 members of the Christian Medical and Dental Association (CMDA), 400 members of the Catholic Medical Association (CMA), 69 members of the Fellowship of Christian Physicians Assistants, 206 members of the Christian Pharmacists Fellowship International, and 8 members of Nurses Christian Fellowship. Respondents were allowed to select membership in multiple organizations.

Each respondent was provided with a unique hyperlink to take the survey, allowing no member to take the survey more than once and prohibiting respondents from passing the link to another individual after completing the survey.

This survey is intended to demonstrate the views and opinions of members surveyed. It is not intended to be representative of the entire medical profession nor of the entire membership rosters of these organizations. Respondents who participated in the survey were self-selecting.

EXHIBIT G

March 26, 2018

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

RE: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN: 0945-ZA03 Comments

Dear Secretary Azar:

On behalf of the more than 123,000 PAs (physician assistants) throughout the United States, the American Academy of PAs (AAPA) welcomes the opportunity to submit comments to the Department of Health and Human Services (HHS) regarding the recent creation of the Conscience and Religious Freedom Division, along with the release of a rule to impose additional enforcement mechanisms with regard to federal laws that grant healthcare professionals the right to decline to participate in medical procedures to which they are opposed on moral or religious grounds.

In the proposed rule, the Office for Civil Rights (OCR) seeks to strengthen enforcement of existing statutory conscience protections for healthcare providers to protect them from being coerced into participating in activities that may violate their beliefs. The proposed rule also creates a new Conscience and Religious Freedom Division within OCR.

AAPA's policy, which is contained in its Guidelines for Ethical Conduct for the PA Profession, provides guidance on how PAs should act in situations where they believe their beliefs may be compromised, and how best to manage these beliefs in relation to a PA's obligation to provide the best possible care to their patients.

AAPA is concerned that the proposal's effort to broaden the scope of conscience objection regulations and to increase related enforcement efforts could have a negative impact on access to healthcare for patients, especially those who are most vulnerable and those who may live in rural or underserved areas. AAPA is also concerned new paperwork requirements related to "Assurance and Certification of Compliance" could be excessively burdensome to healthcare providers.

PA Practice

PAs are medical professionals who manage the full scope of patient care, often serving patients with multiple comorbidities. They conduct physical exams, order and interpret tests, diagnose and treat illnesses, develop and manage treatment plans, prescribe medications, assist in surgery, and counsel

patients on preventative healthcare, and often serve as a patient's principal healthcare professional. PAs are one of three categories of healthcare professionals, including physicians and nurse practitioners, who are authorized by law to provide primary care in the United States. In addition to primary care, PAs practice in a wide range of settings and medical specialties, improving healthcare access and quality.

AAPA Policy on Personal Beliefs and Patient Access to Care

The foremost value of the PA profession is respect for the health, safety, welfare, and dignity of all human beings, which requires PAs to always act in the best interest of their patients. This concept is the foundation of the patient–PA relationship, and underpins PAs' ethical obligation to see that each of their patients receives appropriate care.

The PA profession's policy on nondiscrimination is as follows: "PAs should not discriminate against classes or categories of patients in the delivery of needed healthcare. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation."

Importantly, our policy also holds that, "While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. A PA has an ethical duty to offer each patient the full range of information on relevant options for their healthcare. *If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer a patient to another qualified provider.*" [Emphasis added.]

AAPA View and Recommendations

AAPA has significant concerns about the proposed regulatory changes because they put the personal beliefs of healthcare providers above each provider's paramount responsibility to ensure that every patient has access to care. We urge the administration to be cognizant of creating new barriers for healthcare for our most vulnerable populations, which would undermine the progress made in addressing medical disparities among these groups. Doing what is best for the patient must continue to be of utmost concern.

In promulgating the final rule and undertaking new initiatives, AAPA urges the department to work with all relevant healthcare provider groups to ensure that any actions are supported by and consistent with best healthcare practices, and that every patient has access to appropriate care.

AAPA looks forward to working with Secretary Azar, HHS and all relevant parties moving forward. Please do not hesitate to contact Tate Heuer, AAPA Vice President, Federal Advocacy, at 571-319-4338 or theuer@aapa.org, with any questions.

Sincerely,

L. Gail Curtis, MPAS, PA-C, DFAAPA
President and Chair of the Board

EXHIBIT H

ANA
AMERICAN NURSES ASSOCIATION

AMERICAN ACADEMY OF NURSING
transforming health policy and practice through nursing knowledge

March 23, 2018

Office for Civil Rights
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Constitution Avenue, NW
Washington, DC 20210

Attention: Conscience Notice of Proposed Rule Making (NPRM), RIN 0945-ZA03

Submitted electronically to www.regulations.gov

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority
[HHS-OCR-2018-0002; RIN 0945-ZA03]

Dear Sir/Madam:

The American Nurses Association (ANA) and the American Academy of Nursing (AAN) submit the following comments in response to the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) Proposed Rule: *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*. This proposed rule requests comment on a number of provisions contained therein, and ANA and AAN through this comment letter seek to highlight the potential negative and unintended impacts which might follow from the final implementation of such, and offers policy recommendations. ANA is the premier organization representing the interests of the nation's 3.6 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. AAN serves the public and the nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. The Academy's more than 2,400 fellows are nursing's most accomplished leaders in education, management, practice, and research.

ANA and AAN strongly support the right and prerogative of nurses - and all healthcare workers – to heed their moral and ethical values when making care decisions. However, the primacy of the patient in nursing practice is paramount, and the moral and ethical considerations of the nurse should never, under any circumstance, result in the inability of the patient to receive quality, medically necessary, and compassionate care.

ANA and AAN are concerned that this proposed rule, in strengthening the authority of OCR to enforce statutory conscience rights under the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other federal statutes, could lead to inordinate discrimination against certain patient populations – namely individuals seeking reproductive

health care services and lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) individuals. Proliferation of such discrimination – which in the case of LGBTQ individuals is unlawful under Section 1557 of the Affordable Care Act (ACA) – could result in reduced access to crucial and medically necessary health care services and the further exacerbation of health disparities between these groups and the overall population.

Discrimination in health care settings remains a grave and widespread problem for many vulnerable populations and contributes to a wide range of health disparities. Existing religion-based exemptions already create hardships for many individuals. The mission of HHS is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, patient care, public health, and social services. This proposed rule fails to ensure that all people have equal access to comprehensive and nondiscriminatory services, and dangerously expands the ability of institutions and entities, including hospitals, pharmacies, doctors, nurses, even receptionists, to use their religious or moral beliefs to discriminate and deny patients health care. All patients deserve universal access to high quality care and we as health care providers must guard against any erosion of civil rights protections in health care that would lead to denied or delayed care.

ANA and AAN believe that HHS should rescind this proposed rule and instead, through OCR, should create a standard for health systems and individual practices to ensure prompt, easy access to critical health care services if an individual provider has a moral or ethical objection to certain health care services; such a standard should build on evidence-based and effective mechanisms to accommodate conscientious objections to services including abortion, sterilization, or assisted suicide as cited in the proposed rule. ANA and AAN also believe that in no instance should a nurse – or any health care provider – refuse to treat a patient based on that patient's individual attributes; such treatment violates one of the central tenets of the professional *Code of Ethics for Nurses*. No patient should ever be deprived of necessary health care services or of compassionate health care; it is incumbent upon HHS to work to create accommodations to that end.

Code of Ethics for Nurses and Moral and Ethical Obligations

The critical importance of the relationship between the patient and the nurse is inherent in the fact that Provision 1 and Provision 2 of the *Code of Ethics for Nurses*[1] deal explicitly with these topics.

Affirming Health through Relationships of Dignity and Respect: *Provision 1 of the Code of Ethics:* states that "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person."[2] This includes respect for the human dignity of the patient and the demand that nurses must never behave prejudicially – which is to say, with

[1]American Nurses Association. *Code of Ethics for Nurses with Interpretive Statements*. 2015: Second Edition.
[2]Ibid: Pg. 1.

unjust discrimination. Nurses can and should base patient care on individual attributes, but only in the sense that those individual attributes inform the patient's care plan; nurses must always respect the dignity of such individual attributes.

Health care professionals work within a matrix of legal, institutional, and professional constraints and obligations, and their primary commitment to patients remains the foundational responsibility of health care.[3] *Provision 2* states that "The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population."[4] Provision 2 explicitly establishes the primacy of the patient's interests in health care settings; this principle also situates the nurse-patient relationship within a larger "ethic of care" which encompasses the entire relational nexus in which the nurse and patient are situated, including the patient, the patient's family or close relationships, the nurse, the healthcare team, the institution or agency, and even societal expectations of care."[5]

While the primacy of the patient is not the only consideration when a nurse makes a care decision, it is the consideration which carries by far the most relative weight. Nurses then must base care decisions primarily on patients' needs. If a nurse feels that a moral or ethical consideration prevents him or her from delivering health care services, then the nurse, the full medical team, and/or the practice, institution, health system, or agency, should make an exhaustive and good-faith effort to ensure that the patient easily and promptly receives those health care services. In addition to the provisions contained within this proposed rule, OCR must implement guidelines by which the aforementioned stakeholders must ensure access to essential and quality health care services for all patients.

Considerations for Access to Reproductive Health Care Services

In addition to providing competent, professional and high quality care, there is also an emphasis on providing evidence-informed patient education and support as part of the nursing standard of care. The nursing profession holds sacred the patient's right of autonomy to make informed decisions to direct his or her care, as well as the crucial role that nurses play in supporting the patient. Patient education and advocacy are essential elements of the nursing process. Thus, it is the patients' decisions, regardless of faith or moral convictions, that should guide healthcare providers' care of patients, as articulated in the Code of Ethics for Nurses with Interpretive Statements.

For nurses who have concerns about the provision of specific healthcare services, existing laws and ethical guidelines are more than adequate to protect the rights of health care providers to follow their moral and religious convictions. There already exist effective models to accommodate providers' moral and religious beliefs in training and practice, while striking a

[3]Stahl, Ronit Y. and Emanuel, Ezekiel J. *Physicians, Not Conscripts — Conscientious Objection in Health Care*. The New England Journal of Medicine: 2017 April; 376: 1380-1385.
[4]American Nurses Association. Code *of Ethics for Nurses*: Pgs. 25-26.
[5]Ibid: Pg. 28.

crucial balance with delivering evidence-based, patient-centered care.[6] This proposed rule skews that balance, lowers the bar for care necessary for patients in vulnerable populations, and exposes women who seek reproductive health care to discrimination and harmful delays.[7] Such discrimination is well-documented – one study notes that 24% of women were denied treatment by a health care provider for pregnancy termination.[8] The proposed rule defines "discrimination" for the first time in a way that subverts the language of landmark civil rights statutes to shield those who discriminate, rather than protecting against discrimination.[9]

The proposed rule provides a broad definition of "assist in the performance" of an activity to which an individual can refuse to participate. The definition allows for blanket discrimination by permitting a broad interpretation of not only what type of services that can be refused but also the individuals who can refuse. For example, under this proposed rule, a receptionist can refuse to schedule a patient's pregnancy termination or appointment for contraception consultation. This expansion violates the plain meaning of the existing law and goes against the stated mission of HHS.

Data suggest that health care providers believe that even when they are morally opposed to offering care, they are willing to make referrals and coordinate care according to care coordination standards to ensure adequate, timely and safe care, as well as full information about standard of care and available services, is provided for all patients.[10] Yet, the proposed rule creates a definition of "referral" that allows refusal to provide any information that could help the patient receive the proper care necessary; withholding information or complete care recommendations (e.g., professionals withholding diagnostic or treatment information) is unethical.

International professional associations such as the World Medical Association, as well as national medical and nursing societies and groups such as the American Congress of Obstetricians and Gynecologists and the Royal College of Nursing, Australia, have similarly agreed that the provider's right to conscientiously refuse to provide certain services must be secondary to his or her first duty, which is to the patient.[11] This right to refuse must be bound

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[6]National Women's Law Center. *Trump Administration Proposes Sweeping Rule to Permit Personal Beliefs to Dictate Health Care.* February 16, 2018. Web: https://nwlc.org/resources/trump-administration-proposes-sweeping-rule-to-permit-personal-beliefs-to-dictate-health-care/

[7]Ibid.

[8]Biggs, M. Antonia and John M. Neuhaus and Diana G. Foster. *Mental Health Diagnoses 3 Years After Receiving or Being Denied an Abortion in the United States.* The American Journal of Public Health: 2015 December; 105(12): 2557-2563.

[9]National Women's Law Center. *Trump Administration Proposes Sweeping Rule to Permit Personal Beliefs to Dictate Health Care.*

[10]Harris, LH et al. *Obstetrician-gynecologists' objections to and willingness to help patients obtain an abortion.* Obstetrics and Gynecology: 2011 October; 118(4): 905-912.

[11]Chavkin, W. et al. *Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences, and policy responses.* The International Journal of Gynaecology and Obstetrics: 2013 December; 123 Supplement 3: S41-56.

by obligations to ensure that the patient's autonomous rights to information and services are not infringed upon.[12]

Considerations for the Protection of LGBTQ Access to Health Care Services

LGBTQ populations experience a significant rate of discrimination in health care settings, and also experience negative health outcomes compared with the overall population. The reasons for this are complex and varied, but many stem from a pattern of societal stigma and discrimination[13] exacerbated by the historical designation of homosexuality as a mental disorder[14], the onset of the HIV/AIDS epidemic[15], religious prejudice with respect to homosexuality[16], and government policy such as *Don't Ask, Don't Tell*.[17] Indeed, the current administration filed a brief in federal court with the U.S. Court of Appeals for the 2nd Circuit in the case of *Zarda v. Altitude Express* arguing that sex discrimination provisions under Title VII of the 1964 Civil Rights Act do not protect employees from discrimination based on sexual orientation.[18]

HHS in May 2016 issued a rule to implement Section 1557 of the ACA, which clarifies that discrimination based on sex stereotyping and gender identity is impermissible sex discrimination under the law.[19] The current administration has failed to defend this regulation in federal court in the case of *Franciscan Alliance v. Burwell* (a different federal court recently ruled that Section 1557 *ipso facto* provides for the rule's aforementioned protections);[20] this seems to point to a preferential pattern of treatment in favor of religious conscience objections over the civil rights of LGBTQ populations despite consistent federal court opinions to the contrary.

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[12]Ibid.
[13]U.S. Centers for Disease Control and Prevention. *Gay and Bisexual Men's Health: Stigma and Discrimination.* February 29, 2016. Web: https://www.cdc.gov/msmhealth/stigma-and-discrimination.htm
[14]Burton, Neel. *When Homosexuality Stopped Being a Mental Disorder.* Psychology Today (Blog). September 18, 2015. Web: https://www.psychologytoday.com/blog/hide-and-seek/201509/when-homosexuality-stopped-being-mental-disorder
[15]Barnes, David M. and Meyer, Ilan H. *Religious Affiliation, Internalized Homophobia, and Mental Health in Lesbians, Gay Men, and Bisexuals.* American Journal of Orthopsychiatry: 2012 October; 82(4): 505-515.
[16]DeCarlo, Pamela and Ekstrand, Maria. *How does stigma affect HIV prevention and treatment*? University of California, San Francisco: October 2016. Web: https://prevention.ucsf.edu/library/stigma
[17]U.S. Department of Defense. *Don't Ask, Don't Tell Is Repealed.* September 2011. Web: http://archive.defense.gov/home/features/2010/0610_dadt/
[18]Feuer, Alan and Weiser, Benjamin. *Civil Rights Act Protects Gay Workers, Appeals Court Rules.* The New York Times: February 26, 2018. Web: https://www.nytimes.com/2018/02/26/nyregion/gender-discrimination-civil-rights-lawsuit-zarda.html
[19]Gruberg, Sharita and Bewkes, Frank J. *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial.* Center for American Progress: March 7, 2018: Pg. 1. Web: https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/
[20]Ibid: Pg. 2.

OCR is responsible for accepting and investigating such complaints under Section 1557; the Center for American Progress in 2018 conducted an independent analysis of such complaints from May 2010 to January 2017 and found the following breakdown of complaint issues:[21]

- Denied care because of gender identity – non-transition related (24.3%)
- Misgendering or other derogatory language (18.9%)
- Denied insurance coverage for transition care (13.2%)
- Provider denied transition care (10.8%)
- Inadequate care because of gender identity (10.8%)
- Other discrimination based on sexual orientation (8.1%)
- Denied insurance coverage because of gender identity – non-transition-related (5.4%)
- Denied care because of sexual orientation or HIV status (5.4%)
- Inadequate care because of sexual orientation (2.7%)

It is worth noting that the number of Section 1557 complaints during this 7-year period (34) is comparable to the number of health care conscience complaints (44) during the 10-year period cited in the proposed rule. This comparison not only highlights the balance that must be struck between these two types of complaints, but also raises the question as to how such discrimination translates to actual health outcomes.

Negative health outcomes that disproportionately impact LGTBQ individuals include: increased instances of mood and anxiety disorders and depression, and an elevated risk for suicidal ideation and attempts; higher rates of smoking, alcohol use, and substance use; higher instances of stigma, discrimination, and violence; less frequent use of preventive health services; and increased levels of homelessness among LGBTQ youth.[22] Men who have sex with men (MSM) and transgender women also experience significantly higher rates of HIV/AIDS infections, complications, and deaths; this burden falls particularly heavily on young, African-American MSM and transgender women. As evidenced in the Section 1557 complaints above, this disease burden is itself known to contribute to discrimination against LGBTQ individuals. Transgender individuals also face particularly severe discrimination in health care settings: 33% of transgender patients say that a health care provider turned them away because of being transgender.[23]

As noted in the "*Code of Ethics for Nurses and Moral and Ethical Obligations*" section of this comment letter, nurses are obligated to respect the human dignity of all patients and to ensure that all patients receive quality, medically necessary, and compassionate care that is timely and safe. The health disparities highlighted in this section demonstrate the negative outcomes

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[21]Ibid: Pg. 5.
[22]U.S. Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.* Washington, DC: National Academies Press; 2011.
[23]James, Sandy E. et al. *The Report of the U.S. Transgender Survey.* 2016: 96-97. Web: www.ustranssurvey.org/report

associated with failure to provide such care. The civil rights of LGBTQ individuals – including the accessibility of quality health care services for LGBTQ individuals – should be protected in a manner consistent with the statutory conscience rights of health care workers under this proposed rule; the protection of such conscience rights should never impede the ability of LGBTQ individuals to access health care services.

Policy Recommendations and Conclusion

ANA and AAN do not wish to diminish the role of moral and ethical considerations in patient care. In fact, the *Code of Ethics for Nurses* acknowledges both implicitly and explicitly that such considerations play critical roles when it comes to a patient's care plan. ANA and AAN do, however, reiterate the primacy of the patient in nursing care; ensuring that all patients are able to access quality, medically necessary, and compassionate care is paramount to nursing practice. ANA and AAN also acknowledge the dual roles that OCR plays with respect to simultaneously enforcing the ACA's Section 1557 provisions and the statutory conscience rights provisions referenced in the proposed rule, including those under the Church Amendments, the Coats-Snowe Amendment, and the Weldon Amendment.

To this end, ANA and AAN believe that in order to accommodate both priorities, OCR should implement guidelines for individual providers, practices, agencies, health systems, and institutions to accommodate both employees and patients. Namely, these guidelines must ensure that if any of the aforementioned stakeholders has a moral or ethical objection to providing certain health care services, they must have in place an organized plan by which the patient – without creating or exacerbating inequities - is able to easily access the quality, affordable, compassionate, and comprehensive health care that they need. Such guidelines reflect the primacy of the patient while at the same time recognizing that various federal statutes protect the conscience rights of health care workers. HHS and OCR must also work with stakeholders to implement existing, evidence-based models that facilitate a standard of care that integrates timely care coordination when health care providers or their employers exhibit a moral or ethical objection to providing certain health care services; such models must also protect the ability of the patient to access evidence-informed care and must not expose women and other marginalized populations to discrimination.

ANA and AAN also reiterate in no uncertain terms that nurses (or any other health care provider) cannot cite conscience rights protections as a reason for refusing to treat certain patient populations, including women seeking reproductive health care and LGBTQ populations. Such refusals go far beyond the provisions of any of the federal statutes cited in the proposed rule, a fact again borne out consistently in federal court opinions. As noted above, the nurse's primary concern is the patient's care. To provide inequitable care for an individual, or to refuse to provide that care entirely, would demonstrate unjust discrimination toward that patient. Such care (or lack thereof) directly contradicts one of the central tenets of nursing practice, violates federal law – including Section 1557 of the ACA – and leads to negative health outcomes and population health disparities.

ANA and AAN believe that this proposed rule should be rescinded and that HHS should develop a standard for accommodation for conscientious objection to certain services which in no way limits the ability of the patient to receive timely, affordable, quality, and compassionate care. This proposed rule is restrictive with respect to ensuring such care. Given the current administration's track record when it comes to defending religious objections at the expense of individual rights, it seems to follow that this proposed rule would represent a significant lurch toward such defense in the health care field. This is unacceptable; in health care practice, patients come first, and HHS must make every attempt to strike an equitable balance between conscientious objections and patients' inalienable rights.

ANA and AAN welcome an opportunity to further discuss the issue of statutory conscience rights protections for health care workers. If you have questions, please contact Liz Stokes, Director, Center for Ethics and Human Rights (liz.stokes@ana.org) or Mary Beth Bresch White, Director, Health Policy (marybreschwhite@ana.org).

Sincerely,

Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN
President
American Nurses Association

Karen S. Cox, PhD, RN, FACHE, FAAN
President
American Academy of Nursing

cc: Debbie Hatmaker, PhD, RN, FAAN, Interim Chief Executive Officer, American Nurses Assoc.
Cheryl G. Sullivan, MSES, Chief Executive Officer, American Academy of Nursing

EXHIBIT I

March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945–ZA03
Hubert H. Humphrey Building
200 Independence Avenue SW
Room 509F
Washington, DC 20201

RE: RIN 0945–ZA03

To Whom It May Concern:

The California Primary Care Association (CPCA) represents over 1,300 not-for-profit community clinics and health centers (CCHCs) in California that provide comprehensive, high quality health care services to low-income, uninsured, and underserved Californians. CPCA member health centers provide nearly 20 million patient encounters to over 6.2 million patients each year. CCHC patients are primarily low income, often speak a primary language other than English, come from diverse cultural and ethnic backgrounds, and often have a limited choice of providers due to language, culture, geographic, or income barriers. The potential impact of this regulation will fall heavily on those patients who already face enormous barriers to getting the care they need, making access even harder for vulnerable groups such as those seeking end-of-life care, persons affected by HIV/AIDS, women, persons of color, and lesbian, gay, bisexual, and transgender individuals.

I. The Proposed Rule is Contrary to the Mission of CCHCs

CPCA strongly believes that employers, including health centers, should maintain the right to hire individuals who are able to meet the requirements of their job description, including the provision of the full spectrum of care needed by CCHC patients. Health centers must - by mission and design - conduct their business in a way that meets the health needs of their specific underserved communities. Any efforts by providers or other health care personnel to limit the information and access that patients are entitled to receive, even when the CCHC may not provide those services itself, is incompatible with the mission and function of the organization. As primary care providers who care for patients and communities, we must maintain the ability of our health centers to employ individuals who further our mission of providing comprehensive primary and preventive care and furthering important public health goals.

Nearly all CPCA member health centers have a consumer-majority board of directors that must have the discretion to build a facility and company culture that reflects the core values and meets the health needs of their communities. Forcing health centers to employ practitioners regardless of their aversion to clear, evidence-based public health priorities, such as vaccinations, contraceptives, mental health treatment, and other services covered under this rule, contradicts the spirit and the efficacy of the community health center program.

II. The Proposed Rule Undermines Patient Safety and Medical Standards of Care

The language of this rule is broad and ambiguous enough that medical staff may interpret the regulation to indicate that they can not only refuse, but decline to tell the patient where he would be able to obtain lifesaving services or even inform patients of their treatment options. This puts the health of the patient, and potentially that of others, at risk. Further, the proposed rule threatens informed consent, a necessary principle of patient-centered decision-making. Informed consent relies on disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether. This right relies on two factors: access to relevant and medically-accurate information about treatment choices and alternatives, and provider guidance based on generally accepted standards of practice. Both factors make trust between patients and health care professionals a critical component of quality of care. However, this proposed rule suggests that a medical provider or staff could refuse to offer information, if that information might be used to obtain a service to which the refuser objects, allowing staff to impose their own religious beliefs on their patients by withholding vital information about treatment options. Such an attenuated relationship to informed consent could result in withholding information that would violate medical standards of care.

III. The Office of Civil Rights Should Prevent Discrimination

CPCA appreciates and strongly supports the Office of Civil Rights' (OCR) efforts to prevent discrimination. Always, health centers and our employees act without regard to race, religion, ethnicity, gender identity, or sexual orientation. However, this proposed rule, while cloaked in the language of non-discrimination, is designed to deny care and exclude disadvantaged and vulnerable populations.

This proposed rule represents a dramatic, harmful, and unwarranted departure from OCR's historic and key mission. The proposed rule appropriates language from civil rights statutes and regulations that were designed to improve access to health care and applies that language to deny medically necessary care. By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the Department seeks to use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need.

Rather than preventing discrimination, this proposed rule puts individuals into a position of power to discriminate against those seeking essential care. **For these reasons, CPCA stands firmly against this proposed rule.**

Thank you for the opportunity to comment.

Sincerely,

Andie Patterson
Director of Government Affairs
California Primary Care Association

EXHIBIT J

March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Public Comment in Response to the Proposed Regulation, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03

To whom it may concern:

I am writing on behalf of the California LGBT Health and Human Services Network in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. The California LGBT Health and Human Services Network is a statewide coalition of over 60 non-profit providers, community centers, and researchers working collectively to advocate for state level policies and resources that will advance LGBT health. We strive to provide coordinated leadership about lesbian, gay, bisexual, transgender, and queer (LGBTQ) health policy in a proactive, responsive manner that promotes health and wellness as part of the movement for LGBT equality.

The proposed rule goes far beyond the scope of the underlying statutes, and strays from the original purpose of the Office of Civil Rights (OCR). OCR was created to uphold the principle that all people in the United States have a right to receive health care in a nondiscriminatory manner. OCR has always been an office focused on protecting the rights of consumers and increasing access to health care. The proposed rule would stray from this core tenet of OCR, and instead restrict consumers access to nondiscriminatory health care.

The enforcement actions outlined against recipients of federal funds and subrecipients alike will have the likely impact of encouraging discrimination by health care entities. This new proposal from HHS encourages health care providers to abandon the principle of "first, do no harm" in favor of their personal beliefs. This puts transgender patients, people who need reproductive health care, and many others at risk of being denied necessary and even life-saving

care. The proposed enforcement measures are likely illegal and will result in great costs the health care industry, and to individual patients.

LGBTQ people, women, and other vulnerable groups around the country already face enormous barriers to getting the care they need.[1] In the past year, out of respondents to the 2015 U.S. Transgender Survey who saw a health care provider, one-third were denied treatment, turned away, or mistreated.[2] Accessing quality, culturally competent care and overcoming outright discrimination is even a greater challenge for those living in areas with already limited access to health providers. The proposed regulation threatens to make access even harder and for some people nearly impossible. By expanding the definition of a health care entity, this rule will likely make it more difficult for patients and consumers to access comprehensive and affirming sexual health care.

The proposed rule is in conflict with existing state and local nondiscrimination protections. Even in California, where we have taken proactive steps to increase accessing to affirming health care – that is available in a patient's spoken language, is developmentally appropriate, and culturally responsive – many LGBTQ people still struggle to find supportive and knowledgeable providers. And yet, this proposed rule would have us go backwards. The proposed rule tramples on California's efforts to protect patients' health and safety, including through the California Insurance Gender Nondiscrimination Act, and other rules that have made it clear that all people the right to access coverage for medically necessary care regardless of their gender identity or gender expression.[3] By claiming to allow individuals and institutions to refuse care to patients based on the providers' religious or moral beliefs in such a sweeping way, the proposed rule creates conflicts with hundreds of state and local nondiscrimination laws around the country that apply to health care. It therefore is disingenuous for the Department to claim that the proposed rule "does not impose substantial direct effects on States," "does not alter or have any substantial

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[1] *See, e.g.,* Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx; Sandy E. James et al., *The Report of the U.S. Transgender Survey* 93–126 (2016), www.ustranssurvey.org/report; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), http://www.lambdalegal.org/publications/when-health-care-isnt-caring; Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2016), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

[2] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

[3] *See, e.g.,* California Department of Managed Health Care, *Letter No. 12-K: Gender Nondiscrimination Requirements* (April 9, 2013), http://translaw.wpengine.com/wp-content/uploads/2013/04/DMHC-Director-Letter-re-Gender-NonDiscrimination-Requirements.pdf.

direct effects on the relationship between the Federal government and the States," and "does not implicate" federalism concerns under Executive Order 13132.

The proposed rule goes far beyond established law, appears to have been developed in a rushed and arbitrary manner, and most importantly will put the health and potentially even the lives of patients at risk. We urge you to withdraw the proposed rule.

Sincerely,

Amanda Wallner

Director, California LGBT Health and Human Services Network

EXHIBIT K

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

March 27, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
Attention: Office for Civil Rights
Conscience NPRM
RIN 0945-ZA03
Hubert H. Humphrey Building, Room 209F
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Azar:

On behalf of the National Association of County and City Health Officials (NACCHO) and nearly 3,000 local health departments, thank you for the opportunity to provide comments on the proposed Department of Health and Human Services (HHS) regulation entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."

Local public health departments are the governmental agencies that work every day in their communities to prevent disease, promote wellness, and protect health. They organize community partnerships and facilitate important conversations with a number of stakeholders about how to create the conditions in which all people can be healthy.

NACCHO has several concerns about the proposed rule and its effect on access to necessary primary care services. **The rule's emphasis on accommodating religious beliefs could interfere with delivery of appropriate care and services.** As proposed, the rule will give health care providers a license based on religious beliefs to opt out of evidence-based care that the medical community endorses. If this rule were to be implemented, more women, particularly women of color, will be put in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services.

NACCHO calls on HHS to include explicit language making clear that religious beliefs will not be used to deny access to health services or to discriminate against people based on reproductive health decisions, gender identity or sexual orientation. In addition, NACCHO calls on HHS to continue activities to identify and address health disparities with the ultimate goal of eliminating them. In activities spanning the Office for Civil Rights, Office of Minority Health, Office of Women's Health as well as the Centers for Medicare & Medicaid Services, all of HHS' endeavors must ensure that disparities are not heightened but are prevented.

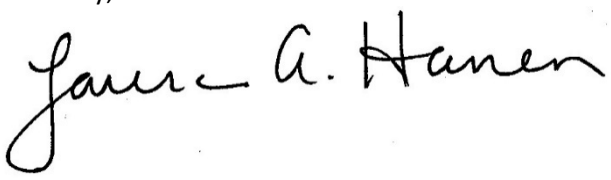
Teen births are decreasing and abortion rates are the lowest they have been since the Roe v Wade Supreme Court decision, in large part because of increased access to evidence-based health education and health services. We cannot afford to turn back the clock on this progress. The proposed rule may open the door to discrimination by health care providers based on individually held beliefs. To protect the public's health, the patient's needs must come first. Furthermore, these new priorities are worrisome as they reflect an ideology that aims to dictate the decisions people can make about their bodies and health care.

Lesbian, gay, bisexual and transgender (LGBT) people are considered a vulnerable population as it concerns their health. LGBT people face higher rates of HIV/AIDS, depression, an increased risk of some cancers, and are twice as likely as their heterosexual peers to have a substance use disorder. 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 the general population, with even higher rates for some populations: for example, nearly one in five (19%) Black transgender women living with HIV, more than 63 times the rate in the general population. Transgender respondents were nearly eight times more like 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.

The medical community and scientific research has repeatedly demonstrated that the poor health outcomes that LGBT people face are not associated with any inherent pathology, but rather high rates of poverty, discrimination in the workplace, schools, and other areas, and barriers to nondiscriminatory health care that meets their needs. Refusals to treat individuals according to medical standards of care put patients' health at risk, particularly for women and LGBT individuals. Expanding religious refusals will further put needed care, including reproductive health care, out of reach for many. Given the broadly-written and unclear language of the proposed rule, if implemented, some providers may misuse this rule to deny services to LGBT individuals on the basis of perceived or actual sexual orientation and gender identity. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care impairs the ability of patients to make a health decision that expresses their self-determination.

Thank you again for the opportunity to comment on "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." NACCHO and local health departments look forward to continued opportunities to partner with the federal government to protect the public and ensure optimal health. Please contact me at lhanen@naccho.org/202-507-4255 for any further information.

Sincerely,



Laura A. Hanen, MPP
Interim Executive Director & Chief of Government Affairs

EXHIBIT L

Physicians for Reproductive Health

March 27, 2018

The Honorable Alex Azar
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03

Dear Secretary Azar:

Physicians for Reproductive Health is committed to ensuring all individuals have access to health care, regardless of their gender identity, sexual orientation, and/or the type of services being requested, including abortion, contraception or sterilization. Physicians for Reproductive Health (Physicians) is a doctor-led national advocacy organization that uses evidence-based medicine to promote sound reproductive health policies. Physicians unites the medical community and concerned supporters. Together, we work to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients. Physicians believes a health care provider's personal beliefs should never determine the care a patient receives. By allowing patient care to be compromised by religious or personal beliefs without consideration of the best medical care for the patient, this rule stands to undermine the very foundation of the doctor-patient relationship. Indeed, one of the reasons cited for the proposed rule is a case—*Chamorro v. Dignity Health*—we filed in California against a Catholic

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hospital network regarding their refusal to allow doctors to provide patients with the standard of care in the form of postpartum tubal ligations. That is why we strongly oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule"), which seeks to permit discrimination in all aspects of health care.[1]

The Proposed Rule seeks to unlawfully expand refusals to provide care by attempting to allow individuals and health care entities who receive federal funding to refuse to provide *any* part of a health service or program. In addition, the Proposed Rule unlawfully attempts to create new refusals seemingly out of thin air. Such expansions exceed the Department's authority; violate the Constitution; undermine the ability of states to protect their citizens; undermine critical HHS programs like Title X; interfere with the provider-patient relationship; and threaten the health and well-being of people across the country and around the world.

By issuing the Proposed Rule and creating a new division within the Office of Civil Rights ("OCR") – the new "Conscience and Religious Freedom Division" – the Department seeks to inappropriately use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. For these reasons Physicians calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

The Proposed Rule Unlawfully Exceeds the Department's Authority by Impermissibly Expanding Religious Refusals to Provide Care

The Proposed Rule attempts to expand the reach not only of existing harmful refusal of care laws but also to create new refusals of care where none were intended.

a. The Proposed Rule Seeks to Allow the Refusal of any Health Service Based on Personal Belief

The Proposed Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion and transition-related care. Specifically, the Department and OCR are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[2] Read in conjunction with

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (*to be codified at* 45 C.F.R. pt. 88) [*hereinafter* Rule].
[2] *See id.* at 12.

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the rest of the Proposed Rule, it is clear this is intended to allow any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care.

b. The Proposed Rule Unlawfully Expands Already Harmful Abortion/Sterilization Refusal of Care Laws

Already existing refusal of care laws are used across the country to deny patients the care they need.[3] The Proposed Rule attempts to expand these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions specifically related to the service or research activity to which they object.[4] But the Proposed Rule attempts to broaden this provision to allow individuals to refuse to perform aspects of their jobs based on a mere reference to a religious or moral belief regardless of whether it relates to the specific biomedical or behavioral service or research activity they are working on.[5] Such an attempted expansion goes beyond what the statute enacted by Congress allows. Furthermore, the Proposed Rule would expansively apply other provisions of the Church Amendments to, among other things, individuals working under global health programs funded by the Department, thereby allowing global health providers and entities to refuse individuals the care they need contrary to the very purpose of such programs.

Similarly, the Proposed Rule defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. For example, the definition of "assist in the performance" greatly expands the types of services that can be

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[3] *See, e.g.*, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Catherine Weiss, et al., *Religious Refusals and Reproductive* Rights, AM. CIVIL LIBERTIES UNION (2002), https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report; Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[4] The Church Amendments, 42 U.S.C. § 300a-7 (2018).

[5] *See* Rule *supra* note 1, at 185.

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refused to include merely "making arrangements for the procedure" no matter how tangential.[6] This means individuals not "assisting in the performance" of a procedure within the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, can now assert a new right to refuse. The Proposed Rule's definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information, including location or funding, that could help an individual to get the care they need.[7]

Furthermore, the Proposed Rule's new and unwarranted expanded definitions often exceed, or are not in accordance with, existing definitions contained within the statutes the Proposed Rule seeks to enforce. Specifically, under the Coats and Weldon Amendments "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.[8] The Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term.[9] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but goes directly against congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert.[10]

When these impermissibly broad definitions are combined with the expansive interpretations of the underlying statutes, they work together to further expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, one way the Weldon Amendment is expanded under the Proposed Rule is through the definition of "discrimination."[11] In particular, the Proposed Rule defines "discrimination" against a health care entity broadly to include a number of activities, including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[12] In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is nonsensical and inappropriate. Further, such a vague and

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[6] *Id.* at 180.
[7] *Id.* at 183.
[8] The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018).
[9] *See* Rule *supra* note 1, at 182.
[10] The doctrine of expression unius est exclusion alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[11] *See* Rule *supra* note 1, at 180.
[12] *Id.*

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inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

The Proposed Rule Carries Severe Consequences for Patients and will Exacerbate Already Existing Inequities

a. Refusals of Care Make it Difficult for Many Individuals to Access the Care They Need

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[13] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[14] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[15] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[16] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[17] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in

[13] *See*, *e.g.*, *supra* note 3.
[14] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[15] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[16] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 29 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[17] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.

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the following days, the hospital did not give her full information about her condition and treatment options.[18]

b. Refusals of Care are Especially Dangerous for Those Already Facing Barriers to Care

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[19] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[20] In rural areas there may be no other sources of health and life preserving medical care.[21] In developing countries where many health systems are weak, health care options and supplies are often unavailable.[22] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen

[18] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 27 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[19] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. *Women's Health Insurance* Coverage, KAISER FAMILY FOUND. 1, 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.

[20] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health & Ctr. For Reproductive Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: the Fight for Women's Reproductive Health in the Rio Grande Valley* 1, 7 (2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf.

[21] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[22] *See* Nurith Aizenman, *Health Care Costs Push a Staggering Number of People into Extreme Poverty*, NPR (Dec. 14, 2017), https://www.npr.org/sections/goatsandsoda/2017/12/14/569893722/health-care-costs-push-a-staggering-number-of-people-into-extreme-poverty; *Tracking Universal Health Coverage: 2017 Global Monitoring Report*, WORLD HEALTH ORG. & THE WORLD BANK (2017), http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf.

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states, women of color are more likely than white women to give birth in Catholic hospitals.[23] These hospitals, as well as many Catholic-affiliated hospitals, must follow the Ethical and Religious Directives (ERDs) which provides guidance on a wide range of hospital matters, including reproductive health care and can keep providers from offering the standard of care.[24] Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women were delayed care or transferred to other facilities at great risk to their health.[25] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[26] In addition, in many of the countries where the Department implements global AIDS programs, many of the patients served already face numerous barriers to care, including a broad and harmful refusal provision contained within the statute governing such programs.[27]

c. In Proposing this Rule, the Agency has Abandoned its Legal Obligations to Adequately Account for Harm to Patients

By expanding refusals of care the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on society."[28] The Proposed Rule plainly fails on both counts. Although the Proposed Rule attempts to quantify the costs of compliance, it

[23] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[24] *See id.* at 10-13.
[25] Lori R. Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.
[26] *See, e.g.*, *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.
[27] *See The Mexico City Policy: An Explainer*, KAISER FAMILY FOUND. (June 1, 2017), https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/.
[28] Improving Regulation and Regulatory Review, Executive Order 13563 (Jan. 18, 2011), https://obamawhitehouse.archives.gov/the-press-office/2011/01/18/executive-order-13563-improving-regulation-and-regulatory-review.

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completely fails to address the costs and burdens to patients who may be denied care and who then may incur and experience even greater social and medical costs.[29]

Moreover, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant religious exemptions and, in fact, bars granting an exemption when it would detrimentally affect any third party.[30] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[31]

The Proposed Rule Will Undermine Critical Federal Health Programs, including Title X

The Proposed Rule would seemingly allow health care entities to receive grants and contracts under HHS-funded programs or other federal health programs, such as Title X, the only domestic family planning program, while refusing to provide key services required by those programs.[32] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[33] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[34] Under the Proposed Rule, the Department would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such

[29] *See* Rule *supra* note 1, at 94-177.
[30] U.S. Const. amend. I; *Cutter v. Wilkinson*. 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[31] Respecting religious exercise may not "unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling." *See Burwell v. Hobby Lobby*, 134 S. Ct. at 2787. When considering whether the birth control coverage requirement was the least restrictive means in Hobby Lobby, the Court considered that the accommodation offered by the government ensured that affected employees "have precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing coverage." *See id.* at 2759. In other words, the effect of the accommodation on women would be "precisely zero." *Id.* at 2760.
[32] *See* Rule *supra* note 1, at 180-181, 183. *See also Title X Family Planning*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2018), https://www.hhs.gov/opa/title-x-family-planning/index.html; *Title X an Introduction to the Nation's Family Planning Program*, NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOC. (2017) (*hereinafter* NFPRHA), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf.
[33] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[34] *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).

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funds are generally conditioned.[35] The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[36] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[37]

The Proposed Rule Will Carry Severe Consequences for Providers and Undermine the Provider-Patient Relationship

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care. Hospital systems across the country use religious beliefs to prevent their employees from treating patients regardless of the professional, ethical, or moral convictions of these providers.[38] The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions, including foreign and international organizations, to bind the hands of providers and attempt to limit the types of care they can provide.

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health providers and patients and ensure patient-centered decision-making.[39] Informed consent requires providers disclose relevant and medically accurate information about treatment choices and alternatives so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment

[35] *See*, *e.g.*, Rule *supra* note 1, at 180-185.
[36] *See* NFPRHA *supra* note 34.
[37] *See id.*
[38] *See* Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[39] *See* TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).

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altogether.[40] By allowing providers, including hospital and health care institutions, to refuse to provide patients with information, the Proposed Rule makes it impossible for patients to have full information regarding treatment options. While the Department claims the Proposed Rule improves communication between patients and providers, in truth it will deter open, honest conversations that are vital to ensuring that a patient can control their medical circumstances.[41]

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[42] Individuals seeking reproductive health care, regardless of their reasons for needing these services, should be treated with dignity and respect. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them.

In addition, the Proposed Rule ignores the many providers with deeply held moral convictions that affirmatively motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. Moreover, the Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[43] No health care professional should face

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[40] *See id.*

[41] *See* Rule *supra* note 1, at 150-151.

[42] For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant. AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE § 114-15, S117 (2017), available at http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf. The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics guidelines state that the risks to the woman from persistent severe pre-eclampsia are such that delivery (abortion) is usually suggested regardless of fetal age or potential for survival. AM. ACAD. OF PEDIATRICS & AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).

[43] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).

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discrimination from their employer because they treated or provided information to a patient seeking an abortion.

The Department is Abdicating its Responsibility to Patients

The Proposed Rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.[44] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce.[45] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[46] If finalized, however, the Proposed Rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities. Through robust enforcement of civil rights laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities,

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[44] *OCR's Mission and Vision*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").

[45] *See* Rule *supra* note 1, at 203-214.

[46] As one of its first official acts in 1967, the Office of Equal Health Opportunity undertook the massive effort of inspecting 3,000 hospitals to ensure they were complying with Title VI's prohibition against discrimination on the basis of race, color, or national origin. 42. U.S.C. § 2000d (1964). After this auspicious start, the Office of Equal Health Opportunity which would eventually become OCR would go on to ensure that health programs and activities it regulated complied with key anti-discrimination laws including Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1973), Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 (1972), the Age Discrimination Act of 1976, 42 U.S.C. § 6101 (1976), and Section 1557 of the Affordable Care Act, 42 U.S.C. §18116 (2010), among others. Through robust enforcement of these laws, OCR has worked to reduce discrimination in health care.

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segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[47]

Nevertheless, there is still work to be done, and the Proposed Rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.[48] And these disparities do not occur in isolation. Black women, for example, are three to four times more likely than white women to die during or after childbirth.[49] Further, the disparity in maternal mortality is growing rather than decreasing,[50] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resulting health disparities. For example, women's pain is routinely undertreated and often dismissed.[51] And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[52] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[53] Eight percent of

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[47] *See, e.g.*, *Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html; *Protecting the Civil Rights and Health Information Privacy Rights of People Living with HIV/AIDS*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/hiv/index.html; *National Origin Discrimination*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/national-origin/index.html; *Health Disparities*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/health-disparities/index.html.

[48] *See* Skinner et al., *Mortality after Acute Myocardial Infarction in Hospitals that Disproportionately Treat African-Americans*, NAT'L INSTIT. OF HEALTH 1 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1626584/pdf/nihms13060.pdf.

[49] *See* Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.

[50] *See id.*

[51] *See, e.g.*, Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001).

[52] *See, e.g.*, Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. of the Am. Heart Ass'n 1 (2015).

[53] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf. A survey examining discrimination against LGBTQ people in health care more than half of respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care

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lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[54]

OCR must work to address these disparities, yet the Proposed Rule seeks to prioritize the expansion of existing religious refusal laws beyond their statutory requirements and create new religious exemptions where none had previously existed, rather than using already limited resources to protect patient access to health care. The Proposed Rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.[55]

The Proposed Rule Conflicts with Other Existing Federal Law

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals to care it would create. For example, the Proposed Rule makes no mention of Title VII,[56] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[57] With respect to religion, Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[58] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The Proposed Rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both. Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel filed

professionals using harsh or abusive language; being blamed for their health care status; or health care professionals being physically rough or abusive.

[54] *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, NAT'L GAY AND LESBIAN TASK FORCE & NAT'L CTR. FOR TRANSGENDER EQUALITY, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

[55] *See supra* note 46.

[56] 42 U.S.C. § 2000e-2 (1964).

[57] *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

[58] *See id.*

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comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[59]

Furthermore, the language in the Proposed Rule would seem to put health care entities in the position of being forced to hire people who intend to refuse to perform essential elements of a position even though Title VII would not require such an "accommodation." For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling even though the employer would not be required to do so under Title VII.[60] It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

In addition, the Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[61] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[62] Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

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[59] Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.
[60] *See* Rule *supra* note 1, at 180-181.
[61] 42 U.S.C. § 1295dd(a)-(c) (2003).
[62] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); In In re Baby K, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, 93 Fair Empl. Prac. Cas. (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).

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The Proposed Rule Will Make It Harder for States to Protect their Residents

The Proposed Rule will have a chilling effect on the enforcement of and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. The preamble of the Proposed Rule discusses at length state laws that the Department finds objectionable, such as state laws that require anti-abortion counseling centers to provide information about where reproductive health care services can be obtained or whether facilities have licensed medical staff, as well as state laws that require health insurance plans to cover abortion.[63] Moreover, the Proposed Rule invites states to further expand refusals of care by making clear that this expansive rule is a floor, and not a ceiling, for religious exemption laws.[64]

Conclusion

The Proposed Rule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The Proposed Rule is discriminatory, violates multiple federal statutes and the Constitution, ignores congressional intent, fosters confusion, and harms patients, contrary to the Department's stated mission. For these reasons Physicians for Reproductive Health calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

Board of Directors, Physicians for Reproductive Health

[63] *See*, *e.g.*, Rule, *Supra* note 1, at 3888-89.
[64] *See id.*

1430 Broadway, Suite 1614, New York, NY 10018
Tel: 646-366-1890 • Fax: 646-366-1897 • www.prh.org • info@prh.org

EXHIBIT M

AAMC

Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400
www.aamc.org

Via Electronic Submission *(www.regulations.gov)*

March 26, 2018

Roger Severino
Director, Office of Civil Rights
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Protecting Statutory Conscience Rights in Health Care, HHS (HHS-OCR-2018-0002)

Dear Mr. Severino:

The Association of American Medical Colleges (AAMC or Association) welcomes the opportunity to comment on the Department of Health and Human Services (HHS' or the Agency's) proposed rule titled *Protecting Statutory Conscience Rights in Health Care, HHS*, 83 *Fed. Reg.* 3880 (January 26, 2018).

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Our members are all 151 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, we serve the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. As will be described in detail below, should the rule be finalized as proposed, it will result in harm to patients, undermine standards of medical professionalism, and raise serious concerns regarding individuals' rights that are protected by other federal and state laws. **Therefore, we urge the Department to withdraw the proposed regulation.**

The Needs of Patients Should Be Put First

Ethical and moral issues within the context of health care are among the most challenging that we face. They require a careful balance between the rights of the health care professional to avoid behavior that violates his/her moral or ethical code, and the rights of a patient to receive lawful health care services that are safe and medically appropriate. In some circumstances, it is difficult to maintain this balance. When that happens, the health and the rights of the patient, who is in the more vulnerable position, must be given precedence. Those who choose the profession of medicine are taught repeatedly during their medical school and residency training that, in the end, their duty to care for the patient must come first, before self. For example, the American Medical Association *Principles of Medical Ethics* state, "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." This does not mean that a physician or other health care provider must act in violation of his or her own moral code,

but it does mean that a physician has the duty to provide information and to refer the patient to other caregivers without judgment.[1]

Julie Cantor wrote about the need for a balance towards professionalism in her article, "Conscientious Objection Gone Awry – Restoring Selfless Professionalism in Medicine" (New England Journal of Medicine, April 9, 2009), which is cited in this proposed rule instead as evidence of rampant discrimination against those who wish to practice women's health. Rather than promote discrimination against health care professionals, Dr. Cantor calls on those who "freely choose their field" to evaluate their beliefs in relation to their specialties and whether they are able to provide all legal options for care. "As gatekeepers to medicine, physicians and other health care providers have an obligation to choose specialties that are not moral minefields for them. … Conscience is a burden that belongs to that individual professional; patients should not have to shoulder it."

There Is No Demonstrable Need for the Proposed Rule

As we stated when we commented on the original 2008 Federal Health Care Conscience Rule, no individual or entity in this country has the option to pick and choose the laws to which he/she will adhere. Every health care provider and entity already has the obligation to comply with all applicable federal laws. The Department has offered little evidence that this has not been the case. The Office of Civil Rights has received just forty-four complaints since it was designated with authority to enforce the Church, Coats-Snow, and Weldon Amendments. The paucity of complaints does not provide compelling evidence of a need for the expansion of OCR's authority, or the need for changes in the current regulations.

Accreditation Organizations Require Medical Students and Residents to Be Taught to Respond to the Many Health Care Needs of a Diverse Patient Population and Respect a Medical Student or Resident's Decision to Not Receive Training in Abortions

Starting with undergraduate medical education and continuing through residency training, physicians are taught that they will be practicing medicine in a multi-cultural, multi-ethnic world in which patients and their families hold diverse viewpoints on many complex ethical issues that affect health care. Their education also occurs in an atmosphere that acknowledges that as health care providers, physicians themselves bring a diversity of religious and moral views on health care issues to their work. Such disparate views are examined during the educational process during a physician's initial training and throughout the individual's professional development.

Belying the concern that medical schools and training program are discriminating against medical students and residents for their religious views are the accreditation requirements of the Liaison Committee for Medical Education (LCME), which accredits all US medical education programs leading to the MD degree, and the Accreditation Council for Graduate Medical Education (ACGME), which accredits residency programs that seek to attract a wide variety of individuals into medicine. Both organizations have standards that are designed to ensure that the education of physicians provides an environment that embraces diversity of views and values for both health care providers and patients. For instance, the LCME requires that "[t]he selection of individual [medical] students must not be influenced by any political or financial factors."

[1] American Medical Association Council on Ethical & Judicial Affairs, "Code of Medical Ethics Opinion 1.1.7" https://www.ama-assn.org/delivering-care/physician-exercise-conscience

Additional requirements include the following:

> A medical school does not discriminate on the basis of age, creed, gender identity, national origin, race, sex, or sexual orientation.
>
> A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, develop and conduct appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.
>
> A medical school develops effective written policies that address violations of the code, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing inappropriate behavior. Mechanisms for reporting violations of the code of professional conduct are understood by medical students, including visiting medical students, and ensure that any violations can be registered and investigated without fear of retaliation. (Standards, Publications, & Notification Forms. LCME. lcme.org/publications. Accessed March 2018).

Further, the LCME's June 2017 Rules of Procedure regarding medical school accreditation state that:

> Medical education programs are reviewed solely to determine compliance with LCME accreditation standards. LCME accreditation standards and their related elements are stated in terms that respect the diversity of mission of U.S. medical schools, including religious missions.

The LCME also recognizes the need for medical students to learn how to care for a diverse patient population. For example,

> The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction regarding the following:
>
> - The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments
> - The basic principles of culturally competent health care
> - The recognition and development of solutions for health care disparities
> - The importance of meeting the health care needs of medically underserved populations
> - The development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society

Similarly, the ACGME states that:

> Residents are expected to demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

> Clinical learning environments (CLEs) need to ensure that their residents and fellows learn to recognize health care disparities and strive for optimal outcomes for all patients, especially those in potentially vulnerable populations. As front-line caregivers, residents and fellows are a valuable resource for formulating strategies on these matters. They can assist the CLEs in addressing not only low-income populations, but also those that experience differences in access or outcome based on gender, race, ethnicity, sexual orientation, health literacy, primary language, disability, geography, and other factors.
>
> The diverse, often vulnerable, patient populations served by CLEs also provide an important opportunity for teaching residents and fellows to be respectful of patients' cultural differences and beliefs, and the social determinants of health.
>
> In considering patient outcomes, it is important to note that patients at risk for disparities are likely to require differences in care that are tailored to their specific needs—based not only on their biological differences, but also on other social determinants of health (e.g., personal social support networks, economic factors, cultural factors, safe housing, local food markets, etc.).

The ACGME's Common Program Requirements state that "Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Standard VI.B.6)

In regard to women's healthcare, both accrediting organizations are clear that a program cannot require training in abortion procedures. The ACGME's Program requirements specific to obstetrics and gynecology state "Residents who have a religious or moral objection may opt-out and must not be required to participate in training in or performing induced abortions." The profession of medicine seeks to embrace within its ranks individuals from diverse racial/ethnic, cultural, religious and socioeconomic backgrounds. Such diversity of backgrounds helps to ensure that physicians will understand and be sympathetic to the traditions, values, and beliefs of their patients and provide competent care.

The Proposed Rule Is Overly Expansive In Its Reach and Is Incongruous with Medical Professionalism

The proposed rule is overly expansive, allowing physicians and others to avoid engaging in any activity "with an articulable connection" to the objectionable procedure, "include[ing] counseling, referral, training, and other arrangements for the procedure." It then proposes a definition of referral that expands the general understanding of referral to include "the provision of ***any*** information…when the entity or health care entity making the referral sincerely understands that particular health care service, activity, or procedure to be a purpose or *possible outcome of the referral*." (emphasis added). The refusal of a physician or other health care professional to provide a patient with information, or to give a patient a referral to a provider where the desired care is available, risks limiting the patient's access to health care. Allowing health care professionals to engage in behavior that could harm patients is incongruous with the standards of medical professionalism that are the core of a physician's education and the practice of medicine.

Similarly, the proposed regulation would interpret the term "assist in the performance" to include "any activity with an articulable connection to a procedure, health service, or research activity[.]" The proposed regulation states that this definition is intended to be broad, and not limited to direct involvement with a procedure, health service, or research activity. For example, this broader definition could apply to an employee whose task is to clean a room where a particular procedure took place. Such a

broad view is unnecessary particularly since the employee has the option to seek employment elsewhere while the patient may have only one place where he/she can receive care.

The Proposed Rule Will Do Harm to Lower Income Americans, Racial and Ethnic Minorities, the LGBTQ Community, and Patients in Rural Areas

The proposed rule would allow physicians and others to avoid engaging in any activity "with an articulable connection" to the objectionable procedure, "includ[ing] counseling, referral, training, and other arrangements for the procedure." This broad reach will create or exacerbate inequities in health care access for Americans whose access may already be limited due to their geographic residence or financial means. For rural- and frontier-dwelling Americans who reside in a health professional shortage area, access to certain services might functionally cease to exist as a result of this proposed rule: seeking care in distant locales might be too burdensome or expensive. This holds, too, for lower income Americans who lack the financial means to seek out care for procedures when their primary physicians decline to provide services.

Racial and ethnic minority women have reported experiencing race-based discrimination when receiving family planning care.[2] The proposed rule may exacerbate this problem and the consequences that follow for women and their children. Research has associated unintended pregnancy with several adverse maternal and child health outcomes, such as delayed prenatal care, tobacco and alcohol use during pregnancy, delivery of low birthweight babies[3], and poor maternal mental health.[4] These negative health outcomes are more prevalent in racial and ethnic minority communities likely would worsen under the proposed rule.

For the lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities, the proposed rule may further exacerbate heath care access disparities. It is well documented that LGBTQ Americans currently experience discrimination in health care settings, erecting a barrier to accessing health care services.[5] This proposed rule would codify what many within and beyond the LGBTQ communities will view as state-sanctioned discrimination, and allow providers to refuse care or appropriate referrals solely on the basis of their patients' sexual orientation or gender identity. This stands in stark opposition to OCR's stated goal to "protect fundamental rights of nondiscrimination."

The Proposed Rule Adds Burdensome Requirements That Have No Commensurate Benefit

The Department and this Administration have undertaken major efforts to reduce regulatory burden, such as "Reducing Regulation and Controlling Regulatory Costs" (Executive Order 13771, issued January 30, 2017), "Enforcing the Regulatory Reform Agenda" (Executive Order 13777, issued February 24, 2017), the Centers for Medicare & Medicaid's "Patient over Paperwork" initiative (launched October 2017, in an effort to reduce unnecessary burden), and several Requests for Information regarding administrative burden. The burden associated with complying with the proposed rule runs counter to this goal. Moreover, the investment in resources that would be required for a large teaching health care system to

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[2] Thorburn S, Bogart LM. "African American women and family planning services: perceptions of discrimination," *Women Health*. 2005;42(1):23–39.
[3] Institute of Medicine (US) Committee on Unintended Pregnancy; Brown SS, Eisenberg L, editors. "The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families. National Academies Press (US); 1995. 3, *Consequences of Unintended Pregnancy*. Available from: https://www.ncbi.nlm.nih.gov/books/NBK232137/
[4] Herd P et al., "The implications of unintended pregnancies for mental health in later life," *American Journal of Public Health*, 2016, 106(3):421–429.
[5] Cahill, S. "LGBT Experiences with Health Care," *Health Affairs* Vol. 36, No.4. 2017. Available from: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0277

ensure compliance and monitoring of all of the proposed requirements would be even more onerous and reduce funds available for the core missions of teaching, patient care, and research.

The Department proposes to modify existing civil rights clearance forms (or develop similar forms in the future), and notes that it might require submission of these documents annually and incorporate by reference in all other applications submitted that year. The receipt of any federal funds already requires the compliance with all federal laws and regulations; assurances and attestations to compliance are routine. OCR has not made clear why there is a need for additional assurance and certification.

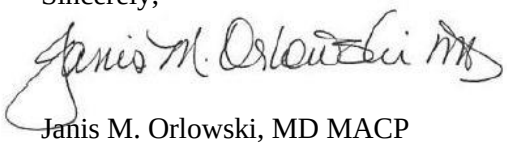
The Department also proposes notice requirements, which includes notice on the funding recipient's website, in prominent and conspicuous physical locations where other notices to the public and notices to the recipient's workforce are customarily posted. The notice is to be posted by April 26, 2018, or for new recipients, within 90 days of becoming a recipient. Even if the rule is finalized by April 26, and no changes are made in the notice requirement, it is unreasonable to expect current recipients to comply by that date.

The rule also proposes that if a sub-recipient is found to have violated federal health care conscience and associated anti-discrimination laws, the recipients "shall be subject to the imposition of funding restrictions and other appropriate remedies." Requiring the imposition of funding restrictions should be dependent on the facts and circumstances of a particular case; however, by using the word "shall" there seems to be no discretion in whether this penalty is appropriate. If the rule is finalized, the AAMC asks that OCR clearly make the penalty optional by using "may" instead of "shall."

The AAMC strongly urges the Department to withdraw the proposed rule. Alternatively, the rule should be re-proposed and narrowed in scope to, at a minimum, appropriately balance the needs of patients with the needs of health care providers who have freely chosen their profession.

If you would like additional information, please contact Ivy Baer, Senior Director and Regulatory Counsel, at 202-828-0499 or ibaer@aamc.org.

Sincerely,



Janis M. Orlowski, MD MACP
Chief, Health Care Affairs

EXHIBIT N

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM
RIN 0945-ZA03
Hubert H. Humphrey Building, Room 209F
200 Independence Avenue SW
Washington, DC 20201

Introduction

On behalf of National Association of Councils on Developmental Disabilities, we submit these comments to the federal Department of Health and Human Services ("Department") and its Office for Civil Rights ("OCR") in opposition to the proposed regulation entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."[1]

The regulations as proposed would introduce broad and poorly defined language to the existing law that already provides ample protection for the ability of health care providers to refuse to participate in a health care service to which they have moral or religious objections. While the proposed regulations purport to provide clarity and guidance in implementing existing federal religious exemptions, in reality they are vague and confusing. The proposed rule creates the potential for exposing patients to medical care that fails to comply with established medical practice guidelines, negating long-standing principles of informed consent, and undermines the ability of health facilities to provide care in an orderly and efficient manner.

Most important, the regulations fail to account for the significant burden that will be imposed on patients, a burden that will fall disproportionately and most harshly on women, people of color, people living with disabilities, and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals. These communities already experience severe health disparities and discrimination, conditions that will be exacerbated by the proposed rule, possibly ending in in poorer health outcomes. By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the Department seeks to use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. For these reasons, the National Health Law Program calls on the Department and OCR to withdraw the proposed rule in its entirety.

I. Under the guise of civil rights, the proposed rule seeks to deny medically necessary care

Civil rights laws and Constitutional guarantees, such as due process and equal protection, are designed to ensure full participation in civil society. The proposed rule,

[1] U.S. Dept. of Health and Human Serv., Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880-3931 (Jan. 26, 2018) (hereinafter "proposed rule").

while cloaked in the language of non-discrimination, is designed to deny care and exclude disadvantaged and vulnerable populations. The adverse consequences of health care refusals and other forms of discrimination are well documented. As the Department stated in its proposed rulemaking for § 1557,

> "[e]qual access for all individuals without discrimination is essential to achieving" the ACA's aim to expand access to health care and health coverage for all, as "discrimination in the health care context can often…exacerbate existing health disparities in underserved communities."[2]

The Department and OCR have an important role to play in ensuring equal health opportunity and ending discriminatory practices that contribute to health disparities. Yet, this proposed rule represents a dramatic, harmful, and unwarranted departure from OCR's historic and key mission. The proposed rule appropriates language from civil rights statutes and regulations that were designed to improve access to health care and applies that language to deny medically necessary care.

The federal government argues that robust religious refusals, as implemented by this proposed rule, will facilitate open and honest conversations between patients and physicians.[3] As an outcome of this rule, the government believes that patients, particularly those who are "minorities", including those who identify as people of faith, will face fewer obstacles in accessing care.[4] The proposed rule will not achieve these outcomes. Instead, the proposed rule will increase barriers to care, harm patients by allowing health care professionals to ignore established medical guidelines, and undermine open communication between providers and patients. The harm caused by this proposed rule will fall hardest on those most in need of care.

II. The expansion of religious refusals under the proposed rule will disproportionately harm communities who already lack access to care

Women, individuals living with disabilities, LGBTQ persons, people living in rural communities, and people of color face severe health and health care disparities, and these disparities are compounded for individuals who hold these multiple identities. For example, among adult women, 15.2 percent of those who identified as lesbian or gay reported being unable to obtain medical care in the last year due to cost, as compared to 9.6 percent of straight individuals.[5] Women of color experience health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.[6]

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[2] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,194 (Sept. 8, 2015) (codified at 45 C.F.R. pt. 2).
[3] 83 Fed. Reg. 3917.
[4] *Id*.
[5] Brian P. Ward et al., *Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey*, NAT'L CTR. FOR HEALTH STATISTICS, 2013 9 (2014), https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf.
[6] In 2014, Latinas had the highest rates of contracting cervical cancer and Black women had the highest death rates. *Cervical Cancer Rates By Rates and Ethnicity*, CTRS. FOR DISEASE CONTROL & PREVENTION, (Jun. 19, 2017), https://www.cdc.gov/cancer/cervical/statistics/race.htm.;At the end of 2014, of the total

Meanwhile, people of color in rural America are more likely to live in an area with a shortage of health professionals, with 83% of majority-Black counties and 81% of majority-Latino/a counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

The expansion of refusals as proposed under this rule will exacerbate these disparities and undermine the ability of these individuals to access comprehensive and unbiased health care, including sexual and reproductive health information and services. Any efforts by providers or other health care personnel to limit the information and access that patients are entitled to receive, even when the organization may not provide those services itself, is incompatible with true consumer choice and individual decision making.

a. The proposed rule will block access to care for low-income women, including immigrant women and African American women

Broadly-defined and widely-implemented refusal clauses undermine access to basic health services for all, but can particularly harm low-income women. The burdens on low-income women can be insurmountable when women and families are uninsured,[7] underinsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services nor travel to another location. This is especially true for immigrant women. In comparison to their U.S. born peers, immigrant women are more likely to be uninsured.[8] Notably, immigrant, Latina women have far higher rates of uninsurance than Latina women born in the United States (48 percent versus 21 percent, respectively).[9]

According to a recent report, doctors often fail to inform Black women of the full range of reproductive health options regarding labor or delivery possibly due to stereotypes about Black women's sexuality and reproduction.[10] Young Black women noted that they were shamed by providers when seeking sexual health information and contraceptive care in part, due to their age, and in some instances, sexual orientation.[11]

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number of women diagnosed with HIV, 60 percent were Black. *HIV Among Women,* CTRS. FOR DISEASE CONTROL & PREVENTION, Nov. 17, 2017, https://www.cdc.gov/hiv/group/gender/women/index.html.

[7] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. KAISER FAMILY FOUND., *Women's Health Insurance Coverage* 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.

[8] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf.

[9] *Id*. at 8, 16.

[10] CTR. FOR REPROD. RIGHTS, NAT'L LATINA INST. FOR REPROD. HEALTH & SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter *Reproductive Injustice*]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), *available at* http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

[11] *Reproductive Injustice*, *supra* note 10, at 16-17.

New research also shows that women of color in many states disproportionately receive their care at Catholic hospitals, subjecting them to treatment that does not comply with the standards of care.[12] In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[13] In New Jersey, for example, women of color make up 50 percent of women of reproductive age in the state, yet have twice the number of births at Catholic hospitals compared to their white counterparts.[14] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on wide range of hospital matters, including reproductive health care. In practice, the ERDs prohibit the provision of emergency contraception, sterilization, abortion, fertility services, and some treatments for ectopic pregnancies. Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals and as a result, women were delayed care or transferred to other facilities, risking their health.[15] The proposed rule will give health care providers a license, such as Catholic hospitals, to opt out of evidence-based care that the medical community endorses. If this rule were to be implemented, more women, particularly women of color, will be put in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services. For many, this choice does not exist.

b. The proposed rule will negatively impact rural communities

The ability to refuse care to patients will leave many individuals in rural communities with no health care options. Medically underserved areas already exist in every state,[16] with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[17] Many rural communities experience a wide array of mental health, dental health, and primary care health professional shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.[18] Among the many geographic and spatial barriers that exist, individuals in rural areas often must have a driver's license and own a private car to access care, as they must travel further distances for regular checkups, often on poorer

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[12] Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT (2018), *available at* https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[13] *Id* at 12.
[14] *Id* at 9.
[15] Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.
[16] Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA, (last visited Mar. 21, 2018).
[17] M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA,* 10 RURAL REMOTE HEALTH (2010), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/.
[18] Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations,* ECON. RESEARCH SERV. (2009), *available at* https://www.ers.usda.gov/publications/pub-details/?pubid=44427.

quality roads, and have less access to reliable public transportation.[19] This scarcity of accessible services leaves survivors of intimate partner violence (IPV) in rural areas with fewer shelter beds close to their homes, with an average of just 3.3 IPV shelter beds per rural county as compared to 13.8 in urban counties.[20] Among respondents of one survey, more than 25 percent of survivors of IPV in rural areas have to travel over 40 miles to the nearest support service, compared to less than one percent of women in urban areas.[21]

Other individuals in rural areas, such as people with disabilities, people with Hepatitis C, and people of color, have intersecting identities that further exacerbate existing barriers to care in rural areas. Racial and ethnic minority communities often live in concentrated parts of rural America, in communities experiencing rural poverty, lack of insurance, and health professional shortage areas.[22] People with disabilities experience difficulties finding competent physicians in rural areas who can provide experienced and specialized care for their specific needs, in buildings that are barrier free.[23] Individuals with Hepatitis C infection find few providers in rural areas with the specialized knowledge to manage the emerging treatment options, drug toxicities and side effects.[24] All of these barriers will worsen if providers are allowed to refuse care to particular patients.

Meanwhile, immigrant, Latina women and their families often face cultural and linguistic barriers to care, especially in rural areas.[25] These women often lack access to transportation and may have to travel great distances to get the care they need.[26] In rural areas there may simply be no other sources of health and life preserving medical care. When these women encounter health care refusals, they have nowhere else to go.

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[19] Thomas A. Arcury et al., *The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region*, 40 HEALTH SERV. RESEARCH (2005) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361130/.

[20] Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources,* 20 J. OF WOMEN'S HEALTH (Nov. 2011) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216064/.

[21] *Id*.

[22] Janice C. Probst et al., *Person and Place: The Compounding Effects of Race/Ethnicity and Rurality on Health,* AM. J. PUB. HEALTH (2011), *available at* http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1695.

[23] Lisa I. Iezzoni et al., *Rural Residents with Disabilities Confront Substantial Barriers to Obtaining Primary Care,* 41 HEALTH SERV. RESEARCH (2006), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1797079/.

[24] Sanjeev Arora et al., *Expanding access to hepatitis C virus treatment – Extension for Community Healthcare Outcomes (ECHO) Project: Disruptive Innovation in Specialty Care,* 52 HEPATOLOGY (2010), *available at* http://onlinelibrary.wiley.com/doi/10.1002/hep.23802/full.

[25] Michelle M. Casey et al., *Providing Health Care to Latino Immigrants: Community-Based Efforts in the Rural Midwest,* AM. J. PUB. HEALTH (2011), *available at* http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1709.

[26] NAT'L LATINA INST. FOR REPROD. HEALTH & CTR. FOR REPROD. RIGHTS, NUESTRA VOZ, NUESTRA SALUD, NUESTRO TEXAS: THE FIGHT FOR WOMEN'S REPRODUCTIVE HEALTH IN THE RIO GRANDE VALLEY, 7 (2013), *available at* http://www.nuestrotexas.org/pdf/NT-spread.pdf.

c. The proposed rule would harm LGBTQ Communities who continue to face rampant discrimination and health disparities

The proposed rule will compound the barriers to care that LGBTQ individuals face, particularly the effects of ongoing and pervasive discrimination by potentially allowing providers to refuse to provide services and information vital to LGBTQ health.

LGBTQ people continue to face discrimination in many areas of their lives, including health care, on the basis of their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[27] LGBTQ people still face discrimination in a wide variety of services affecting access to health care, including reproductive services, adoption and foster care services, child care, homeless shelters, and transportation services – as well as physical and mental health care services.[28] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.[29] They concluded that discrimination as well as insensitivity or disrespect on the part of health care providers were key barriers to health care access and that increasing efforts to provide culturally sensitive services would help close the gaps in health care access.[30]

i. Discrimination against the transgender community

Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[31] Numerous federal courts have found that federal sex discrimination

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[27] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 8, 2018).

[28] HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

[29] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.

[30] *Id*.

[31] *See, e.g.*, *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018); *Whitaker v. Kenosha Unified Sch. Dist*., 858 F.3d 1034 (7th Cir. 2017) (Title IX and Equal Protection Clause); Doddsv. U.S. Dep't of Educ., 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *A.H. ex rel. Handling v. Minersville Area School District*, 3:17-CV-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and Equal Protection Clause); *Stone v. Trump*, ---F.Supp.3d ---, No. 17–2459 (D. Md. Nov. 21, 2017) (Equal Protection Clause); Doe v. Trump, ---F.Supp.3d ---, 2017 WL 4873042 (D.D.C. Oct. 30, 2017) (Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, ---F.Supp.3d ---, 2017 WL 4310756 (S.D. Cal. Sept. 27, 2017) (Section 1557); *E.E.O.C. v. Rent-a-Center East, Inc*., ---F.Supp.3d ---, 2017 WL 4021130 (C.D. Ill. Sept. 8, 2017) (Title VII); *Brown v. Dept. of Health and Hum. Serv.*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017) (Equal Protection Clause); *Smith v. Avanti*, 249 F.Supp.3d 1194 (D. Colo. 2017) (Fair Housing Act); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill.

statutes reach these forms of gender-based discrimination.[32] In 2012, the Equal Employment Opportunity Commission (EEOC) likewise held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[33]

Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity and 29 percent experienced unwanted physical contact from a health care provider.[34] Additionally, the 2015 U.S. Transgender Survey found that 23 percent respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[35] Data obtained by Center for American Progress (CAP) under a FOIA request indicates the Department's enforcement was effective in resolving issues of anti-LGBTQ discrimination. CAP received information on closed complaints of discrimination based on sexual orientation, sexual orientation-related sex stereotyping, and gender identity that were filed with the Department under Section 1557 of the ACA from 2012 through 2016.

- "In approximately 30% of these claims, patients alleged denial of care or insurance coverage simply because of their gender identity – not related to gender transition."
- "Approximately 20% of the claims were for misgendering or other derogatory language."

Oct. 18, 2016) (Title IX); *Mickens v. Gen. Elec. Co.* No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hosp. of Cent. Conn*., 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016) (Section 1557); *Doe v. State of Ariz*., No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016) (Title VII); *Dawson v. H&H Elec., Inc.*, No. 4:14CV00583 SWW, 2015 WL 5437101 (E.D. Ark. Sept. 15, 2015) (Title VII); *U.S. v. S.E. Okla. State Univ*., No. CIV–15–324–C, 2015 WL 4606079 (W.D. Okla. 2015) (Title VII); *Rumble v. Fairview Health Serv.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557); *Finkle v. Howard Cty*., 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Lopez v. River Oaks Imaging & Diagnostic Grp*., Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); *Mitchell v. Axcan Scandipharm,* Inc., No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); *Tronettiv. Healthnet Lakeshore Hosp*., No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII).

[32] *See, e.g*., *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

[33] *Macy v. Holder*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).

[34] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AMERICAN PROGRESS, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

[35] NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf [hereinafter *2015 U.S. Transgender Survey*].

- "Patients denied care due to their gender identity or transgender status included a transgender woman denied a mammogram and a transgender man refused a screening for a urinary tract infection."[36]

As proposed, the rule could allow religiously affiliated hospitals to not only refuse to provide transition related treatment for transgender people, but to also deny surgeons who otherwise have admitting privileges to provide transition related surgery in the hospital. Transition-related care is not only medically necessary, but for many transgender people it is lifesaving.

ii. Discrimination Based Upon Sexual Orientation

Many LGBTQ people lack insurance and providers are not competent in health care issues and obstacles that the LGBTQ community experiences.[37] LGBTQ people still face discrimination. According to one survey, 8 percent of lesbian, gay, bisexual, and queer individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and 7 percent experienced unwanted physical contact and violence from a health care provider.[38]

Fear of discrimination causes many LGB people to avoid seeking health care, and, when they do seek care, LGB people are frequently not treated with the respect that all patients deserve. The study "When Health Care Isn't Caring" found that 56 percent of LGB people reported experiencing discrimination from health care providers – including refusals of care, harsh language, or even physical abuse – because of their sexual orientation.[39] Almost ten percent of LGB respondents reported that they had been denied necessary health care expressly because of their sexual orientation.[40] Delay and avoidance of care due to fear of discrimination compound the significant health disparities that affect the lesbian, gay, and bisexual population. These disparities include:

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[36] Sharita Gruberg & Frank J. Bewkes, Center for American Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (March 7, 2018), *available at* https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.

[37] Medical schools often do not provide instruction about LGBTQ health concerns that are not related to HIV/AIDS. Jen Kates et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S*, KAISER FAMILY FOUND.12 (2017), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US.

[38] Mirza, *supra* note 34.

[39] LAMBDA LEGAL, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 5 (2010), *available at* .http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

[40] *Id*.

- LGB individuals are more likely than heterosexuals to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities.[41]
- Lesbian and bisexual women report poorer overall physical health than heterosexual women.[42]
- Gay and bisexual men report more cancer diagnoses and lower survival rates, higher rates of cardiovascular disease and risk factors, as well as higher total numbers of acute and chronic health conditions.[43]
- Gay and bisexual men and other men who have sex with men (MSM) accounted for more than half (56 percent) of all people living with HIV in the United States, and more than two-thirds (70 percent) of new HIV infections.[44]
- Bisexual people face significant health disparities, including increased risk of mental health issues and some types of cancer.[45]

This discrimination affects not only the mental health and physical health of LGBTQ people, but that of their families as well. One pediatrician in Alabama reported that "we often see kids who haven't seen a pediatrician in 5, 6, 7 years, because of fear of being judged, on the part of either their immediate family or them [identifying as LGBTQ]".[46] It is therefore crucial that LGBTQ individuals who have found unbiased and affirming providers, be allowed to remain with them. If turned away by a health care provider, 17 percent of all LGBTQ people, and 31 percent of LGBTQ people living outside of a metropolitan area, reported that it would be "very difficult" or "not possible" to find the same quality of service at a different community health center or clinic.[47]

The proposed rule allowing providers to deny needed care would reverse recent gains in combatting discrimination and health care disparities for LGBT persons. Refusals also implicate standards of care that are vital to LGBTQ health. Medical professionals are expected to provide LGBTQ individuals with the same quality of care as they would anyone else. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and competency with LGBTQ issues as they pertain to any health services provided.[48] The World Professional

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[41] David J. Lick, Laura E. Durso & Kerri L. Johnson, *Minority Stress and Physical Health Among Sexual Minorities*, 8 PERS. ON PSYCHOL. SCI. 521 (2013), *available at* http://williamsinstitute.law.ucla.edu/research/health-and-hiv-aids/minority-stress-and-physical-health-among-sexual-minorities/.

[42] *Id*.

[43] *Id*.

[44] CTRS FOR DISEASE CONTROL & PREVENTION, *CDC Fact Sheet: HIV Among Gay and Bisexual Men* 1(Feb. 2017), https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf.

[45] HUMAN RIGHTS CAMPAIGN ET AL., *Health Disparities Among Bisexual People* (2015) *available at* http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/HRC-BiHealthBrief.pdf.

[46] HUMAN RIGHTS WATCH, *supra* note 28.

[47] Mirza, *supra* note 34.

[48] *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, GAY LESBIAN BISEXUAL & TRANSGENDER HEALTH ACCESS PROJECT, http://www.glbthealth.org/CommunityStandardsofPractice.htm (last visited Jan. 26, 2018, 12:59 PM); *Creating an LGBTQ-friendly Practice*, A.M.A., https://www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice#Meet a Standard of Practice (last visited Jan. 26, 2018, 12:56 PM).

Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.[49] The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.[50] LGBTQ individuals already experience significant health disparities, and denying medically necessary care on the basis of sexual orientation or gender identity exacerbates these disparities.

In addition, LGBTQ individuals face disparities in medical conditions that may implicate the need for reproductive health services. For example, lesbian and bisexual women report heightened risk for and diagnosis of some cancers and higher rates of cardiovascular disease.[51] The LGBTQ community is significantly at risk for sexual violence.[52] Eighteen percent of lesbian, gay, bisexual students have reported being forced to have sex.[53] Transgender women, particularly women of color, face high rates of HIV.[54]

Refusals to treat individuals according to medical standards of care put patients' health at risk, particularly for women and LGBTQ individuals. Expanding religious refusals will further put needed care, including reproductive health care, out of reach for many. Given the broadly-written and unclear language of the proposed rule, if implemented, some providers may misuse this rule to deny services to LGBTQ individuals on the basis of perceived or actual sexual orientation and gender identity. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care impairs the ability of patients to make a health decision that expresses their self-determination.

Finally, the proposed rule threatens to turn back the clock to the darkest days of the AIDS pandemic when same-sex partners were routinely denied hospital visitation and health care providers scorned sick and dying patients.

d. The proposed rule will hurt people living with disabilities

Many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously-affiliated providers. Historically,

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[49] *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, WORLD PROF. ASS'N FOR TRANSGENDER HEALTH (2011), https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf.

[50] *Committee Opinion 512: Health Care for Transgender Individuals*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Dec. 2011), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals.

[51] Kates, *supra* note 37, at 4.

[52] Forty-six percent of bisexual women have been raped and 47 percent of transgender people are sexually assaulted at some point in their lifetime. This rate is particularly higher for transgender people of color. Kates, *supra* note 37, at 8.; *2015 U.S. Transgender Survey*, *supra* note 35, at 5.

[53] *Health Risks Among Sexual Minority Youth*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/healthyyouth/disparities/smy.htm (last updated May 24, 2017).

[54] More than 1 in 4 transgender women are HIV positive. Kates, *supra* note 37, at 6.

people with disabilities who rely on these services have sometimes faced discrimination, exclusion, and a loss of autonomy due to provider objections. Group homes have, for example, refused to allow residents with intellectual disabilities who were married to live together in the group home.[55] Individuals with HIV – a recognized disability under the ADA – have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. One man with HIV was refused care by six nursing homes before his family was finally forced to relocate him to a nursing home 80 miles away.[56] Given these and other experiences, the extremely broad proposed language at 45 C.F.R. § 88.3(a)(2)(vi) that would allow any individual or entity with an "articulable connection" to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a moral or religious objection is extremely alarming and could seriously compromise the health, autonomy, and well-being of people with disabilities.

Many people with disabilities live or spend much of their day in provider-controlled settings where they often receive supports and services. They may rely on a case manager to coordinate necessary services, a transportation provider to get them to community appointments, or a personal care attendant to help them take medications and manage their daily activities. Under this broad new proposed language, any of these providers could believe they are entitled to object to providing a service covered under the regulation and not even tell the individual where they could obtain that service, how to find an alternative provider, or even whether the service is available to them. A case manager might refuse to set up a routine appointment with a gynecologist because contraceptives might be discussed. A personal home health aide could refuse to help someone take a contraceptive. An interpreter for a deaf individual could refuse to mediate a conversation with a doctor about abortion. In these cases, a denial based on someone's personal moral objection can potentially impact every facet of life for a person with disabilities – including visitation rights, autonomy, and access to the community.

Finally, due to limited provider networks in some areas and to the important role that case managers and personal care attendants play in coordinating care, it may be more difficult for people with disabilities and older adults to find an alternate providers who can help them. For example, home care agencies and home-based hospice agencies in rural areas are facing significant financial difficulties staying open. Seven percent of all zip codes in the United States to not have any hospice services available to them.[57] Finding providers competent to treat people with certain disabilities can increase the challenge. Add in the possibility of a case manager or personal care attendant who

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[55] See *Forziano v. Independent Grp. Home Living Prog*., No. 13-cv-00370 (E.D.N.Y. Mar. 26, 2014) (dismissing lawsuit against group homes, including a religiously affiliated group home, that refused to allow married couple with intellectual disabilities live together). Recent regulations have reinforced protections to ensure available choice of roommates and guests. 42 C.F.R. §§ 441.301(c)(4)(vi)(B) & (D).

[56] NAT'L WOMEN'S LAW CTR., *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS,* (May 2014), *available at* https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf.

[57] Julie A. Nelson & Barbara Stover Gingerich, *Rural Health: Access to Care and Services*, 22 HOME HEALTH CARE MGMT. PRAC. (2010), *available at* http://globalag.igc.org/ruralaging/us/2010/access.pdf.

objects to helping and the barrier to accessing these services can be insurmountable. Moreover, people with disabilities who identify as LGBTQ or who belong to a historically disadvantaged racial or ethnic group may be both more likely to encounter service refusals and also face greater challenges to receive (or even know about) accommodations.

III. The proposed rule undermines longstanding ethical and legal principles of informed consent

The proposed rule threatens informed consent, a necessary principle of patient-centered decision-making. Informed consent relies on disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[58] This right relies on two factors: access to relevant and medically-accurate information about treatment choices and alternatives, and provider guidance based on generally accepted standards of practice. Both factors make trust between patients and health care professionals a critical component of quality of care.

The proposed rule purports to improve communication between patients and providers, but instead, will deter open, honest conversations that are vital to ensuring that a patient is able to be in control of their medical circumstances. For example, the proposed rule suggests that someone could refuse to offer information, if that information might be used to obtain a service to which the refuser objects. Such an attenuated relationship to informed consent could result in withholding information far beyond the scope of the underlying statutes, and would violate medical standards of care.

In recent decades, the U.S. medical community has primarily looked to informed consent as key to assuring patient autonomy in making decisions.[59] Informed consent is intended to help balance the unequal balance of power between health providers and patients and ensure patient-centered decision-making. Moreover, consent is not a yes or no question but rather is dependent upon the patient's understanding of the procedure that is to be conducted and the full range of treatment options for a patient's medical condition. Without informed consent, patients will be unable to make medical decisions that are grounded in agency, their beliefs and preferences, and that meet their personal needs. This is particularly problematic as many communities, including women of color and women living with disabilities, have disproportionately experienced abuse and trauma at the hands of providers and institutions.[60] In order to ensure that patient

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[58] TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).

[59] BEAUCHAMP & CHILDRESS, *supra* note 58; Robert Zussman, *Sociological perspectives on medical ethics and decision-making*, 23 ANN. REV. SOC. 171-89 (1997).

[60] Gutierrez, E. R. *Fertile Matters: The Politics of Mexican Origin Women's* Reproduction, 35-54 (2008) (discussing coercive sterilization of Mexican-origin women in Los Angeles); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 411-12 (2000) (referencing one 1974 study indicating that Indian Health Services would have coercively sterilized approximately 25,000 Native American Women by 1975); Alexandra Minna Stern, *Sterilized in the Name of Public Health*, 95 AM. J. PUB. H. 1128, 1134 (July 2005) (discussing African-American women forced

decisions are based on free will, informed consent must be upheld in the patient-provider relationship. The proposed rule threatens this principle and may very well force individuals into harmful medical circumstances.

According to the American Medical Association: "The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."[61]The American Nursing Association similarly requires that patient autonomy and self-determination are core ethical tenets of nursing. "Patients have the moral and legal right to determine what will be done with their own persons; to be given accurate, complete and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens and available options in their treatment."[62] Similarly, pharmacists are called to respect the autonomy and dignity of each patient.[63]

Various state and federal laws require that health care professionals inform and counsel patients on specific issues such as preventing the spread of HIV/AIDS, non-directional information on family planning and abortion options, and emergency contraception to prevent pregnancy from rape.[64] In *Brownfield v. Daniel Freeman Marina Hospital*, a California court addressed the importance of patients' access to information in regard to emergency contraception. The court found that:

> "The duty to disclose such information arises from the fact that an adult of sound mind has 'the right, in the exercise of control over [her] own body, to determine whether or not to submit to lawful medical treatment.' [citation omitted] Meaningful exercise of this right is possible only to the extent that patients are provided with adequate information upon which to base an intelligent decision with regard to the option available."[65]

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to choose between sterilization and medical care or welfare benefits and Mexican women forcibly sterilized). *See also Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding state statute permitting compulsory sterilization of "feeble-minded" persons); Vanessa Volz, *A Matter of Choice: Women With Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 WOMEN RTS. L. REP. 203 (2006) (discussing sterilization reform statutes that permit sterilization with judicial authorization).

[61] *The AMA Code of Medical Ethics' Opinions on Informing Patients: Opinion 9.09 – Informed Consent*, 14 AM. MED. J. ETHICS 555-56 (2012), http://journalofethics.ama-assn.org/2012/07/coet1-1207.html.

[62] *Code of ethics for nurses with interpretive statements, Provision 1.4 The right to self-determination*, AM. NURSES ASS'N (2001), https://www.truthaboutnursing.org/research/codes/code_of_ethics_for_nurses_US.html.

[63] *Code of Ethics for Pharmacists*, AM. PHARMACISTS ASS'N (1994).

[64] *See, e.g.*, *State HIV Laws*, CTR. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/hiv/policies/law/states/index.html (last visited Nov. 13, 2017, 1:22PM); *Emergency Contraception*, GUTTMACHER INST. (Oct. 1, 2017), https://www.guttmacher.org/state-policy/explore/emergency-contraception.

[65] *Brownfield v. Daniel Freeman Marina Hospital*, 256 Cal. Rptr. 240 (Ct. App. 1989).

In addition, the proposed rule does not provide any protections for health care professionals who want to provide, counsel, or refer for health care services that are implicated in this rule, for example, reproductive health or gender affirming care. Due to the rule's aggressive enforcement mechanisms and its vague and confusing language, providers may fear to give care or information. The inability of providers to give comprehensive, medically accurate information and options that will help patients make the best health decisions violates medical principles such as, beneficence, nonmaleficence, respect for autonomy, and justice. In particular, the principle of beneficence "requires that treatment and care do more good than harm; that the benefits outweigh the risks, and that the greater good for the patient is upheld."[66] In addition, the proposed rule undermines principles of quality care. Health care should be safe, effective, patient-centered, timely, efficient, and equitable.[67] Specifically, the provision of the care should not vary due to the personal characteristics of patients and should ensure that patient values guide all clinical decisions.[68] The expansion of religious refusals as envisioned in the proposed rule may compel providers to furnish care and information that harms the health, well-being, and goals of patients.

In particular, the principles of informed consent, respect for autonomy, and beneficence are important when individuals are seeking end of life care. These patients should be the center of health care decision-making and should be fully informed about their treatment options. Their advance directives should be honored, regardless of the physician's personal objections. Under the proposed rule, providers who object to various procedures could impose their own religious beliefs on their patients by withholding vital information about treatment options— including options such as voluntarily stopping eating and drinking, palliative sedation or medical aid in dying. These refusals would violate these abovementioned principles by ignoring patient needs, their desires, and autonomy and self-determination at a critical time in their lives. Patients should not be forced to bear the brunt of their provider's religious or moral beliefs regardless of the circumstances.

IV. The regulations fail to consider the impact of refusals on persons suffering from substance use disorders (SUD)

The over breadth of this proposed rule could be devastating to people with Substance Use Disorder (SUD). Rather than promoting the evidence-based standard of care, the rule could allow anyone from practitioners to insurers to refuse to provide, or even recommend, Medication Assisted Treatment (MAT) and other evidence-based interventions due simply to a personal objection.

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[66] Amy G. Bryant & Jonas J. Schwartz, *Why Crisis Pregnancy Centers Are Legal but Unethical*, 20 AM. MED. ASS'N J. ETHICS 269, 272 (2018).

[67] INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 3 (Mar. 2001), *available at* http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf.

[68] *Id.*

The opioid epidemic continues to claim too many lives. According to the Centers for Disease Control and Prevention (CDC), over 63,000 people in the U.S. died from drug overdose in 2016.[69] The latest numbers show a 2017 increase in emergency department overdose admissions of 30% across the country, and up to 70% in some areas of the Midwest.[70]

The clear, evidence-based treatment standard for opioid use disorder (OUD) is medication-assisted treatment (MAT).[71] Buprenorphine, methadone, and naltrexone are the three FDA-approved drugs for treating patients with opioid use disorder. MAT is so valuable to treatment of addiction that the World Health Organization considers buprenorphine and methadone "Essential Medications."[72] Buprenorphine and methadone are, in fact, opioids. However, while they operate on the same receptors in the brain as other opioids, they do not produce the euphoric effect of other opioids but simply keep the user from experiencing withdrawal symptoms. They also keep patients from seeking opioids on the black market, where risk of death from accidental overdose increases. Patients on MAT are less likely to engage in dangerous or risky behaviors because their physical cravings are met by the medication, increasing their safety and the safety of their communities.[73] Naloxone is another medication key to saving the lives of people experiencing an opioid overdose. This medication reverses the effects of an opioid and can completely stop an overdose in its tracks.[74] Information about and access to these medications are crucial factors in keeping patients suffering from SUD from losing their jobs, losing their families, and losing their lives.

However, stigma associated with drug use stands in the way of saving lives.[75] America's prevailing cultural consciousness, after decades of treating the disease of addiction as largely a criminal justice and not a public health issue, generally perceives drug use as a moral failing and drug users as less deserving of care. For example, a needle exchange program designed to protect injection drug users from contracting blood

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[69] Holly Hedegaard M.D., et al. *Drug Overdose Deaths in the United States, 1999-2016*, NAT'L CTR. FOR HEALTH STATISTICS1-8 (2017).

[70] *Vital Signs*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/vitalsigns/opioid-overdoses/.

[71] U.S. DEP'T HEALTH & HUM. SERV., PUB NO. (SMA)12-4214, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS (2012), https://store.samhsa.gov/shin/content/SMA12-4214/SMA12-4214.pdf; National Institute on Drug Abuse, *Effective Treatments for Opioid Addiction*, https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction.

[72] World Health Organization, 19th WHO Model List of Essential Medicines (April 2015), http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf

[73] OPEN SOC'Y INST., BARRIERS TO ACCESS: MEDICATION-ASSISTED TREATMENT AND INJECTION-DRIVEN HIV EPIDEMICS 1 (2009), https://www.opensocietyfoundations.org [https://perma.cc/YF94-88AP].

[74] *See* James M. Chamberlain & Bruce L. Klein, *A Comprehensive Review of Naloxone for the Emergency Physician*, 12 AM. J. EMERGENCY MED. 650 (1994).

[75] Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL'Y 49, 56 (2010); German Lopez, *There's a highly successful treatment for opioid addiction. But stigma is holding it back.*, VOX, Nov. 15, 2017, https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone.

borne illnesses such as HIV, Hepatitis C, and bacterial endocarditis was shut down in October 2017 by the Lawrence County, Indiana County Commission due to their moral objection to drug use, despite overwhelming evidence that these programs are effective at reducing harm and do not increase drug use.[76] One commissioner even quoted the Bible as he voted to shut it down. Use of naloxone to reverse overdose has been decried as "enabling these people" to go on to overdose again.[77]

In this frame of mind, only total abstinence is seen as successful treatment for SUD, usually as a result of a 12-step or faith-based program. MAT is considered by many to be simply "substituting one drug for another drug."[78] This belief is so common that even the former Secretary of the Department is on the record as opposing MAT because he didn't believe it would "move the dial," since people on medication would be not "completely cured."[79] The scientific consensus is that SUD is a chronic disease, and yet many recoil from the idea of treating SUD with medication like any other illness such as diabetes or heart disease.[80] The White House's own opioid commission found that "negative attitudes regarding MAT appeared to be related to negative judgments about drug users in general and heroin users in particular."[81]

People with SUD already suffer due to stigma and have a difficult time finding appropriate care. For example, it can be difficult to find access to local methadone clinics in rural areas.[82] Other roadblocks, such as artificial caps on the number of patients to whom doctors can prescribe buprenorphine, further prevent people with SUD from receiving appropriate care.[83] Only one-third of treatment programs across the country provide MAT, even though treatment with MAT can cut overdose mortality rates in half and is considered the gold standard of care. [84] The current Secretary of the

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[76] German Lopez, *An Indiana county just halted a lifesaving needle exchange program, citing the Bible,* VOX, Oct. 20, 2017, https://www.vox.com/policy-and-politics/2017/10/20/16507902/indiana-lawrence-county-needle-exchange.

[77] Tim Craig & Nicole Lewis, *As opioid overdoses exact a higher price, communities ponder who should be saved*, WASH. POST, Jul. 15, 2017, https://www.washingtonpost.com/world/as-opioid-overdoses-exact-a-higher-price-communities-ponder-who-should-be-saved/2017/07/15/1ea91890-67f3-11e7-8eb5-cbccc2e7bfbf_story.html?utm_term=.4184c42f806c.

[78] Lopez, *supra* note 75.

[79] Eric Eyre, *Trump officials seek opioid solutions in WV*, CHARLESTON GAZETTE-MAIL, May 9, 2017, https://www.wvgazettemail.com/news/health/trump-officials-seek-opioid-solutions-in-wv/article_52c417d8-16a5-59d5-8928-13ab073bc02b.html.

[80] Nora D. Volkow et al., *Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic*, 370 NEW ENG. J. MED. 2063, http://www.nejm.org/doi/full/10.1056/NEJMp1402780.

[81] Report of the President's Commission on Combating Drug Addiction and the Opioid Crisis, Nov. 1, 2017, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

[82] Christine Vestal, *In Opioid Epidemic, Prejudice Persists Against Methadone*, STATELINE, Nov. 11, 2016, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/11/11/in-opioid-epidemic-prejudice-persists-against-methadone

[83] 42 C.F.R. §8.610.

[84] Matthais Pierce, et al., *Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England*, 111:2 ADDICTION 298 (Nov. 2015); Luis Sordo, et al., Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies, BMJ (2017), http://www.bmj.com/content/357/bmj.j1550.; Alex Azar, Secretary, U.S. Dep't of Health & Hum. Serv., Plenary Address to National Governors Association, (Feb. 24, 2018),

Department has noted that expanding access to MAT is necessary to save lives and that it will be "impossible" to quell the opioid epidemic without increasing the number of providers offering the evidence-based standard of care.[85] This rule, which allows misinformation and personal feelings to get in the way of science and lifesaving treatment, will not help achieve the goals of the administration; it will instead trigger countless numbers of deaths.

V. The proposed rule permits health care professionals to opt out of providing medical care that the public expects by allowing them to disregard evidence-based standards of care

Medical practice guidelines and standards of care establish the boundaries of medical care that patients can expect to receive and that providers should be expected to deliver. The health services impacted by refusals are often related to reproductive and sexual health, which are implicated in a wide range of common health treatment and prevention strategies. Information, counseling, referral and provisions of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer. Many of these conditions disproportionately affect women of color.[86] The expansion of these refusals as outlined in the proposed rule will put women, particularly women of color, who experience these medical conditions at greater risk for harm.

Moreover, a 2007 survey of physicians working at religiously-affiliated hospitals found that nearly one in five (19 percent) experienced a clinical conflict with the religiously-based policies of the hospital.[87] While some of these physicians might refer their patients to another provider who could provide the necessary care, one 2007 survey found that as many as one-third of patients (nearly 100 million people) may be receiving

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https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/plenary-addres-to-national-governors-association.html.

[85] Azar, *supra* note 84.

[86] For example, Black women are three times more likely to be diagnosed with lupus than white women. Latinas and Asian, Native American, and Alaskan Native women also are likely to be diagnosed with lupus. Office on Women's Health, *Lupus and women*, U.S. DEP'T HEALTH & HUM. SERV. (May 25, 2017), https://www.womenshealth.gov/lupus/lupus-and-women. Black and Latina women are more likely to experience higher rates of diabetes than their white peers. Office of Minority Health, *Diabetes and African Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Jul. 13, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18; Office of Minority Health, *Diabetes and Hispanic Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (May 11, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63. Filipino adults are more likely to be obese in comparison to the overall Asian population in the United States. Office of Minority Health, *Obesity and Asian Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Aug. 25, 2017), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=55. Native American and Alaskan Native women are more likely to be diagnosed with liver and kidney/renal pelvis cancer in comparison to non-Hispanic white women. Office of Minority Health, *Cancer and American Indians/Alaska Natives*, U.S. DEP'T OF HEALTH & HUM. SERV. (Nov. 3, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=31.

[87] Debra B. Stulberg M.D. M.A., et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, J. GEN. INTERN. MED. 725-30 (2010) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881970/.

care from physicians who do not believe they have any obligations to refer their patients to other providers.[88] Meanwhile, the number of Catholic hospitals in the United States has increased by 22 percent since 2001, and now own one in six hospital beds across the country.[89] The increase of Catholic hospitals poses a danger for women seeking reliable access to medical services, many of whom do not understand the full range of services that may be denied them. One public opinion survey found that, among the less than one-third of women who understood that a Catholic hospital might limit care, only 43 percent expected limited access to contraception, and a mere 6 percent expected limited access to the morning-after pill.[90]

a. Pregnancy prevention

The importance of the ability of women to make decisions for themselves to prevent or postpone pregnancy is well-established within the medical guidelines across a range of practice areas. Millions of women live with chronic conditions such as cardiovascular disease, diabetes, lupus, and epilepsy, which if not properly controlled, can lead to health risks to the pregnant woman or even death during pregnancy. Denying these women access to contraceptive information and services violates medical standards that recommend pregnancy prevention for these medical conditions. For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care.[91] Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant.[92]

Moreover, women who are struggling to make ends meet are disproportionately impacted by unintended pregnancy. In 2011, 45% of pregnancies in the U.S. were unintended – meaning that they were either unwanted or mistimed.[93] Low-income women have higher rates of unintended pregnancy as they are least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy.[94] The Institute of Medicine has

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[88] Farr A. Curlin M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, NEW ENG. J. MED. 593–600 (2007) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2867473/.

[89] Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, AM. CIVIL LIBERTIES UNION 22 (2017), *available at* https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[90] Nadia Sawicki, *Mandating Disclosure Of Conscience-Based Limitations On Medical Practice*, 42 AM. J. OF LAW & MED. 85-128 (2016) *available at* http://journals.sagepub.com/doi/pdf/10.1177/0098858816644717.

[91] AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE S115, S117 (2017), available at: http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf

[92] *Id.* at S114.

[93] *Unintended Pregnancy in the United States*, Guttmacher Inst. (Sept. 2016), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.

[94] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in rates of unintended pregnancy in the United*

documented negative health effects of unwanted pregnancy for mothers and children. Unwanted pregnancy is associated with maternal morbidity and risky health behaviors as well as low-birth weight babies and insufficient prenatal care.[95]

b. Sexually transmitted infections (STIs)

Religious refusals also impact access to sexual health care more broadly. Contraceptives and access to preventative treatment for sexually transmitted infections are a critical aspect of health care. The CDC estimates that 20 million new sexually transmitted infections occur each year. Chlamydia remains the most commonly reported infectious disease in the U.S., while HIV/AIDS remains the most life threatening. Women, especially young women, and Black women, are hit hardest by Chlamydia—with rates of Chlamydia 5.6 times higher for Black than for white Americans.[96] Consistent use of condoms results in an 80 percent reduction of HIV transmission, and the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the World Health Organization all recommend the condom use be promoted by providers.[97]

c. Ending a Pregnancy

While there are numerous reasons for why a person would seek to end a pregnancy, there are many medical conditions in which ending a pregnancy is recommended as treatment. These conditions include: preeclampsia and eclampsia, certain forms of cardiovascular disease, and complications for chronic conditions. Significant racial disparities exist in rates of and complications associated with preeclampsia.[98] For example, the rate of preeclampsia is 61% higher for Black women than for white women, and 50% higher than women overall.[99] The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics guidelines state

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States, 1994 and 2001, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90-6 (2006).

[95] INSTITUTE OF MEDICINE COMMITTEE ON UNINTENDED PREGNANCY, THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES (Sarah S. Brown & Leon Eisenberg eds.,1995).

[96] *Sexually Transmitted Disease Surveillance 2016*, CTR. FOR DISEASE CONTROL & PREVENTION (Sept. 2017), https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf.

[97] American Academy of Pediatrics Committee on Adolescence, *Condom Use by Adolescents*, 132 PEDIATRICS (Nov. 2013), http://pediatrics.aappublications.org/content/132/5/973; American Academy of Pediatrics, American College of Obstetricians and Gynecologists, March of Dimes Birth Defects Foundation. Guidelines for perinatal care. 6th ed. Elk Grove Village, IL; Washington, DC: American Academy of Pediatrics; American College of Obstetricians and Gynecologists; 2007; American College of Obstetricians and Gynecologists. Barrier methods of contraception. Brochure (available at http://www.acog.org/publications/patient_education/bp022.cfm). Washington, DC: American College of Obstetricians and Gynecologists; 2008 July; World Health Organization, UNAIDS, UNFPA, *Position statement on condoms and HIV prevention*, UNICEF (2009), https://www.unicef.org/aids/files/2009_position_paper_condoms_en.pdf.

[98] Sajid Shahul et al., *Racial Disparities in Comorbidities, Complication, and Maternal and Fetal Outcomes in Women With Preeclampsia/eclampsia*, 34 HYPERTENSION PREGNANCY (Dec. 4, 2015), http://www.tandfonline.com/doi/abs/10.3109/10641955.2015.1090581?journalCode=ihip20.

[99] Richard Franki, *Preeclampsia/eclampsia rate highest in black women*, OB.GYN. NEWS (Apr. 29., 2017), http://www.mdedge.com/obgynnews/article/136887/obstetrics/preeclampsia/eclampsia-rate-highest-black-women.

that the risks to the woman from persistent severe pre-eclampsia are such that delivery (abortion) is usually suggested regardless of fetal age or potential for survival.[100] ACOG and American Heart Association recommend that a pregnancy be avoided or ended for certain conditions such as severe pulmonary hypertension.[101] Many medications can cause significant fetal impairments, and therefore the Federal Food and Drug Administration and professional medical associations recommend that women use contraceptives to ensure that they do not become pregnant while taking these medications.[102] In addition, some medical guidelines counsel patients to end a pregnancy if they are taking certain medications for thyroid disease.[103]

d. Emergency contraception

The proposed rule will magnify the harm in circumstances where women are already denied the standard of care. Catholic hospitals have a record of providing substandard care or refusing care altogether to women for a range of medical conditions and crises that implicate reproductive health. For example, in a 2005 study of Catholic hospital emergency rooms by Ibis Reproductive Health for Catholics for Choice, it was found that 55 percent would not dispense emergency contraception under any circumstances.[104] Twenty three percent of the hospitals limited EC to victims of sexual assault.[105]

These hospitals violated the standards of care established by medical providers regarding treatment of sexual assault. Medical guidelines state that survivors of sexual assault should be provided emergency contraception subject to informed consent and that it should be immediately available where survivors are treated.[106] At the bare

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[100] AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).

[101] Mary M. Canobbio et al., *Management of Pregnancy in Patients With Complex Congenital Heart Disease*, 135 CIRCULATION e1-e39 (2017); Debabrata Mukherjee, *Pregnancy in Patients With Complex Congenital Heart Disease*, AM. COLL. CARDIOLOGY (Jan. 24, 2017), http://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/01/24/14/40/management-of-pregnancy-in-patients-with-complex-chd.

[102] ELEANOR BIMLA SCHWARZ M.D. M.S., et al., *Documentation of Contraception and Pregnancy When Prescribing Potentially Teratogenic Medications for Reproductive-Age Women*, 147 Annals of Internal Medicine. (Sept. 18, 2007).

[103] For example, the American College of Obstetricians and Gynecologists specifically recommends that if a woman taking Iodine 131 becomes pregnant, her physician should caution her to consider the serious risks to the fetus, and consider termination. American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 37: Thyroid disease in pregnancy* 100 OBSTETRICS & GYNECOLOGY 387-96 (2002).

[104] Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 ANNALS EMERGENCY MED. 105-10 (Aug. 2005), http://www.annemergmed.com/article/S0196-0644(05)00083-1/pdf

[105] *Id*. at 105.

[106] *Committee Opinion 592: Sexual Assault*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Apr. 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co592.pdf?dmc=1&ts=20170213T2116487879; *Management of the Patient with the Complaint of Sexual Assault*, AM. COLL. EMERGENCY MED. (Apr. 2014), https://www.acep.org/Clinical---Practice-Management/Management-of-the-Patient-with-the-Complaint-of-Sexual-Assault/#sm.00000bexmo6ofmepmultb97nfbh3r.

minimum, survivors should be given comprehensive information regarding emergency contraception.[107]

e. Artificial Reproductive Technology (ART)

Refusals to provide the standard of care to LGBTQ individuals because of their sexual orientation or gender identity can impact access to care across a broad spectrum of health concerns, which includes primary and specialty care settings. One example of refusals that impacts LGBTQ patients, as well as non-LGBTQ patients, is refusals to educate about, provide, or cover ART procedures for religious reasons. For individuals with cancer, the standard of care includes education and informed consent around fertility preservation, according to the American Society for Clinical Oncology and the Oncology Nursing Society.[108] Refusals to educate patients about or to provide ART occur for two reasons: refusal based on religious beliefs about ART itself and refusals to provide ART to LGBTQ individuals because of their LGBTQ identity. In both situations, refusals to educate patients about ART and fertility preservation, and to facilitate ART when requested, are against the standard of care.

The lack of clarity in the rule could lead a hospital or an individual provider to refuse to provide ART to same-sex couples based on religious belief. For some couples, this discrimination would increase the cost and emotional toll of family building. In some parts of the country, however, these refusals would be a complete barrier to parenthood. More broadly, these refusals deny patients the human right and dignity to be able to decide to have children, and cause psychological harm to patients who are already vulnerable because of their health status or their experience of health disparities.

f. HIV Health

For HIV, in addition to consistent condom use, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are an important part of prevention for those at high risk for contracting HIV. The American College of Obstetricians and Gynecologists recommends that PrEP be considered for individuals at high risk of contracting HIV.[109] Under the proposed rule, an insurance company could refuse to cover PrEP or PEP

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[107] *Access to Emergency Contraception H-75.985*, AMA (2014), https://policysearch.ama-assn.org/policyfinder/detail/emergency%20contraception%20sexual%20assault?uri=%2FAMADoc%2FHOD.xml-0-5214.xml.

[108] Alison W. Loren et al., *Fertility Preservation for Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500-10 (July 1, 2013); Ethics Committee of the American Society for Reproductive Medicine, *Fertility preservation and reproduction in patients facing gonadotoxic therapies: a committee opinion*, 100 AM. SOC'Y REPROD. MED. 1224-31 (Nov. 2013), http://www.allianceforfertilitypreservation.org/_assets/pdf/ASRMGuidelines2014.pdf; Joanne Frankel Kelvin, *Fertility Preservation Before Cancer Treatment: Options, Strategies, and Resources*, 20 CLINICAL J. ONCOLOGY NURSING 44-51 (Feb. 2016).

[109] ACOG *Committee Opinion 595: Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (May 2014), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Preexposure-Prophylaxis-for-the-Prevention-of-Human-Immunodeficiency-Virus.

because of a religious belief. Refusals to promote and facilitate condom use because of religious beliefs and refusals to prescribe PrEP or PEP because of a patient's perceived or actual sexual orientation, gender identity, or perceived or actual sexual behaviors is in violation of the standards of care and harms patients already at risk for experiencing health disparities. Both PrEP and PEP have been shown to be highly effective in preventing HIV infection. Denying access to this treatment would adversely impact vulnerable, highest risk populations including gay and bisexual men.

VI. The proposed rule violates the Establishment Clause

The Establishment Clause of the First Amendment bars the government from granting religious and moral exemptions that would harm any third party.[110] It requires the Department to "take adequate account of the burdens" that an exemption "may impose on nonbeneficiaries" and must ensure that any exemption is "measured so that it does not override other significant interests."[111]

The Supreme Court acknowledged the limitations imposed by the Establishment Clause in *Burwell v. Hobby Lobby Stores, Inc*., declaring the effect on employees of an accommodation provided to employers under the Religious Freedom Restoration Act (RFRA) "would be precisely zero."[112] Justice Kennedy emphasized that an accommodation must not "unduly restrict other persons, such as employees, in protecting their own interests."[113] The proposed exemptions clearly impose burdens on and harm others and thus, violate the clear mandate of the Establishment Clause.

VII. The regulations are overly broad, vague, and will cause confusion in the health care delivery system

The regulations dangerously expand the application of the underlying statutes by offering an extremely broad definition who can refuse and what they can refuse to do. Under the proposed rule, any one engaged in the health care system could refuse services or care. The proposed rule defines workforce to include "volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity."[114] Under this definition, could any member of the health care workforce refuse to serve a patient in any way – could a nurse assistant refuse to serve lunch to a transgender patient, could a billing specialist refuse to help a patient who had sought contraceptive counseling?

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[110] E.g., *Burwell v. Hobby Lobby Stores, Inc*., 134 S. Ct. 2751, 2781 n.37 (2014); *Cutter v. Wilkinson*, 544 U.S.709, 720, 726 (2005*); Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 18 n.8 (1989).
[111] *Cutter*, 544 U.S. at 720, 722; see also *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709-10 (1985).
[112] *Hobby Lobby*, 134 S. Ct. 2751, 2760 (2014).
[113] *Id*. at 2786-87 (Kennedy, J., concurring).
[114] 83 Fed. Reg. 3894.

a. Discrimination

The failure to define the term "discrimination" will cause confusion for providers, and as employers, expose them to liability. Title VII already requires that employers accommodate employees' religious beliefs to the extent there is no undue hardship on the employer.[115] The regulations make no reference to Title VII or current EEOC guidance, which prohibits discrimination against an employee based on that employee's race, color, religion, sex, and national origin.[116] The proposed rule should be read to ensure that the long-standing balance set in Title VII between the right of individuals to enjoy reasonable accommodation of their religious beliefs and the right of employers to conduct their businesses without undue interference is to be maintained.

If this balance is not maintained, the language in the proposed rule could force health care providers to hire people who intend to refuse to perform essential elements of a position. For example, the proposed rule lacks clarity about whether a Title X-funded health center's decision not to hire a counselor or clinician who objected to provide non-directive options counseling as an essential job function of their position would be deemed discrimination under the rule. Furthermore, the proposed rule does not provide guidance on whether it is impermissible "discrimination" for a Title X-funded state or local health department to transfer such a counselor or clinician to a unit where pregnancy counseling is not done.

By failing to define "discrimination," supervisors in health care settings will be unable to proceed in the orderly delivery of health care services, putting women's health at risk. The proposed rule impermissibly muddies the interpretation of Title VII and current EEOC guidance. If implemented, health care entities may be forced to choose between complying with a fundamentally misguided proposed rule and long-standing interpretation of Title VII.

Finally, the proposed rule's lack of clarity regarding what constitutes discrimination, may undermine non-discrimination laws. Because of the potential harm to individuals if religious refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.[117] Instead, courts have held that the government has a compelling interest in ending discrimination

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[115] 42 U.S.C. § 2000e-2.; *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

[116] *Id*.

[117] See e.g., *Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government's interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc*., 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that "the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family"); *Hamilton v. Southland Christian Sch., Inc*., 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

and that anti-discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race," and are narrowly tailored to meet that "critical goal."[118] The uncertainty regarding how the proposed rule will interact with non-discrimination laws is extremely concerning.

b. Assist in the performance

The definition of "assist in the performance" greatly expands the types of services that can be refused beyond any reasonable stretch of the imagination. The proposed rule defines "assistance" to include participation "in any activity with an *articulable connection* to a procedure, health service or health service program, or research activity."[119] In addition, the Department includes activities such as "making arrangements for the procedure."[120] If workers in very tangential positions, such as schedulers, are able to refuse to do their jobs based on personal beliefs, the ability of any health system or entity to plan, to properly staff, and to deliver quality care will be undermined. Employers and medical staff may be stymied in their ability to establish protocols, policies and procedures under these vague and broad definitions. The proposed rule creates the potential for a wide range of workers to interfere with and interrupt the delivery of health care in accordance with the standard of care.

The regulations also leave unclear whether a worker can assert his or her moral belief in refusing to treat patients on the basis of their identity or deny care for reasons outside of religious or moral beliefs. Even though women living with disabilities report engaging in sexual activities at the same rate as women who do not live with disabilities, they often do not receive the reproductive health care they need for multiple reasons, including lack of accessible provider offices and misconceptions about their reproductive health needs.[121] Biased counseling can contribute to unwanted health outcomes and exacerbate health disparities.[122] The proposed rule is especially alarming as it does not articulate a definition of moral beliefs. The prejudices of a health care professional could easily inform their beliefs and consequently, serve as the basis of denying care to an individual based on characteristics alone. The proposed rule will foster discriminatory health care settings and interactions between patients and

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[118] *Burwell v. Hobby Lobby Stores, Inc*., 134 S. Ct. 2751, slip op. at 46 (2014).
[119] 83 Fed. Reg. 3892.
[120] *Id*.
[121] RM Haynes et al., *Contraceptive Use at Last Intercourse Among Reproductive-Aged Women with Disabilities: An Analysis of Population-Based Data from Seven States*, CONTRACEPTION (2017), https://www.ncbi.nlm.nih.gov/pubmed/29253580; *See generally* Alex Zielinski, *Why Reproductive Health Can Be A Special Struggle for Women with Disabilities*, THINKPROGRESS, Oct. 1, 2015, https://thinkprogress.org/why-reproductive-health-can-be-a-special-struggle-for-women-with-disabilities-73ececea23c4/.
[122] In one study in Massachusetts, women living with intellectual and developmental disabilities, including those who were Black and Latina, faced increased risks of preterm delivery and very low and low birth weight babies. M. Mitra et al., *Pregnancy Outcomes Among Women with Intellectual and Developmental Disabilities*, AM. J. PREV. MED. (2015), https://www.ncbi.nlm.nih.gov/pubmed/25547927.

providers that are informed by bias instead of medically accurate, evidence-based, patient-centered care.

Moreover, in the preamble, the proposed rule states that the exemptions that Weldon provides is not limited to refusals of abortion care on the basis of religious or moral beliefs.[123] Due to this, health care professionals may think they can deny abortion care and other health services just because they do not want to provide the service. The preamble uses language such as "those who choose not to provide" or "Would rather not" as justification for a refusal. This is more concerning because the proposed rule contains no mechanism to ensure that patients receive the care they need if their provider refuses to furnish a service. The onus will be on the patient to question whether her hospital, medical doctor, or health care professional has religious, moral, or other beliefs that would lead them to deny services or if services were denied, the basis for refusal. This is likely to occur as the proposed rule does not have any provisions that stipulate that patients must be given notice that they may be refused certain health care services on the basis of religious or moral beliefs.

c. Referral

The definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information based on which an individual could get the care they need. Any information distributed by any method, including online or print, regarding any service, procedure, or activity could be refused by an entity if the information given would lead to a service, activity, or procedure that the entity or health care entity objects. Under this definition, could a medical doctor refuse to provide a website describing the medical conditions which contraception treats? Or could an entity refuse to provide a list of LGBTQ-friendly providers? In addition, the Department states that the underlying statutes of the proposed rule permits entities to deny help to anyone who is likely to make a referral for an abortion or for other services.[124] The breadth and vagueness of this definition will possibly lead providers to refrain from providing information vital to patients out of anxiety and confusion of what the proposed rule permits them to do.

d. Health Care Entity

The proposed rule's definition of "health care entity" conflicts with Federal religious refusal laws such as the Coats and Weldon Amendments, thus fostering confusion regarding which entities are required to comply with the proposed rule and existing Federal religious refusals. Specifically, under the Coats and Weldon Amendments a "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in health care delivery. Under the proposed rule, a plan sponsor "not primarily engaged in the business of health care" would be deemed a "health care entity."[125] This definition would mean that an employer acting as a third party administrator or sponsor could count as a "health care entity" and deny coverage. In

[123] 83 Fed. Reg. 3890-91.
[124] *Id*. at 3895.
[125] *Id*. at 3893.

2016, OCR found that religiously affiliated employers were not health care entities under the Weldon amendment.[126]

Moreover, the Department states that their definition of "health care entity" is "not an exhaustive list" for concern that the Department would "inadvertently omit[ting] certain types of health care professionals or health care personnel."[127] Additionally, the proposed rule incorporates entities as defined in 1 USC 1 which includes corporations, firms, societies, etc.[128] States and public agencies and institutions are also deemed to be entities.[129] The Department's inclusion of entities who are primarily not engaged in the health care delivery system highlights the true purpose of the proposed rule, to permit a greater number of entities to interfere in the provider-patient relationship and deter a patient from making the best decision based on their circumstances, preferences, and beliefs.

Conclusion

National Association of Councils on Developmental Disabilities opposes the proposed rule as it expands religious refusals to the detriment of patients' health and well-being. We are concerned that these regulations, if implemented, will interfere in the patient-provider relationship by undermining informed consent. The proposed rule will allow anyone in the health care setting to refuse health care that is evidence-based and informed by the highest standards of medical care. The outcome of this regulation will harm communities who already lack access to care and endure discrimination.

Thank you for your attention to our comments. If you have any questions, please reach out to Erin Prangley, Public Policy Director at EPrangley@nacdd.org.

[126] Office for Civil Rights, Decision Re: OCR Transaction Numbers: 14-193604, 15-193782 & 15-195665, 4 (Jun. 21, 2016) (letter on file with NHeLP-DC office).
[127] 83 Fed. Reg. 3893.
[128] *Id*.
[129] *Id*.

EXHIBIT O

March 27, 2018
U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Public Comment in Response to the Proposed Regulation, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03

To Whom It May Concern:

I am writing on behalf of the Oregon Foundation for Reproductive Health in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1] The Oregon Foundation for Reproductive Health (OFRH) is a non-profit advocacy organization located in Portland, that provides a channel for Oregon women's voices from all over the state to be heard, particularly those historically under-served. We believe that all people should have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction for themselves and their families without fear of discrimination, exclusion, or harm. We will work to break down barriers to health care so that all people have the opportunity to thrive. Our mission is to improve access to comprehensive reproductive health care, such as preventing unintended pregnancy and planning healthy families, and we are committed to advancing reproductive rights and advocating for reproductive health equity in all Oregon communities.

This proposed regulation would exacerbate the challenges that many patients—especially women, LGBTQ people, people of color, immigrants and low-income people—already face in getting the health care they need in a timely manner and at an affordable cost. The rule would expose vulnerable patients to increased discrimination and denials of medically-indicated care by broadening religious health care provider exemptions beyond the existing limited circumstances allowed by law. Moreover, while protecting health providers who deny care, the rule would provide *no protections for patients who are being denied care—even in emergencies*. As drafted, the rule would not even require that patients be informed of all their potential treatment options or referred to alternative providers of needed care.

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (*to be codified at* 45 C.F.R. pt. 88) [*hereinafter* Rule].

Indeed, this proposal runs in the opposite direction of everything the American health system is striving to achieve in the pursuit of "patient-centered care." We urge the administration to put patients first, and withdraw the proposed regulation because of the serious problems enumerated below.

1. The rule improperly seeks to expand on existing religious refusal exemptions to potentially allow denial of any health care service based on a provider's personal beliefs or religious doctrine.

Existing refusal of care laws (such as those for abortion and sterilization services) are already being used across the country to deny patients the care they need.[2] The proposed rule attempts to expand on these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. Specifically, the Department and its Office for Civil Rights (OCR) are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[3]

This expansive interpretation could lead to provider denials based on personal beliefs that are biased and discriminatory, such as objections to providing care to people who are transgender or in same-sex relationships. We are aware of cases in which this type of unjust denial of care has occurred, such as a California physician's denial of donor insemination to a lesbian couple, even though the doctor routinely provided the same service to heterosexual couples. [4]

We are also concerned about potential enabling of care denials by providers based on their non-scientific personal beliefs about other types of health services. For example, certain religiously-affiliated hospitals and individual clinicians have refused to provide rape victims with emergency contraception to prevent pregnancy[5] based on the belief that it can cause an abortion, even though there is no scientific evidence that this is the case.

2. The rule would protect refusals by anyone who would be "assisting in the performance of" a health care service to which they object, not just clinicians.

The rule seeks to protect refusals by any "member of the workforce" of a health care institution whose actions have an "articulable connection to a procedure, health services or health service program, or research activity." The rule includes examples such as "counseling, referral, training and other arrangements for the procedure, health service or research activity."

An expansive interpretation of "assist in the performance of" thus *could conceivably allow an ambulance driver to refuse to transport a patient to the hospital for care he/she finds objectionable*. It

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[2] *See, e.g.*, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Uttley, L., et al, *Miscarriage of Medicine,* MergerWatch and the ACLU (2013), https://www.aclu.org/report/miscarriage-medicine.

[3] *See* Rule *supra* note 1, at 12.

[4] Hardaway, Lisa, *Settlement Reached in Case of Lambda Legal Lesbian Client Denied Infertility Treatment by Christian Fundamentalist Doctors,* Lambda Legal, September 29, 2009, accessed at https://www.lambdalegal.org/news/ca_20090929_settlement-reached.

[5] Erdely, Sabrina, *Doctors' beliefs can hinder patient care*, SELF magazine, June 22, 2007, accessed at http://www.nbcnews.com/id/19190916/print/1/displaymode/1098/

could mean a hospital admissions clerk could refuse to check in a patient for treatment the clerk finds objectionable or a technician could refuse to prepare surgical instruments for use in a service.

On an institutional level, the right to refuse to "assist in the performance of" a service could mean *a* religiously-affiliated hospital or clinic could deny care, and *then also refuse to provide a patient with a referral or transfer to a willing provider* of the needed service.

The proposed rule thus could be read as allowing health providers to refuse to inform patients of all potential treatment options. A 2010 publication of the National Health Law Program, "Health Care Refusals: Undermining Quality of Care for Women," noted that "refusal clauses and institutional restrictions can operate to deprive patients of the complete and accurate information necessary to give informed consent."[6]

3. The rule does not address how a patient's needs would be met in an emergency situation.

There have been reported instances in which pregnant women suffering medical emergencies—including premature rupture of membranes (PPROM) and ectopic pregnancies[7]—have gone to hospital emergency departments and been denied prompt, medically-indicated care because of institutional religious restrictions.[8] The proposed rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[9] Under EMTALA, every hospital is required to comply – even those that are religiously affiliated.[10] Because the proposed rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

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[6] The NHeLP publication noted (at page 21) that the Ethical and Religious Directives for Catholic Healthcare Services, which govern care at Catholic hospitals, limit the information a patient can be given about treatment alternatives to those considered "morally legitimate" within Catholic religious teachings. (Directive No. 26).

[7] Foster, AM, and Smith, DA, *Do religious restrictions influence ectopic pregnancy management? A national qualitative study*, Jacob Institute for Women's Health, Women's Health Issues, 2011 Mar-Apri; 21(2): 104-9, accessed at https://www.ncbi.nlm.nih.gov/pubmed/21353977

[8] Stein, Rob, *Religious hospitals' restrictions sparking conflicts, scrutiny,* The Washington Post, January 3, 2011, accessed at https://www.washingtonpost.com/health-environment-science/religious-hospitals-restrictions-sparking-conflicts-scrutiny/2011/01/03/ABVVxmD_story.html?utm_term=.cc34abcbb928

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

[10] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); *In re Baby K*, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, *93 Fair Empl. Prac. Cas.* (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).

4. **Health care institutions would be required to notify employees that they have the right to refuse to provide care, *but would not be required to notify patients about the types of care they will not be able to receive at that hospital, pharmacy, clinic or doctor's office*.**

The rule sets forth extensive requirements for health care institutions, such as hospitals, to notify employees about their refusal rights, including how to file a discrimination complaint with OCR. The rule requires posting of such notices on the employer's website and in prescribed physical locations within the employer's building. The rule also sets forth the expectation that OCR would investigate or conduct compliance reviews of whether health care institutions are following the posting rule.[11]

By contrast, the rule contains no requirement that patients be notified of institutional restrictions on provision of certain types of care. Such notification is essential because research has found that patients often are unaware of service restrictions at religiously-sponsored health care institutions. [12]

5. The rule conflicts with other existing federal laws, including the Title VII framework for accommodation of employees' religious beliefs.

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals of care it would create. For example, the proposed rule makes no mention of Title VII,[13] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[14] Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[15] The proposed rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both.

5. There is no provision protecting the rights of health care providers with religious or moral convictions to *provide* (not deny) services their patients need.

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. The

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[11] The notice requirement is spelled out in section 88.5 of the proposed rule.

[12] *See*, for example, Freedman, Lori R., Luciana E. Hebert, Molly F. Battistelli, and Debra B. Stulberg, *Religious hospital policies on reproductive care: what do patients want to know?* American Journal of Obstetrics & Gynecology 218, no. 2 (2018): 251-e1, accessed here: http://www.ajog.org/article/S0002-9378(17)32444-4/fulltext; also Guiahi, Maryam, Jeanelle Sheeder, and Stephanie Teal, *Are women aware of religious restrictions on reproductive health at Catholic hospitals? A survey of women's expectations and preferences for family planning care*, Contraception and Stulberg, D., et all, accessed here: http://www.contraceptionjournal.org/article/S0010-7824(14)00358-8/fulltext; *Do women know when their hospital is Catholic and how this affects their care? Restrictions in Catholic Hospitals (PARRCH) national survey*, Contraception, Volume 96, Issue 4, 268-269,accessed here: http://www.contraceptionjournal.org/article/S0010-7824(17)30235-4/fulltext; a

[13] 42 U.S.C. § 2000e-2 (1964).

[14] *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

[15] *See id.*

rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[16]

Doctors are, in effect, forced to abandon their patients when they are prevented by health care institutions from providing a service they believe is medically-indicated. This was the case for a doctor in Sierra Vista, Arizona, who was prevented from ending a patient's wanted, but doomed, pregnancy after she suffered premature rupture of membranes. The patient had to be sent to the nearest non-objecting hospital, which was 80 miles away, far from her family and friends. The physician described the experience as "a very gut wrenching thing to put the staff through and the patient, obviously."[17]

6. The proposed rule carries severe consequences for patients and will exacerbate existing inequities.

a. Refusals of care make it difficult for many individuals to access the care they need

Across the country, refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[18] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously-affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[19] Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.[20] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[21] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[22] Another woman was sent home by a religiously-affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[23]

b. Refusals of care are especially dangerous for those already facing barriers to care

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another

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[16] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).
[17] Uttley, L, et all, *Miscarriage of Medicine,* MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.
[18] *See, e.g.*, *supra* note 2.
[19] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[20] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[21] *See* Kira Shepherd, et al., *supra* note 19, at 29.
[22] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.
[23] *See* Kira Shepherd, et al., *supra* note 19, at 27.

location, refusals bar access to necessary care.[24] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[25] In rural areas there may be no other sources of health and life preserving medical care.[26] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that In 19 states, women of color are more likely than white women to give birth in Catholic hospitals.[27] Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provide guidance on a wide range of hospital matters, including reproductive health care, and can keep providers from offering the standard of care.[28] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[29]

7. The Department is abdicating its responsibility to patients

If finalized, the proposed rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care and eliminate health disparities

The proposed rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. For example, Black women are three to four times more likely than white women to die during or after childbirth.[30] Lesbian, gay, bisexual and transgender individuals also encounter high rates of discrimination in health care.[31] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[32] OCR must work to address these disparities, yet the proposed rule is antithetical to OCR's mission.

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[24] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. *Women's Health Insurance* Coverage, KAISER FAMILY FOUND. 1, 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.

[25] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health & Ctr. For Reproductive Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: the Fight for Women's Reproductive Health in the Rio Grande Valley* 1, 7 (2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf.

[26] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[27] *See* Kira Shepherd, et al., *supra* note 19, at 12.

[28] *See id.* at 10-13.

[29] *See, e.g.*, *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

[30] *See* Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.

[31] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf.

[32] *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, NAT'L GAY AND LESBIAN TASK FORCE & NAT'L CTR. FOR TRANSGENDER EQUALITY, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

8. The proposed rule will make it harder for states to protect their residents

The proposed rule will have a chilling effect on the enforcement and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. Moreover, the proposed rule invites states to further expand refusals of care by making clear that this expansive rule is a floor, and not a ceiling, for religious exemption laws.[33]

Conclusion

The proposed pule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The proposed rule is discriminatory, violates multiple federal statutes and the Constitution, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons the Oregon Foundation for Reproductive Health calls on the Department to withdraw the proposed rule in its entirety.

[33] *See, e.g.*, Rule, *Supra* note 1, at 3888-89.

EXHIBIT P

north carolina
JUSTICE CENTER

March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Public Comment in Response to the Proposed Regulation, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03

To Whom It May Concern:

I am writing on behalf of the North Carolina Justice Center in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1]

The North Carolina Justice Center advocates for the social, political, economic, and healthful well-being of all North Carolinians. Our mission is to eliminate poverty by ensuring that every household has access to the resources, services and fair treatment it needs to enjoy economic security and participate equally in the opportunities available in the state. A project of the NC Justice Center, the Health Advocacy Project works to ensure that all North Carolinians, especially underserved populations, including racial and ethnic minorities and rural communities, have meaningful access to high quality, affordable, equitable, and comprehensive health care so that children, adults, and families have better health outcomes and live productive lives. In addition, each of the undersigned organizations joining to support these comments also advocates for policies that would improve access to health care for North Carolinians.

This proposed regulation would exacerbate the challenges that many patients -- especially women, LGBTQ people, people of color, immigrants and low-income people -- already face in getting the health care they need in a timely manner and at an affordable cost. The rule would expose vulnerable patients to increased discrimination and denials of medically-indicated care by broadening religious health care provider exemptions beyond the existing limited circumstances allowed by law. Moreover, while protecting health providers who deny care, the rule would provide *no protections for patients who are being denied care – even in emergencies*. As drafted, the rule would not even require that patients be informed of all their potential treatment options and referred to alternative providers of needed care.

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (*to be codified at* 45 C.F.R. pt. 88) [*hereinafter* Rule].

Indeed, this proposal runs in the opposite direction of everything the American health system is striving to achieve in the pursuit of "patient-centered care." We urge the administration to put patients first, and withdraw the proposed regulation because of the serious problems enumerated below.

1. The rule improperly seeks to expand on existing religious refusal exemptions to potentially allow denial of any health care service based on a provider's personal beliefs or religious doctrine.

Existing refusal of care laws (such as for abortion and sterilization services) are already being used across the country to deny patients the care they need.[2] The proposed rule attempts to expand on these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. Specifically, the Department and its Office for Civil Rights (OCR) are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[3]

This expansive interpretation could lead to provider denials based on personal beliefs that are biased and discriminatory, such as objections to providing care to people who are transgender or in same-sex relationships. We are aware of cases in which this type of unjust denial of care has occurred, such as a California physician's denial of donor insemination to a lesbian couple, even though the doctor routinely provided the same service to heterosexual couples. [4]

We are also concerned about potential enabling of care denials by providers based on their non-scientific personal beliefs about other types of health services. For example, certain religiously-affiliated hospitals and individual clinicians have refused to provide rape victims with emergency contraception to prevent pregnancy[5] based on the belief that it can cause an abortion, even though there is no scientific evidence that this is the case.

2. The rule would protect refusals by anyone who would be "assisting in the performance of" a health care service to which they object, not just clinicians.

The rule seeks to protect refusals by any "member of the workforce" of a health care institution whose actions have an "articulable connection to a procedure, health services or health service program, or research activity." The rule includes examples such as "counseling, referral, training and other arrangements for the procedure, health service or research activity."

An expansive interpretation of "assist in the performance of" thus *could conceivably allow an ambulance driver to refuse to transport a patient to the hospital for care he/she finds objectionable*. It

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[2] *See, e.g.*, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Uttley, L., et al, *Miscarriage of Medicine,* MergerWatch and the ACLU (2013), https://www.aclu.org/report/miscarriage-medicine.

[3] *See* Rule *supra* note 1, at 12.

[4] Hardaway, Lisa, *Settlement Reached in Case of Lambda Legal Lesbian Client Denied Infertility Treatment by Christian Fundamentalist Doctors,* Lambda Legal, September 29, 2009, accessed at https://www.lambdalegal.org/news/ca_20090929_settlement-reached.

[5] Erdely, Sabrina, *Doctors' beliefs can hinder patient care*, SELF magazine, June 22, 2007, accessed at http://www.nbcnews.com/id/19190916/print/1/displaymode/1098/

could mean a hospital admissions clerk could refuse to check a patient in for treatment the clerk finds objectionable or a technician could refuse to prepare surgical instruments for use in a service.

On an institutional level, the right to refuse to "assist in the performance of" a service could mean *a* religiously-affiliated hospital or clinic could deny care, and *then also refuse to provide a patient with a referral or transfer to a willing provider* of the needed service.

The proposed rule thus could be read as allowing health providers to refuse to inform patients of all potential treatment options. A 2010 publication of the National Health Law Program, "Health Care Refusals: Undermining Quality of Care for Women," noted that "refusal clauses and institutional restrictions can operate to deprive patients of the complete and accurate information necessary to give informed consent."[6]

3. The rule does not address how a patient's needs would be met in an emergency situation.

There have been reported instances in which pregnant women suffering medical emergencies – including premature rupture of membranes (PPROM) and ectopic pregnancies[7] -- have gone to hospital emergency departments and been denied prompt, medically-indicated care because of institutional religious restrictions.[8] The proposed rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[9] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[10] Because the proposed rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

4. **Health care institutions would be required to notify employees that they have the right to refuse to provide care, *but would not be required to notify patients about the types of care they will not be able to receive at that hospital, pharmacy, clinic or doctor's office*.**

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[6] The NHeLP publication noted (at page 21) that the Ethical and Religious Directives for Catholic Healthcare Services, which govern care at Catholic hospitals, limit the information a patient can be given about treatment alternatives to those considered "morally legitimate" within Catholic religious teachings. (Directive No. 26).

[7] Foster, AM, and Smith, DA, *Do religious restrictions influence ectopic pregnancy management? A national qualitative study*, Jacob Institute for Women's Health, Women's Health Issues, 2011 Mar-Apri; 21(2): 104-9, accessed at https://www.ncbi.nlm.nih.gov/pubmed/21353977

[8] Stein, Rob, *Religious hospitals' restrictions sparking conflicts, scrutiny,* The Washington Post, January 3, 2011, accessed at https://www.washingtonpost.com/health-environment-science/religious-hospitals-restrictions-sparking-conflicts-scrutiny/2011/01/03/ABVVxmD_story.html?utm_term=.cc34abcbb928

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

[10] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); *In re Baby K*, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, *93 Fair Empl. Prac. Cas.* (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).

The rule sets forth extensive requirements for health care institutions, such as hospitals, to notify employees about their refusal rights, including how to file a discrimination complaint with OCR. The rule requires posting of such notices on the employer's website and in prescribed physical locations within the employer's building. The rule also sets forth the expectation that OCR would investigate or do compliance reviews of whether health care institutions are following the posting rule.[11]

By contrast, the rule contains no requirement that patients be notified of institutional restrictions on provision of certain types of care. Such notification is essential because research has found that patients often are unaware of service restrictions at religiously-sponsored health care institutions. [12]

5. The rule conflicts with other existing federal laws, including the Title VII framework for accommodation of employee's religious beliefs.

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals of care it would create. For example, the proposed rule makes no mention of Title VII,[13] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[14] Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[15] The proposed rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both.

5. There is no provision protecting the rights of health care providers with religious or moral convictions to *provide* (not deny) services their patients need.

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care and end-of-life care. The rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[16]

Doctors are, in effect, forced to abandon their patients when they are prevented by health care institutions from providing a service they believe is medically-indicated. This was the case for a doctor in Sierra Vista, Arizona, who was prevented from ending a patient's wanted, but doomed, pregnancy after

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[11] The notice requirement is spelled out in section 88.5 of the proposed rule.

[12] *See*, for example, Freedman, Lori R., Luciana E. Hebert, Molly F. Battistelli, and Debra B. Stulberg, *Religious hospital policies on reproductive care: what do patients want to know?* American Journal of Obstetrics & Gynecology 218, no. 2 (2018): 251-e1, accessed here: http://www.ajog.org/article/S0002-9378(17)32444-4/fulltext; also Guiahi, Maryam, Jeanelle Sheeder, and Stephanie Teal, *Are women aware of religious restrictions on reproductive health at Catholic hospitals? A survey of women's expectations and preferences for family planning care*, Contraception and Stulberg, D., et all, accessed here: http://www.contraceptionjournal.org/article/S0010-7824(14)00358-8/fulltext; *Do women know when their hospital is Catholic and how this affects their care? Restrictions in Catholic Hospitals (PARRCH) national survey*, Contraception, Volume 96, Issue 4, 268-269,accessed here: http://www.contraceptionjournal.org/article/S0010-7824(17)30235-4/fulltext; a

[13] 42 U.S.C. § 2000e-2 (1964).

[14] *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

[15] *See id.*

[16] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).

she suffered premature rupture of membranes. The patient had to be sent to the nearest non-objecting hospital, which was 80 miles away, far from her family and friends. The physician described the experience as "a very gut wrenching thing to put the staff through and the patient, obviously."[17]

6. The proposed rule carries severe consequences for patients and will exacerbate existing inequities.

a. Refusals of care make it difficult for many individuals to access the care they need

Across the country, refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[18] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[19] Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.[20] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[21] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[22] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[23]

b. Refusals of care are especially dangerous for those already facing barriers to care

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[24] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[25] In rural

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[17] Uttley, L, et all, *Miscarriage of Medicine,* MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.

[18] *See, e.g.*, *supra* note 2.

[19] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[20] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[21] *See* Kira Shepherd, et al., *supra* note 19, at 29.

[22] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.

[23] *See* Kira Shepherd, et al., *supra* note 19, at 27.

[24] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. *Women's Health Insurance* Coverage, KAISER FAMILY FOUND. 1, 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.

[25] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health &

areas there may be no other sources of health and life preserving medical care.[26] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that In 19 states, women of color are more likely than white women to give birth in Catholic hospitals.[27] Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provide guidance on a wide range of hospital matters, including reproductive health care, and can keep providers from offering the standard of care.[28] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[29]

7. The Department is abdicating its responsibility to patients

If finalized, the proposed rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities

The proposed rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. For example, Black women are three to four times more likely than white women to die during or after childbirth.[30] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[31] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[32] OCR must work to address these disparities, yet the proposed rule is antithetical to OCR's mission.

8. The proposed rule will make it harder for states to protect their residents

The proposed rule will have a chilling effect on the enforcement and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. Moreover, the proposed rule invites states to further expand refusals of care by making clear that this expansive rule is a floor, and not a ceiling, for religious exemption laws.[33]

Ctr. For Reproductive Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: the Fight for Women's Reproductive Health in the Rio Grande Valley* 1, 7 (2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf.

[26] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[27] *See* Kira Shepherd, et al., *supra* note 19, at 12.

[28] *See id.* at 10-13.

[29] *See, e.g.*, *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

[30] *See* Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.

[31] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf.

[32] *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, NAT'L GAY AND LESBIAN TASK FORCE & NAT'L CTR. FOR TRANSGENDER EQUALITY, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

[33] *See, e.g.*, Rule, *Supra* note 1, at 3888-89.

Conclusion

The proposed pule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The proposed rule is discriminatory, violates multiple federal statutes and the Constitution, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons, the North Carolina Justice Center calls on the Department to withdraw the proposed rule in its entirety.

Thank you for this opportunity to comment. If you have any questions, please contact Brendan Riley at Brendan@ncjustice.org.

North Carolina Justice Center

EXHIBIT Q

NCLR NATIONAL CENTER FOR LESBIAN RIGHTS

WASHINGTON DC OFFICE
1776 K Street NW, Suite 852
Washington, D.C. 20006

March 26, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Protecting Statutory Conscience Rights in Health Care (RIN 0945-ZA03)

The National Center for Lesbian Rights (NCLR) writes to urge that the above-referenced Proposed Rule be withdrawn in its entirety, as it would endanger patient health and encourage widespread discrimination in health care delivery.

NCLR is a non-profit, public interest law firm that litigates precedent-setting cases at the trial and appellate court levels, advocates for equitable public policies affecting the lesbian, gay, bisexual, and transgender (LGBT) community, provides free legal assistance to LGBT people and their advocates, and conducts community education on LGBT issues. NCLR has been advancing the civil and human rights of LGBT people and their families across the United States through litigation, legislation, policy, and public education since its founding in 1977. We also seek to empower individuals and communities to assert their own legal rights and to increase public support for LGBT equality through community and public education. NCLR recognizes the critical importance of access to affordable health care for all people, and is concerned about the increasing use of religious exemptions to undercut civil rights protections and access to services for our community.

Our overarching objections to this Proposed Rule are twofold. First, it strays far from the primary mission of the Department of Health & Human Services. Our nation's premier public health agency should always maintain a focus on protecting the health of all, rather than seeking to empower health care providers to withhold care, in contravention of the core principles of informed consent and adherence to accepted standard of care. Second, it exceeds the agency's authority and was promulgated in violation of the Administrative Procedure Act. We provide further detail below.

I. The Proposed Rule disregards HHS's core mission

The Proposed Rule disregards the health care needs of patients and the core mission of the Department of Health & Human Services (HHS). The purpose of our nation's health care delivery system is to deliver health care to the people of this country. As the nation's largest public health agency, and one that is charged with furthering the health of all Americans, HHS is primarily charged with assisting patients in accessing care and health care providers in

delivering high-quality, culturally-competent care to everyone. Access to care, rather than denials of care, should be the goal. This Proposed Rule, in addition to being on questionable legal ground, focuses exclusively on purported rights of health care providers to turn patients away, with virtually no mention of the impact on patient health and well-being or on how access to care will be ensured. The priorities reflected in the Rule represent a sharp departure from the missions of HHS and its Office for Civil Rights (OCR) and should be withdrawn.

A. HHS should be trying to broaden access, not encourage denials of care

The HHS web site states: "It is the mission of the U.S. Department of Health & Human Services (HHS) to enhance and protect the health and well-being of all Americans. We fulfill that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services" (emphasis added).[1] The Proposed Rule departs significantly from that vision as well as the Office for Civil Rights (OCR's) mission to address health disparities and discrimination that harm patients.[2] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended, proposing a regulatory scheme that would be affirmatively harmful to many patients seeking care.

HHS, through OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[3] If finalized, however, the Proposed Rule will undermine HHS's mission of combating discrimination, protecting patient access to care, and eliminating health disparities. Through enforcement of civil rights laws, OCR has in the past worked to reduce discrimination in health care by ending discriminatory practices such as segregation in health care facilities based on race or disability, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[4]

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[1] *See* https://www.hhs.gov/about/index.html.

[2] *OCR's Mission and Vision*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").

[3] As one of its first official acts in 1967, the Office of Equal Health Opportunity undertook the massive effort of inspecting 3,000 hospitals to ensure they were complying with Title VI's prohibition against discrimination on the basis of race, color, or national origin. 42. U.S.C. § 2000d (1964). After this auspicious start, the Office of Equal Health Opportunity, which would eventually become OCR, would go on to ensure that health programs and activities it regulated complied with key anti-discrimination laws, including Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1973), Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 (1972), the Age Discrimination Act of 1976, 42 U.S.C. § 6101 (1976), and Section 1557 of the Affordable Care Act, 42 U.S.C. §18116 (2010), among others. Through robust enforcement of these laws, OCR has in the past worked to reduce discrimination in health care.

[4] *See, e.g., Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html; *Protecting the Civil Rights and Health Information Privacy*

Despite this past progress, there is still much work to be done, and the Proposed Rule would divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.[5] Black women are three to four times more likely than are white women to die during or after childbirth.[6] And the disparity in maternal mortality is growing rather than decreasing,[7] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resultant health disparities. Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care (we discuss this further below).

There is an urgent need for OCR to address these disparities, yet the Proposed Rule seeks instead to prioritize the expansion of existing religious refusal laws beyond their statutory requirements to create new religious exemptions. The Proposed Rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.

B. The evidence does not support the existence of the problem the Proposed Rule purports to address

Rather than focusing on the overarching aim of ensuring that all people in this country have access to the health care they need, the Proposed Rule seeks to empower health care providers, whose very jobs are to deliver health care, to instead deny not only health care services but even information about services to which they might personally object. It would create additional barriers to care in a health care system already replete with obstacles, particularly for people with limited incomes or those who are LGBT.

Through prior rulemaking in this area, HHS has already created mechanisms by which any provider who believes they have been subject to discrimination in violation of any of the federal health care refusal statutes may file a complaint with OCR and seek redress. Complaints have been filed and resolved through this process. And HHS has the ability to decline to fund entities that engage in violations of these laws. Individual health care providers who wish to exercise a conscientious objection to participating in certain health care services have the ability to do so and HHS, through OCR, already has the tools it needs to protect those rights. Rather than seeking to engage in a sweeping new rulemaking effort that would inappropriately

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Rights of People Living with HIV/AIDS, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/hiv/index.html; *National Origin Discrimination*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/national-origin/index.html; *Health Disparities*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/health-disparities/index.html.

[5] *See* Skinner et al., *Mortality after Acute Myocardial Infarction in Hospitals that Disproportionately Treat African-Americans*, NAT'L INSTIT. OF HEALTH 1 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1626584/pdf/nihms13060.pdf.

[6] *See* Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.

[7] *See id.*

shift the balance too far in the direction of care denial, the agency should instead devote its resources to expanding access to health care for all.

1. Discrimination against LGBT people in health care is pervasive

LGBT people, women, and other vulnerable groups already face significant barriers to getting the care they need.[8] The Proposed Rule will compound the barriers to care that LGBT individuals face, particularly the effects of ongoing and pervasive discrimination, by inviting providers to refuse to provide services and information vital to LGBT health.

As a civil rights organization that has been advocating for the LGBT community for over four decades, we at NCLR see firsthand the negative effects of stigma and discrimination on LGBT people seeking care. Despite significant gains in societal acceptance and legal protections, we still face hostility and ill treatment simply for being who we are, and sometimes the consequences are fatal. For example, NLCR currently represents the parents of a transgender youth who died by suicide after being denied appropriate care and discharged prematurely by a hospital in southern California.[9]

LGBT people of all ages continue to face discrimination in health care on the basis of their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes that "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[10] This surfaces in a wide variety of contexts, including physical and mental health care services.[11] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.[12] They concluded that discrimination, as well as insensitivity or disrespect on the part of health care providers, were key barriers to health care access.[13]

There is a growing body of research documenting how LGBT people encounter barriers in the health care system and suffer disproportionately from a variety of conditions due to health care

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[8] *See, e.g.,* Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care; Sandy E. James et al., *The Report of the U.S. Transgender Survey* 93–126 (2016), www.ustranssurvey.org/report; Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), http://www.lambdalegal.org/publications/when-health-care-isnt-caring.

[9] *See* http://www.nclrights.org/cases-and-policy/cases-and-advocacy/case-prescott-v-rchsd/.

[10] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 8, 2018).

[11] HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

[12] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.

[13] *Id*.

access issues compounded by stigma and discrimination. In 2010, Lambda Legal found that fifty-six percent of lesbian, gay, and bisexual survey respondents (out of 4,916 total respondents) experienced health-care discrimination in forms such as refusal of health care, excessive precautions used by health-care professionals, and physically rough or abusive behavior by health-care professionals. Seventy percent of transgender and gender nonconforming respondents experienced the same, and sixty-three percent of respondents living with HIV/AIDS had experienced health-care discrimination. In addition, low-income LGBT people and LGBT people of color experienced increased barriers to health care. Approximately seventeen percent of low-income lesbian, gay, and bisexual respondents and twenty-eight percent of low-income transgender respondents reported harsh language from health-care providers compared to under eleven percent of LGB respondents and twenty-one percent of transgender respondents, overall.[14] The 2015 U.S. Transgender Survey found that 23 percent respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[15]

A recent survey conducted by the Center for American Progress found that among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:

- 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation;
- 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation;
- 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner;
- 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them;
- 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[16]

Among transgender people who had visited a doctor or health care providers' office in the past year:

- 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity;

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[14] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination against LGBT People and People with HIV*, 2010, https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isntcaring.pdf.

[15] NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[16] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

- 12 percent said a doctor or other health care provider refused to give them health care related to gender transition;
- 23 percent said a doctor or other health care provider intentionally used the wrong name;
- 21 percent said a doctor or other health care provider used harsh or abusive language when treating them;
- 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[17]

When LGBT patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In the CAP study, nearly one in five LGBT people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBT people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.[18] For these patients, being turned away by a medical provider is not just an inconvenience: it often means being denied care entirely with nowhere else to go.

Health-care disparities in general are often more pronounced in rural areas in the United States, and this is further compounded for LGBT individuals, often due to a lack of cultural competency. This hinders physical and mental health providers from meeting the health needs of rural communities.[19] The lack of connection to positive, affirming resources also isolates LGBT youth, making them more susceptible to self-destructive behavior patterns.[20] Isolation continues into adulthood, when LGBT populations are more likely to experience depression and engage in high-risk behaviors.[21]

NCLR has been holding convenings of LGBT people in rural communities for the past several years, and we hear consistently about difficulties in accessing adequate health care. The challenges our community faces in these rural settings include having few providers with LGBT competency, difficulty maintaining health insurance coverage due to employment challenges, transportation difficulties to get to what medical providers there are, food deserts, and specific health conditions that are often more prevalent among LGBT people because of having to live with discrimination and social isolation, including poor eating habits, smoking, and substance abuse.

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[17] *Id*.
[18] *Id*.
[19] Cathleen E. Willging, Melina Salvador, and Miria Kano, "Pragmatic Help Seeking: How Sexual and Gender Minority Groups Access Mental Health Care in a Rural State," *Psychiatric Services* 57, no. 6 (June 2006): 871–4, http://doi.org/10.1176/ps.2006.57.6.871.
[20] Colleen S. Poon and Elizabeth M. Saewyc, "Out Yonder: Sexual-Minority Adolescents in Rural Communities in British Columbia," *American Journal of Public Health* 99, no. 1 (January 2009): 118–24, http://doi.org/10.2105/AJPH.2007.122945.
[21] Trish Williams et al., "Peer Victimization, Social Support, and Psychosocial Adjustment of Sexual Minority Adolescents," *Journal of Youth and Adolescence* 34, no. 5 (October 2005): 471–82, https://doi.org/10.1007/s10964-005-7264-x.

In rural areas, if care is denied for religious reasons, there may be no other sources of health and life-preserving medical care.[22] The ability to refuse care to patients would therefore leave many individuals in rural communities with no health care options. Medically underserved areas already exist in every state,[23] with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[24] Many rural communities experience a wide array of mental health, dental health, and primary care health professional shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.[25]

In addition to geographic challenges, the problems for patients presented by the expansion of refusal provisions in both federal and state law have been exacerbated by the growth in health care systems owned and operated by religious orders. Mergers between Catholic and nonsectarian hospitals have continued as hospital consolidation has intensified. Catholic hospitals and health systems must follow the church's Ethical and Religious Directives for Catholic Health Care Services ("Directives"), which prohibit a wide range of reproductive health services, such as contraception, sterilization, abortion care, and other needed health care.[26] Nonsectarian hospitals must often agree to comply with these Directives in order to merge with Catholic hospitals.[27]

Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women's care was delayed or they were transferred to other facilities at great risk to their health.[28] The reach of this type of religious refusal of care is growing with the proliferation of religiously affiliated entities that provide health care and related services.[29] New research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than are white women to give birth in Catholic hospitals.[30]

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[22] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[23] Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA, (last visited Mar. 21, 2018).

[24] M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH (2010), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/.

[25] Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations*, ECON. RESEARCH SERV. (2009), *available at* https://www.ers.usda.gov/publications/pub-details/?pubid=44427.

[26] U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.

[27] Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 Yale L. J. 2470, 2488 (2015).

[28] Lori R. Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.

[29] *See, e.g.*, *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

[30] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

Refusals in the context of reproductive health care sometimes run in both directions – they prevent access to contraception and abortion, but also to assisted reproductive technologies (ART) to enable pregnancy. Not only does this infringe on individuals' right to information and care, for those with certain medical conditions it directly contravenes the standard of care. For individuals with cancer, for example, the standard of care includes education and informed consent around fertility preservation, according to the American Society for Clinical Oncology and the Oncology Nursing Society.[31] Refusals to educate patients about or to provide ART, or to facilitate ART when requested, are contrary to the standard of care.

While religiously-based objections to contraception and abortion are well known and have posed access barriers for years, less evident is how these types of refusals can also affect the LGBT community. Not only are LGBT people affected by denials of reproductive health care, other types of medically necessary care, such a transition-related care, are also frequently refused.

Many religious health care providers are opposed to infertility treatments altogether or are opposed to providing it to certain groups of people such as members of the LGBT community.[32] Health care providers have even sought exemptions from state antidiscrimination laws to avoid providing reproductive services to lesbian parents.[33] For example, in one case, an infertility practice group subjected a woman to a year of invasive and costly treatments only to ultimately deny her the infertility treatment that she needed because she is a lesbian.[34] When doctors at the practice group recognized that the woman needed in vitro fertilization to become pregnant, every doctor in the practice refused, claiming that their religious beliefs prevented them from performing the procedure for a lesbian.[35] Because this was the only clinic covered by her health insurance plan, the woman had to pay out-of-pocket for the treatment at another clinic, which subjected her to serious financial harm.

The lack of clarity in the Proposed Rule could lead a hospital or an individual provider to refuse to provide ART to same-sex couples based on religious belief. For some couples, this

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[31] Alison W. Loren et al., *Fertility Preservation for Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500-10 (July 1, 2013); Ethics Committee of the American Society for Reproductive Medicine, *Fertility preservation and reproduction in patients facing gonadotoxic therapies: a committee opinion*, 100 AM. SOC'Y REPROD. MED. 1224-31 (Nov. 2013), http://www.allianceforfertilitypreservation.org/_assets/pdf/ASRMGuidelines2014.pdf; Joanne Frankel Kelvin, *Fertility Preservation Before Cancer Treatment: Options, Strategies, and Resources*, 20 CLINICAL J. ONCOLOGY NURSING 44-51 (Feb. 2016).

[32] U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. (Directive 41 of the Ethical and Religious Directives for Catholic Health Care states: "Homologous artificial fertilization is prohibited when it separates procreation from the marital act in its unitive significance.")

[33] Douglas Nejaime et al., *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 Yale L.J. 2516, 2518 (2015). *See*, e.g., *N. Coast Women's Care Med. Grp., Inc. v. San Diego Cnty. Superior Court*, 189 P.3d 959 (Cal. 2008) (on the potential impact of healthcare refusal laws on same-sex couples).

[34] *Benitez v. N. Coast Women's Care Med. Grp., Inc.*, 106 Cal. App. 4th 978 (2003); *see also* LAMBDA LEGAL, BENITEZ V. NORTH COAST MEDICAL GROUP (Jul. 1, 2001), http://www.lambdalegal.org/in-court/cases/benitez-v-north-coast-womens-care-medical-group.

[35] *Id.*

discrimination would increase the cost and emotional toll of family building. In some parts of the country, however, these refusals would be a complete barrier to parenthood. More broadly, these refusals deny patients the human right and dignity to be able to decide to have children, and cause psychological harm to patients who are already vulnerable because of their health status or their experience of health disparities.

Religiously-based refusals can also result in the denial of other medically necessary care to LGBT people, particularly those who are transgender and in need of gender-affirming services. The following is one example that we learned about through a call to our Legal Help Line:

- Carl,[36] a transgender man, needed to undergo a hysterectomy and oophorectomy as part of his medically-supervised transition. Working with his healthcare providers, Carl obtained insurance coverage for the procedure. His surgeon, who had privileges at several hospitals in the area, scheduled the procedure at the hospital that was nearest to Carl and the surgeon. That hospital happened to be a religiously-affiliated facility. A few days before the procedure was scheduled to occur, Carl was informed that he could not have the procedure done at the hospital. According to the surgeon, the decision was made by the hospital's Ethics Committee. The reason Carl was given for the decision was that "the hospital does not perform that type of hysterectomy." Due to the short notice of the cancellation, the surgeon was unable to get the procedure moved to another hospital.

The foregoing barriers and challenges are evident in the stories we are hearing from NCLR supporters who are alarmed by the prospect of this Rule, including the following comments that have been submitted already to HHS:[37]

- I and many of my community members struggle to afford healthcare as it is, even with full time jobs. I live in a rural area and even if you do have health insurance, access to healthcare is very difficult. I do not see how my sexual orientation, religion, or other parts of me that one might disagree with at a personal level has anything to do with my right to receive healthcare. This regulation, whatever its intentions, will give those who are discriminatory the ability to act on this in a way that can harm the community and disproportionately provide support based on personal differences. I fear this will only further drive people apart.

- As a retired nurse educator I find this proposed rule unethical, immoral, unconscionable & inhumane. All health professionals essentially take an oath to treat & or take care of any person regardless of their race/religion/age/sexual orientation/ethnic background. And women have a right to choose their own reproduction health care. I strongly oppose this rule which promotes discrimination & urge HHS to withdraw it.

[36] This incident was reported to NCLR Legal Help Line attorneys; the name has been changed to protect the caller's privacy.
[37] Some have been edited slightly for length and clarity.

- If this rule is allowed to exist, it will allow emergency room staff to turn away people maimed by car accidents, mass shootings and terrorist attacks. Do you really want to be waiting for life saving care as you are interviewed (interrogated) to determine that you are the "right" sort of person who aligns with a hospital staff member's religious beliefs? You could easily die as you try to prove that you are "worthy" of their care.

- I happen to be a health care provider and I see LGBT people in my practice regularly. I understand the disadvantages they face every day as they go to work, to school, and even at home in their families and communities. Access to health care is a critical problem for many people, and HHS should not be making the problem worse by inviting health care institutions and providers to turn people away based on religious or moral reasons.

- I am a US citizen, I am also Romani Hindu. I am an intersex female and lesbian. I greatly oppose any rules or laws that would allow any person to establish their personal religious views as a means to hold others as a lesser person. This archaic way of thinking does not create a peaceful and free nation. I live in America that is said to be a free nation. Yet I am not free simply because of who I am. I have a difficult time finding the heath care I need because of discrimination. I am a senior citizen of America and have been denied medical care. Giving any person the right to discriminate for any purpose does great harm to an entire country.

- I am an LBGTX woman, married and the mother of two adult children. I travel frequently for work and have paid into my company's health insurance system for over 40 years. While I'm fairly confident that wouldn't be refused treatment locally, the thought that I might be refused treatment during an emergency while I'm traveling because I am a gay woman is both appalling and frightening.

- I am a 75 year-old lesbian living in San Francisco. As an R.N. and an LCSW, I have worked in the healthcare field for my entire adult life. The proposed rule entitled "Protecting Statutory Conscience Rights in Health Care" would give permission to mistreat or not treat an entire group of citizens. This is outrageous! This would be against any oath that a healthcare provider has taken to provide healthcare to all - without exception. An individual's personal opinions or biases have no place in the healthcare field. HHS should not promote discrimination of any kind. I am sure this proposed rule would prove to be unconstitutional if tested in our courts - and it surely would be. This proposed rule should be withdrawn immediately! It's shocking that it's even been suggested.

- In many small communities there is a limited number of health care providers. Allowing this kind of bigotry and prejudice could be life-threatening to any number of people. I know of no religion that preaches withholding life-saving care from anyone. The whole idea of government sponsored bigotry is outrageous and about as un-American as you can get.

- In the last year alone, I had to be taken by ambulance to Emergency Rooms in Northern and Southern California due to a heart issue. I also had to go to an Emergency Room in

Rochester, NY. I dare to think what might have happened to me if the health care providers refused service because my same sex spouse was with me and they "objected" to our relationship.

- I fear we will return to the days where we could be refused health care because of who we love. In 2008, I had to carry legal papers with me to the emergency room so that my partner, before marriage was legal, could be informed about my illness and be involved in making decisions. We were lucky to have a nurse who was also lesbian and while she was on duty I had excellent care. One of my care givers was not happy that I had a female partner and excused himself from the room to send in another therapist a few hours later. We cannot go back, lives are at stake.

- I have personally known people who have come within inches of death from complications due to HIV/AIDS because of the neglect of a doctor based on that doctor's personal beliefs. Discrimination and personal beliefs should not factor in to medical treatment, ever.

- In our community there is a shortage of health care providers to begin with, and if you reduce the number of providers that LGBT people can use, people will die.

- My children (one of whom is still a minor) are part of the LGBTQ community, and your rule would allow physicians to deny them lifesaving medical treatment, should they fall ill or have a medical emergency, such as a car accident or appendicitis, because they are gay or trans. They could die in the waiting area of the ER while someone who would be willing to treat them is located, and brought to the hospital, or in transit to a hospital where someone would treat them. It would allow doctors providing preventative care like pap smears to turn away my trans son, so that he wouldn't be able to find out if he had ovarian cancer until it was too late. Or to deny them vaccines for preventable diseases, or even just the flu. It would allow pharmacists to deny my children a prescription for antibiotics, because they feel morally or religiously opposed to their "lifestyle choices." It could have allowed one of my best friends to die from the heart attack he had a few years ago, because he's married to another man - because he was taken to a Catholic hospital by the ambulance crew. If it happened again, and your rule is in place, that hospital, one of the largest and most comprehensive in coverage in our area, could start turning people away en mass, for simply not being Catholic. In a predominantly Mormon state, that means about half the population.

The fear expressed throughout these comments is palpable. LGBT people are all too familiar with discrimination and hostile treatment, including in health care settings, and inviting health care institutions and providers to turn away people and deny them care would exacerbate the widespread mistreatment experienced by many LGBT people in the health care system today.

2. The Proposed Rule fits a troubling pattern at HHS

We are concerned that this overemphasis on the right to deny care rather than the right to receive it reflects a broader orientation on the part of the agency. In 2017, HHS adopted rules – with no prior public comment – vastly expanding existing religious exemptions from the

ACA's requirement of birth control coverage. This was followed by a Request for Information (RFI) regarding supposed barriers to participation in health care by religious entities, a puzzling choice given the proliferation of religiously affiliated health care systems in this country. The FY 2018 – 2022 HHS Strategic Plan also overemphasized accommodating religious beliefs and moral convictions of health care providers, while failing to mention key populations (like LGBT people) or include any measurable goals, as such a document is supposed to do. Taken together, these issuances from HHS signal an alarming approach to public health, one that elevates the personal religious beliefs of some health care providers far above patients' well-being.

C. The Proposed Rule fails completely to address its impact on patients

The Proposed Rule is silent with regard to the needs of patients and the impact that expanding religious refusals can have on their health. It includes no limitations to its sweeping exemptions that would protect patients' rights under the law and ensure that they receive medically necessary treatment. Any extension of religious accommodation should always be accompanied by equally extensive protections for patients to ensure that their medical needs remain paramount, and that they are able to receive both accurate information and quality health services.

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care.[38] The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions to bind the hands of providers and attempt to limit the types of care they can provide. This has profound implications for the core medical ethical precept of informed consent, and for the ability of health care providers to follow accepted standards of care for their patients.

1. Informed consent

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making. Informed consent relies on disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their medical treatment.[39] This right relies on two factors: access to relevant and medically-accurate information about treatment choices and alternatives, and provider guidance based on generally

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[38] *See, e.g.*, Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf; *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; Catherine Weiss, et al., *Religious Refusals and Reproductive* Rights, AM. CIVIL LIBERTIES UNION (2002), https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report;.

[39] TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).

accepted standards of practice. Both factors make trust between patients and health care professionals a critical component of quality care.

According to the American Medical Association: "The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."[40]The American Nursing Association similarly maintains that patient autonomy and self-determination are core ethical tenets of nursing. "Patients have the moral and legal right to determine what will be done with their own persons; to be given accurate, complete and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens and available options in their treatment."[41] Pharmacists are also expected to respect the autonomy and dignity of each patient.[42]

The Proposed Rule purports to improve communication between patients and providers,[43] but in reality it will have the opposite effect, deterring open, honest conversations that are vital to ensuring that a patient is able to be in control of their medical circumstances. Informed consent is intended to address the unequal balance of power between health providers and patients and ensure patient-centered decision-making. Moreover, consent is not a "yes or no" question but rather is dependent upon the patient's understanding of the procedure that is to be conducted and the full range of treatment options for a patient's medical condition. [44] Without informed consent, patients will be unable to make medical decisions that are grounded in agency, their beliefs and preferences, and that meet their personal needs. This is particularly problematic as many communities, including women of color and women living with disabilities, have disproportionately experienced abuse and trauma at the hands of providers and institutions.[45]

In order to ensure that patient decisions are based on free will, informed consent is essential to the patient-provider relationship. The Proposed Rule threatens this principle by inviting

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[40] *The AMA Code of Medical Ethics' Opinions on Informing Patients: Opinion 9.09 – Informed Consent*, 14 AM. MED. J. ETHICS 555-56 (2012), http://journalofethics.ama-assn.org/2012/07/coet1-1207.html.
[41] *Code of ethics for nurses with interpretive statements, Provision 1.4 The right to self-determination*, AM. NURSES ASS'N (2001), https://www.truthaboutnursing.org/research/codes/code_of_ethics_for_nurses_US.html.
[42] *Code of Ethics for Pharmacists*, AM. PHARMACISTS ASS'N (1994).
[43] 83 Fed. Reg. 3917.
[44] BEAUCHAMP & CHILDRESS, *supra* note 39; Robert Zussman, *Sociological perspectives on medical ethics and decision-making*, 23 ANN. REV. SOC. 171-89 (1997).
[45] Gutierrez, E. R. *Fertile Matters: The Politics of Mexican Origin Women's* Reproduction, 35-54 (2008) (discussing coercive sterilization of Mexican-origin women in Los Angeles); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 411-12 (2000) (referencing one 1974 study indicating that Indian Health Services would have coercively sterilized approximately 25,000 Native American Women by 1975); Alexandra Minna Stern, *Sterilized in the Name of Public Health*, 95 AM. J. PUB. H. 1128, 1134 (July 2005) (discussing African-American women forced to choose between sterilization and medical care or welfare benefits and Mexican women forcibly sterilized). *See also Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding state statute permitting compulsory sterilization of "feeble-minded" persons); Vanessa Volz, *A Matter of Choice: Women With Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 WOMEN RTS. L. REP. 203 (2006) (discussing sterilization reform statutes that permit sterilization with judicial authorization).

institutions and individual providers to withhold information about services to which they personally object, without regard for the patient's needs or wishes.

2. Standards of care

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are not only important services in their own right, they are also part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[46] Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them. It is alarming that a public health agency would actively encourage compromising patient health by facilitating departures from accepted standards of care.

A 2007 survey of physicians working at religiously-affiliated hospitals found that nearly one in five (19 percent) experienced a clinical conflict with the religiously-based policies of the hospital.[47] While some of these physicians might refer their patients to another provider who could provide the necessary care, another survey found that as many as one-third of patients (nearly 100 million people) may be receiving care from physicians who do not believe they have any obligations to refer their patients to other providers.[48] Meanwhile, the number of Catholic hospitals in the United States has increased by 22 percent since 2001, and they now control one in six hospital beds across the country.[49] The increase of Catholic hospitals poses a danger for women seeking reliable access to medical services, many of whom do not understand the full range of services that may be denied them. One public opinion survey found

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[46] For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant. AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE § 114-15, S117 (2017), available at http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf. The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics guidelines state that the risks to the woman from persistent severe pre-eclampsia are such that delivery (abortion) is usually suggested regardless of fetal age or potential for survival. AM. ACAD. OF PEDIATRICS & AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).

[47] Debra B. Stulberg M.D. M.A., et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, J. GEN. INTERN. MED. 725-30 (2010) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881970/.

[48] Farr A. Curlin M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, NEW ENG. J. MED. 593–600 (2007) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2867473/.

[49] Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, AM. CIVIL LIBERTIES UNION 22 (2017), *available at* https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

that, among the less than one-third of women who understood that a Catholic hospital might limit care, only 43 percent expected limited access to contraception, and a mere 6 percent expected limited access to the morning-after pill.[50]

As outlined below, there are significant questions regarding the authority of HHS to enforce the statutes cited in the Proposed Rule in the manner suggested. But even if the types of care denials this rule encourages are ultimately found to contravene federal law, we have grave concerns that the very promulgation of this Rule in its current form will encourage some health care providers and institutions to improperly restrict access to care for LGBT people, those seeking reproductive health care, and others, with harmful consequences. The ability to seek legal redress at a later date is cold comfort to a patient denied essential, even life-saving, care.

II. HHS has failed to establish its authority to issue the Proposed Rule

It is incumbent upon HHS to set forth with specificity the source of its purported authority to engage in this rulemaking, through which it seeks to reinterpret the scope of over two dozen federal statutes by, among other things, redefining key terms and adopting a wider array of enforcement tools. Absent such a detailed showing, the Proposed Rule should be withdrawn because, in addition to representing misguided and dangerous public health policy, it goes well beyond the authority of HHS and is therefore unlawful.

A. HHS has exceeded its rulemaking authority

The Proposed Rule exceeds HHS's authority under the various federal refusal statutes it references and seeks to enforce. An agency may not promulgate regulations that purport to have the force of law without delegated authority from Congress.[51] Yet none of the 25 statutory provisions cited by the Proposed Rule delegates authority to HHS to engage in rulemaking as contemplated in the Proposed Rule. Specifically, nothing within the 25 statutes cited by the Proposed Rule gives HHS the authority to require healthcare entities to provide assurances or certifications, to post the extensive notice included as Appendix A of the Proposed Rule, or to keep and make records available for review.[52] Nor does it give HHS the authority to conduct periodic compliance reviews or to subject healthcare entities to the full investigative process described in Section 88.7 of the Proposed Rule.[53]

The Department draws this purported authority not from the cited statutes but from its desire to implement a regulatory scheme "comparable to the regulatory schemes implementing other civil rights laws."[54] This desire arises from HHS's belief that the 25 cited statutes provide rights

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[50] Nadia Sawicki, *Mandating Disclosure Of Conscience-Based Limitations On Medical Practice*, 42 AM. J. OF LAW & MED. 85-128 (2016) *available at* http://journals.sagepub.com/doi/pdf/10.1177/0098858816644717.
[51] *Gonzales v. Oregon*, 546 U.S. 243, 274–75 (2006); *United States v. Mead*, 533 U.S. 218, 229–30 (2001); *Motion Picture Ass'n of Am., Inc. v. FCC*, 309 F.3d 796, 801 (D.C. Cir. 2002); *Amalgamated Transit Union v. Skinner*, 894 F.2d 1362, 1371 (D.C. Cir. 1990)*Pharm. Research & Mfrs. of Am. v. U.S. Dep't of Health & Human Servs.*, 43 F. Supp. 3d 28, 39–40 (D.D.C. 2014).
[52] *See* 83 Fed. Reg. at 3928–30.
[53] *Id.* at 3930–31.
[54] 83 Fed. Reg. 3904.

"akin to other civil rights to be free from discrimination on the basis of race, national origin, disability, etc."[55] Both the plain text and legislative history of these "other civil rights laws" distinguish them from the 25 statutes cited by the Proposed Rule, however. Each of the "other civil rights laws" cited by the Proposed Rule expressly authorizes HHS to promulgate regulations for their uniform implementation.

Title VI of the Civil Rights Act of 1964,[56] for example, which prohibits discrimination on the basis of race, color, or national origin in federal funding, states that "[e]ach Federal department and agency which is empowered to extend Federal financial assistance to any program or activity . . . is authorized and directed to effectuate the provisions of [Title VI] with respect to such program or activity by issuing rules, regulations, or orders of general applicability."[57] Title VI soon became the model for other nondiscrimination laws.[58]

Most recently, in Section 1557 of the Patient Protection and Affordable Care Act of 2009 (ACA), Congress clarified that the protections of Title VI, Title IX, the Age Discrimination Act, and Section 504 of the Rehabilitation Act of 1973 apply to all health programs or activities that receive federal financial assistance.[59] Congress explicitly granted HHS the authority to promulgate regulations to implement Section 1557.[60] Section 1553 of the ACA, which contains one of the refusal provisions cited by the Proposed Rule, does *not* contain such a grant.[61] Rather, Section 1553 gives HHS the authority to "receive complaints of discrimination" based on its provisions.[62] When Congress has explicitly granted an agency rulemaking authority in one section of a statute, the lack of such a grant in another section of the statute clearly indicates that Congress did not intend the agency to exercise rulemaking authority over that section.[63] The ACA conforms to the pattern Congress has followed for the past half-century: When it intends to grant HHS the kind of rulemaking authority claimed by the Proposed Rule, it does so expressly. The lack of such an explicit grant in any of the 25 cited statutes is

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[55] *Id.* at 3903.

[56] 42 U.S.C. 2000d *et seq*.

[57] Pub. L. No. 88-352, Title VI, § 602, 78 Stat. 252 (1964) (codified at 42 U.S.C. § 2000d-1).

[58] Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, both of which prohibit disability discrimination, explicitly refer to Title VI's enforcement provisions. *See* 29 U.S.C. § 794a(a)(2) (Section 504); 42 U.S.C. § 12133 (ADA). The Age Discrimination Act of 1975 not only permitted but required the Department to promulgate regulations to carry out its nondiscrimination provisions. 42 U.S.C. § 6103(a)(1). Title IX of the Education Amendments Act of 1972, which prohibits sex discrimination in education, contained delegation language that exactly mirrors that of Title VI. 20 U.S.C. § 1682.

[59] *See* Pub. L. 111-148, Title I, § 1557 (2010) (codified at 42 U.S.C. § 18116(a)). Congress did not include conscience protections in Section 1557, strongly implying that it does not see them as being "akin to," 83 Fed. Reg. at 3904, or "on an equal basis" with "other civil rights laws," *id*. at 3896. See *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 600 (2004) (noting that relationship with other federal statutes can be useful in statutory interpretation).

[60] 42 U.S.C. § 18116(c). The Department did so on May 18, 2016. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376 (May 18, 2016) (to be codified at 45 C.F.R. part 92). The final rule contains no mention of conscience protections.

[61] *See* 42 U.S.C. § 18113.

[62] *Id*.

[63] *See Amalgamated Transit Union*, 894 F.2d at 1371 ("[O]n the few occasions when Congress intended to give UMTA broad rulemaking authority . . . it did so expressly.").

therefore clear evidence that HHS does not have congressional authority to promulgate the Proposed Rule.

B. The Proposed Rule violates the Administrative Procedure Act

Even if HHS could promulgate a rule such as this based on its general authority to engage in rulemaking, that authority is not without limits. Under the Administrative Procedure Act (APA), "agency action, findings, and conclusions found to be… arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," "contrary to a constitutional right," or "in excess of statutory jurisdiction, authority, or limitations" shall be held unlawful and set aside.[64] An agency must provide "adequate reasons" for its rulemaking, in part by "examin[ing] the relevant data and articulat[ing] a satisfactory explanation for its action including a rational connection between the fact found and the choice made."[65] In addition, an agency can only change an existing policy if it provides a "reasoned explanation" for disregarding or overriding the basis for the prior policy.[66]

1. The Proposed Rule is arbitrary and capricious

In promulgating this Proposed Rule, HHS acted in an arbitrary and capricious manner in violation of the APA, and as a result the rule should be withdrawn in its entirety. The Proposed Rule is arbitrary and capricious on a number of grounds.

HHS fails to provide "adequate reasons" or a "satisfactory explanation" for this rulemaking based on the underlying facts and data. As stated in the Proposed Rule itself, between 2008 and November 2016, the Office of Civil Rights received ten complaints alleging violations of federal religious refusal laws; OCR received an additional 34 such complaints between November 2016 and January 2018. By comparison, during a similar time period from fall 2016 to fall 2017, OCR received *over 30,000 complaints* alleging either civil rights or HIPAA violations. These numbers demonstrate that rulemaking to enhance enforcement authority over religious refusal laws is not warranted.

HHS also fails to adequately assess the costs imposed by this Proposed Rule, both by underestimating quantifiable costs, and by neglecting to address the costs that would result from delayed or denied care. Under Executive Order 12866, when engaging in rulemaking, "each agency shall assess both the costs and the benefits of the intended regulation and, recognizing that some costs and benefits are difficult to quantify, propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify the costs."[67] Under Executive Order 13563, an agency must "tailor its regulations to impose the least burden on society" and choose "approaches that maximize net benefits (including

[64] 5 U.S.C. § 706(2)(A), (B), (C).
[65] *Encino Motorcars, LLC v. Navarro*, 136 S.Ct. 2117, 2125 (June 20, 2016) (citing *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 103 (1983)).
[66] *Id*. at 2125-26.
[67] Executive Order 12866 on Regulatory Planning and Review (September 30, 1993).

potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity)."[68]

HHS has failed to take the appropriate steps to ensure that the Proposed Rule is consistent with applicable law and does not conflict with the policies or actions of other agencies. Under Executive Order 12866, in order to ensure that agencies does not promulgate regulations that are "inconsistent, incompatible, or duplicative with its other regulations of those of other Federal agencies," each agency must include any significant regulatory actions in the Unified Regulatory Agenda.[69] HHS failed to include any reference to this significant regulation in its regulatory plans, and therefore failed to put impacted entities, including other federal agencies, on notice of possible rulemaking in this area. In addition, prior to publication in the Federal Register, the Proposed Rule must be submitted to the Office of Information and Regulatory Affairs (OIRA), within the Office of Management and Budget (OMB), to provide "meaningful guidance and oversight so that each agency's regulatory actions are consistent with applicable law, the President's priorities, and the principles set forth in this Executive order [12866] and do not conflict with the policies or actions of another agency."[70] According to OIRA's website, HHS submitted the Proposed Rule to OIRA for review on January 12, 2018, one week prior to the Proposed Rule being published in the Federal Register. Standard review time for OIRA is often between 45 and 90 days; one week was plainly insufficient time for OIRA to review the rule, including evaluating the paperwork burdens associated with implementing it. In addition, it is extremely unlikely that within that one week timeframe, OIRA could or would have conducted the interagency review necessary to ensure that this Proposed Rule does not conflict with other federal statutes or regulations.

The timing of the Proposed Rule also illustrates a lack of sufficient consideration. The Proposed Rule was published just two months after the close of a public comment period for a Request for Information closely related to this Rule.[71] The 12,000-plus public comments were not all posted until mid-December, one month before this Proposed Rule was released. Nearly all of the comments submitted at that time related to the subjects covered by the Proposed Rule—namely, the refusal of care by federally funded health care institutions or their employees on the basis of personal beliefs. This short period of time calls into question the comprehensiveness of the review of the Request for Information and whether the Proposed Rule was developed in an arbitrary and capricious manner.

The Proposed Rule also conflicts with several key federal statutes, as well as the U.S. Constitution. It makes no mention of Title VII,[72] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[73] With respect to religion, Title VII requires reasonable accommodation of

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[68] Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Sec. 1 (b).
[69] Executive Order 12866, at Sec. 4(b),(c).
[70] *Id*. at Sec. 6(b).
[71] "Removing Barriers for Religious and Faith-Based Organizations To Participate in HHS Programs and Receive Public Funding," 82 Fed. Reg. 49300 (Oct. 25, 2017).
[72] 42 U.S.C. § 2000e-2 (1964).
[73] *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[74] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The Proposed Rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both. Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[75]

Furthermore, the language in the Proposed Rule could put health care entities in the untenable position of being forced to hire people who intend to refuse to perform essential elements of the job for which they are being hired. For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling. It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

The Proposed Rule also conflicts with the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[76] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[77] Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances – such as those experiencing an ectopic pregnancy or miscarriage - not receiving necessary care. The Proposed Rule fails to explain how entities will be able to comply with the new regulatory requirements in a manner consistent with the statutory requirements of EMTALA, making the Proposed Rule unworkable.

Finally, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant

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[74] *See id.*

[75] Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.

[76] *See* 42 U.S.C. s 1295dd(a)-(c)

[77] *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); In In re Baby K, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, 93 Fair Empl. Prac. Cas. (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).

religious exemptions to existing legal requirements and, in fact, bars granting an exemption when it would detrimentally affect any third party.[78] It requires an agency to "take adequate account of the burdens" that an exemption "may impose on nonbeneficiaries" and must ensure that any exemption is "measured so that it does not override other significant interests."[79] The proposed exemptions clearly impose burdens on and harm others and thus, violate the clear mandate of the Establishment Clause.

In promulgating a regulation that is inconsistent with federal statutes and regulations, as well as the Constitution, HHS engaged in arbitrary and capricious rulemaking, and its conduct was further compounded by a failure by OIRA to engage in appropriate oversight and review. For these reasons, the Proposed Rule should be withdrawn.

2. The Proposed Rule is not in accordance with law and exceeds statutory authority

The Proposed Rule is also not in accordance with law because much of its language exceeds the plain parameters and intent of the underlying statutes it purports to enforce. It defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. Therefore, the Proposed Rule violates the APA and should be withdrawn.

For example, the Church Amendments prohibit federal funding recipients from discriminating against those who refuse to perform, or "assist in the performance" of, sterilizations or abortions on the basis of religious or moral objections, as well as those who choose to provide abortion or sterilization.[80] The statute does not contain a definition for the phrase "assist in the performance." Instead the Proposed Rule creates a definition, but one that is not in accordance with the Church Amendments themselves. The proposed definition includes participation "in any activity with an *articulable connection* to a procedure, health service or health service program, or research activity" and greatly expands the types of services that can be refused to include merely "making arrangements for the procedure" no matter how tangential.[81] This means individuals not "assisting in the performance" of a procedure within the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, could now assert a new right to refuse. As Senator Church stated from the floor of the Senate during debate on the Church Amendments: "The amendment is meant to give protection to the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions. There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal

[78] U.S. Const. amend. I; *Cutter v. Wilkinson*. 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 18 n.8 (1989); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[79] *Cutter*, 544 U.S. at 720, 722; see also *Thornton*, 472 U.S. at 709-10.
[80] 42 USC 300a-7.
[81] 83 Fed. Reg. 3892.

to perform what would otherwise be a legal operation."[82] This overly broad definition opens the door for religious and moral refusals from precisely the type of individuals that the amendment's sponsor himself sought to exclude. This arbitrary and capricious broadening of the amendment's scope goes far beyond what was envisioned when the Church Amendments were enacted.

If workers in very tangential positions, such as schedulers, are able to refuse to do their jobs based on personal beliefs, the ability of any health system or entity to plan, to properly staff, and to deliver quality care will be undermined. Employers and medical staff may be stymied in their ability to establish protocols, policies and procedures under these vague and broad definitions. The Proposed Rule creates the potential for a wide range of workers to interfere with and interrupt the delivery of health care in accordance with applicable standards of care.

The definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information based on which an individual could get the care they need.[83] Any information distributed by any method, including online or print, regarding any service, procedure, or activity could be refused by an individual or entity if the information given would lead to a service, activity, or procedure to which the provider objects.

Under the Coats and Weldon Amendments, "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.[84] The Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term.[85] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but contravenes congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms HHS now attempts to insert.[86]

The Proposed Rule defines workforce to include "volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity."[87] Under this definition, virtually any member of the health care workforce could ostensibly refuse to serve a patient in any way.

The Weldon Amendment is expanded under the Proposed Rule by defining "discrimination" against a health care entity broadly to include a number of activities, including denying a grant

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[82] S9597, https://www.gpo.gov/fdsys/pkg/GPO-CRECB-1973-pt8/pdf/GPO-CRECB-1973-pt8.pdf (emphasis added). Senator Church went on to reiterate that "[t]his amendment makes it clear that Congress does not intend to compel the courts to construe the law as coercing religious affiliated hospitals, doctors, or nurses to perform surgical procedures against which they may have religious or moral objection." S9601 (emphasis added).
[83] 83 Fed. Reg. 3895.
[84] The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018).
[85] 83 Fed. Reg. 3893.
[86] The doctrine of expressio unius est exclusio alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[87] 83 Fed. Reg. 3894.

or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[88] Such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion and undermining non-discrimination laws. Because of the potential harm to individuals if religious refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.[89] Instead, courts have held that the government has a compelling interest in ending discrimination and that anti-discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race," and are narrowly tailored to meet that "critical goal."[90] In seeking to craft a regulatory scheme mirroring "other civil rights laws," HHS is in fact hampering enforcement of the very civil rights laws it claims to be emulating.

Moreover, the Proposed Rule states that the exemptions that Weldon provides is not limited to refusals of abortion care on the basis of religious or moral beliefs – the denial may be for any reason at all.[91] The preamble uses language such as "those who choose not to provide" or "would rather not" as justification for a refusal. This unbounded license to deny care is made more dangerous by the fact that the Proposed Rule contains no mechanism to ensure that patients receive the care they need if their provider refuses to furnish a service. The onus will be on the patient to question whether her hospital, medical doctor, or health care professional has religious, moral, or other beliefs that would lead them to deny services, or if services were denied, the basis for refusal. The Proposed Rule does not have any provisions that stipulate that patients must be given notice that they may be refused certain health care services on the basis of religious or moral beliefs.

The Proposed Rule also purports to equip OCR with a range of enforcement tools that it in fact lacks the authority to employ, including referring matters to the Department of Justice "for additional enforcement,"[92] something not contemplated within any of the statutes referenced in the Proposed Rule. These measures, combined with the impermissibly broad definitions and other inappropriately expansive interpretations of the underlying statutes, would have a chilling effect on the provision of a range of medically necessary health care services.

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[88] 83 Fed. Reg. 3892.

[89] *See, e.g., Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government's interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that "the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family"); *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

[90] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, slip op. at 46 (2014).

[91] 83 Fed. Reg. 3890-91.

[92] 83 Fed. Reg. 3898.

Conclusion

The Proposed Rule departs from the core mission of HHS, would undermine patient care, and is contrary to law. We therefore urge that it be withdrawn.

If you have any questions regarding these comments, please contact Julianna S. Gonen, PhD, JD, NCLR Policy Director, at jgonen@nclrights.org or 202-734-3547.

National Center for Lesbian Rights

EXHIBIT R

ADL
Anti-Defamation League®

BY E-MAIL

March 26, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, D.C. 20201

Re: Docket HHS-OCR-2018-0002

On behalf of the Anti-Defamation League, we are writing to offer our comments on the proposed 45 CFR Part 88, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," as outlined at 83FR 3880 ("Proposed Rule" or "Part 88").

For more than a century, the Anti-Defamation League (ADL) has been an active advocate for religious freedom for all Americans – whether in the majority or minority. Among ADL's core beliefs is strict adherence to the separation of church and state effectuated through both the Establishment Clause and the Free Exercise Clause of the First Amendment. We believe a high wall of separation between government and religion is essential to the continued flourishing of religious practice and belief in America, and to the protection of all religions and their adherents.

ADL believes that true religious freedom is best achieved when all individuals are able to practice their faith or choose not to observe any faith; when government neutrally accommodates religion, but does not favor any particular religion; and when religious belief is not used to harm or infringe on the rights of others by government action or others in the public marketplace.

The "play in the joints" between the Establishment Clause and Free Exercise Clause allows and, in many instances, mandates government to accommodate the religious beliefs and observances of citizens. Religious accommodation, however, has its limitations. The United States government should not sanction discrimination or harm in the name of religion. The right to individual religious belief and practice is fundamental. But there should be no license to discriminate or to do harm with government authority.

As noted in the background for this Proposed Rule, healthcare providers – whether individuals or entities – already have robust statutory religious or moral exemptions from performing abortions or sterilization procedures, or complying with advanced directives, and in certain international programs, they have even broader exemptions ("Statutory Exemptions").[1] Provided that the health and safety of patients are safeguarded, such

[1] *See* The Church Amendments, 42 U.S.C. 300a-7; The Coats-Snowe Amendment, 42 U.S.C. 238n; Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. H, Tit. V, sec. 507(d) (the Weldon Amendment) and at Div. H, Tit. II, sec. 209; Patient Protection and Affordable Care Act related to assisted suicide 42 U.S.C. 18113; 42 U.S.C. 1395cc(f), 1396a(w)(3), and 14406; 22 U.S.C. 7631(d); Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. J, Tit. VII, sec. 7018 (Helms Amendment).

accommodations are appropriate for doctors, nurses, and others, who actually may be called on to perform these medical procedures or services.

The Proposed Rule, however, crosses the line from providing appropriate accommodations to allowing individuals or entities with incidental or tangential relationships to such procedures or services to detrimentally impose their religious or moral beliefs on patients and other third parties. It does so in two ways. First, Part 88 provides excessively broad and vague definitions of persons, entities, and activities covered by Statutory Exemptions. Second, it includes an excessively broad interpretation of Statutory Exemptions the enforcement of which is delegated to the Office of Civil Rights ("OCR").

As a result, Part 88 would impede access to federally-supported healthcare and in particular have a disparate impact on women, LGBTQ people and religious minorities. It thereby would undermine the mission of OCR, which is to "... enforce laws against discrimination based on race, color, national origin, disability, age, sex, and religion by certain health care and human services." Moreover, the Proposed Rule and the accompanying creation of a new OCR division to implement it convey the distinct message that enforcement of civil rights protections for such groups is secondary.

The Proposed Rule Provides Excessively Broad Definitions of Persons and Entities Covered by Statutory Exemptions

The "Descriptions of the Proposed Rule" ("Rule Descriptions") advise that the term "Entity" means a person or any legal entity whether private or public, and the definition of "Health Care Entity" is not definitive. Rather, it includes examples of covered persons or entities such as "...an individual physician or other health care professional, health care personnel, ... a hospital, a laboratory, an entity engaging in biomedical or behavioral research, ... a or health insurance plan ... , or any other kind of health care organization." However, these examples are "... an illustrative, not an exhaustive list." Additionally, while Part 88 contains a definition of "Health Program or Activity," which will be discussed, *infra*, it does not appear to contain a definition of "health care."

With respect to employees of or other persons associated with Entities or Health Care Entities, the Rule Descriptions provide the following definitions for the terms "Workforce" and "Individual." Workforce means:

> *employees, volunteers, trainees, contractors, and other persons whose conduct in the performance of work for an entity or health care entity is under the direct control of such entity or health care entity, whether or not they are paid by the entity or health care entity, as well as health care providers holding privileges with the entity or health care entity.*

The term "Individual" means "a member of the workforce of an entity or health care entity," including "... volunteers, trainees, or other members or agents of a covered entity, broadly defined, when the conduct of the person is under the control of such entity" (emphasis added).

The Statutory Exemptions are intended to cover persons, who actually may be called on to perform medical procedures. Yet, based on these definitions, virtually any person, including volunteers, who work, for example, at a federally-funded or supported hospital, pharmacy, medical or nursing school, nursing home, or "any other kind of health care organization" would be covered by Statutory Exemptions. Simply put, any person performing work for such a facility

– whether paid or unpaid – would be encompassed by the Proposed Rule irrespective of their non-medical job description or role. That unnecessarily-inclusive definition would compromise and harm the rights of third parties.

The Proposed Rule Provides Excessively Broad Definitions of Activities Covered by Statutory Exemptions

The Rule Descriptions advise that term "Healthcare Program or Activity … include the provision or administration of any health-related services, health service programs and research activities, health-related insurance coverage, health studies, or any other service related to health or wellness whether directly, through payments, grants, contracts, or other instruments, through insurance, or otherwise" (emphasis added). Part 88 does not define the meaning of "health-related services" or "service related to health or wellness."

These terms must be read in conjunction with two other definitions: "Assist in the Performance" and "Referral or Refer for." The Rule Descriptions advise that the Department of Health and Human Services ("HHS") intends Assist in the Performance to "… to provide broad protection for individuals, consistent with the plain meaning of the statutes …" because "[t]he Department believes that a more narrow definition of the statutory term 'assist in the performance,' such as a definition restricted to those activities that constitute direct involvement with a procedure, health service, or research activity, would fall short of implementing the protections Congress provided (emphasis added). To this end, the term applies "… to activities with an articulable connection to the procedure, health service, health service program, or research activity in question."

Furthermore, "Referral or Refer for" includes

> *… the provision of any information (including but not limited to name, address, phone number, email, or website) by any method (including but not limited to notices, books, disclaimers, or pamphlets online or in print) pertaining to a service, activity, or procedure, including related to availability, location, training, information resources, private or public funding or financing, or direction that could provide any assistance in a person obtaining, assisting, training in, funding, financing, or performing a particular health care service, activity, or procedure, when the entity or health care entity making the referral sincerely understands that particular health care service, activity, or procedure to be a purpose or possible outcome of the referral.*

Based on these definitions a person who performs work for a federally-supported healthcare facility could refuse, without penalty, to perform their responsibilities for any service related to health or wellness that has an indirect or possible articulable connection to a statutorily-covered procedure, including providing any information about or how to obtain a procedure.

Application of the Proposed Rule's Definitions to 45 CFR Part 88's Interpretation of Statutory Exemptions Will Impede Access to Healthcare

The Proposed Rule's definitions operating in conjunction with its interpretation of substantive Statutory Exemptions could impede access to or deny federally-funded or supported healthcare. And the harm caused by enforcement of the Proposed Rule would disparately impact women, LGBT people, and religious minorities.

For example, with respect to federally supported healthcare within the United States, here are some examples of the harms that could result:

- An administrator at the only healthcare provider in a rural area could refuse to perform intake or process paperwork for a woman who must terminate her pregnancy due to an ectopic pregnancy or who is getting a tubal ligation. Similarly, the administrator could refuse to do the same for a transgender person, who is undergoing gender reassignment surgery because the surgery requires a hysterectomy. At the same provider, the only administrator or receptionist on shift could refuse to provide a referral to or any information about a health clinic that provides abortions.
- An administrator at a healthcare provider, even one that does not provide abortions or sterilization procedures, could refuse to disclose the provider's policy on these procedures based on the sincerely-held belief that the person seeking the information will either obtain the procedure at the contacted provider or at an alternative provider, which offers these procedures.
- A lab technician could refuse to perform any tests for a patient who will undergo an abortion, sterilization procedure, hysterectomy, or gender reassignment surgery.
- A hospital maintenance worker or contractor directed by the healthcare provider could refuse to perform any upkeep or construction work on an operating room or other facility that is used for abortions, sterilization procedures or hysterectomies.
- A hospital orderly could refuse to provide wheelchair service to a patient who is getting a hysterectomy or gender reassignment surgery.
- An administrator or employee of an insurance company that provides federally funded Medicare or Medicaid insurance policies could refuse to disclose to a prospective purchaser of insurance whether policies cover sterilization, gender reassignment surgery or services related to advance directives.
- At a federally supported medical school, an administrator could refuse to register students based on the sincerely-held belief that they will obtain medical training on abortion, sterilization, gender reassignment surgery, or advance directives, and will perform or assist with such procedures or services during or after their training. Or an employee of such a school's bookstore could refuse to sell medical books to students that provide information on abortion, sterilization or advance directives based on the sincerely-held belief that providing these books will train students to prospectively perform such procedures or services.

In the international arena, Part 88 could have an even wider detrimental impact. Pursuant to the Proposed Rule "[a]ny entity" that receives federal financial assistance for HIV/AIDS prevention, treatment or care under section 104A of the Foreign Assistance Act of 1961 shall not "endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the applicant has a religious or moral objection, as a condition of assistance" (emphasis added).

Thus, with respect to programs funded under section 104A, a health care organization, doctor, nurse or administrator, for example, could not be penalized for refusing, based on religious or moral objection, to treat or offer services to LGBT people, Muslims or other religious minorities, or sex workers.

The Proposed Rule Raises Significant Constitutional Issues

The U.S. Supreme Court "'has long recognized that government may (and sometimes must) accommodate religious practices.'" *See Corp. of Presiding Bishop v. Amos*, 483 U.S. 327, 334. (1987) (citations omitted). However, it cautioned that "[a]t some point, accommodation may devolve into "an unlawful fostering of religion.'" *Id* at 334-35.

Indeed, religious accommodations that unduly burden third parties violate the Establishment Clause. *See Sherbert v. Verner*, 374 U.S. 398 (1963); see also *Estate of Thornton* v. *Caldor*, 472 U.S. 703, 710 (1985). More recently, the Court has found that for statutory exemptions under the Religious Land Use and Institutionalized Persons Act, 42 U.S.C. § 2000cc et seq., to comport with the Establishment Clause, reviewing courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries." *See Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005).

Furthermore, in *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014), every member of the Court authored or joined an opinion recognizing that detrimental effects on nonbeneficiaries must be considered when evaluating requests for accommodations under the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb et seq. *See Hobby Lobby*, 134 S. Ct. at 2760 ("Nor do we hold * * * that * * * corporations have free rein to take steps that impose 'disadvantages . . . on others' or that require 'the general public to pick up the tab.'" (brackets omitted)); *id.* at 2781 n.37 ("It is certainly true that in applying RFRA 'courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries.'"); *id.* at 2787 (Kennedy, J., concurring) (religious exercise must not "unduly restrict other persons * * * in protecting their own interests"); *id.* at 2790 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ., dissenting) ("Accommodations to religious beliefs or observances * * * must not significantly impinge on the interests of third parties."); *see also Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., joined by Sotomayor, J., concurring) (Court's recognition of right to accommodation under RLUIPA was constitutionally permissible because "accommodating petitioner's religious belief in this case would not detrimentally affect others who do not share petitioner's belief").

The Proposed Rule goes well beyond a religious accommodation that safeguards the health and safety of patients while exempting doctors, nurses, and medical professionals, who actually may be called on to perform abortions, sterilization, or other medical procedures, or to comply with advance directives. Rather, as detailed above, Part 88 broadly allows a wide swath of non-medical personnel far removed from these procedures or services to detrimentally impose their particular religious beliefs about them on innocent third parties. The Proposed Rule therefore raises serious constitutional issues because the broad exemptions provide a license to discriminate and would unduly burden – or, in some instances – deny patient access to federally-supported healthcare services.

We urge you to recall the Proposed Rule for modifications in light of these serious policy and constitutional arguments.

Sincerely,

Jonathan A. Greenblatt
CEO

David L. Barkey
Southeastern & National
Religious Freedom Counsel

Michael Lieberman
Washington Counsel

EXHIBIT S

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

March 27, 2018

Submitted electronically via regulations.gov

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

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority Notice of Proposed Rule Making (RIN 0945-ZA03; Docket No. HHS-OCR-2018-0002)

Justice in Aging appreciates the opportunity to respond to the Department of Health and Human Services (HHS) Notice of Proposed Rule Making entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." For the reasons below, we strongly urge HHS not to finalize the proposed rule. This submission supplements the comments of the Leadership Conference on Civil and Human Rights, which we also support.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Ensuring that all consumers are protected from discrimination in health care is integral to the mission of the HHS Office for Civil Rights (OCR). This mission cannot be carried out without also ensuring that providers, whatever their religious beliefs or moral convictions, adhere to nondiscrimination laws and the medical and health-related standard of care. The proposed rule would greatly expand current "conscience" protections and religious refusals, and we are deeply concerned that it would allow employees in health care settings to discriminate against and deny care to older adults and people with disabilities. Existing law already provides ample protection for health care providers to refuse to participate in a health care service to which they have religious or moral objections. As proposed, the rule will harm consumers by increasing barriers to care, allowing health care professionals to ignore established medical guidelines, and undermining open communication between providers and patients.

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

I. The proposed rule's expansion of conscience protections and religious refusals could seriously compromise the health, autonomy, and well-being of older adults and people with disabilities.

The extremely broad language proposed in the rule would allow any individual or entity with an "articulable connection" to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a moral or religious objection. The rule's definitions could both undermine nondiscrimination laws that are meant to protect consumers and even foster health care settings and interactions between patients and providers that are informed by bias instead of medically accurate, evidence-based, person-centered care. This would seriously jeopardize the health, autonomy, and well-being of older adults and people with disabilities.

We are concerned that the rule's proposed definitions and applicability, which HHS repeatedly states are meant to be "broadly defined" and "illustrative, not exhaustive," could allow any member of the health care workforce to refuse to serve a patient in any way. Under the proposed rule's definitions, any individual who is a member of an entity's workforce could refuse to assist in the performance of any services or activities that have any "articulable connection"[1] to a procedure they object to. This includes "volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity."[2] Also, the definition of "referral"[3] would allow an entity to refuse to provide any information distributed by any method, including online or print, regarding any service, procedure, or activity if that information would lead to a service, activity, or procedure that the entity objects to.

The proposed rule does not articulate a definition of moral beliefs. This opens the door to a provider's own prejudices serving as the basis of denying services or care based on an individual's characteristics. For example, could a nurse assistant refuse to serve lunch to a transgender patient? Could office staff refuse to schedule an appointment for a person whom they believe to be from another country or who does not speak English well?

II. The expansion of religious refusals under the proposed rule is contrary to the mission of HHS and OCR and would disproportionately harm communities that already lack access to care

HHS OCR has worked for decades to ensure that the health programs and activities it regulated comply with vital nondiscrimination laws, including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act (ACA). HHS has enforced these laws by ending overtly discriminatory practices such as race segregation and segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for gender transition related services, and insurance benefit designs that

[1] 83 Fed. Reg. 3880, 3892 (Jan 26, 2018).
[2] *Id.* at 3894 (Jan 26, 2018).
[3] *Id.*

discriminate against people who are HIV positive. OCR has also sought to ensure compliance with civil rights statutes by requiring covered entities to provide auxiliary aids and services to ensure effective communication for individuals with disabilities and taking steps to ensure that individuals with limited English proficiency have meaningful access to health facilities, such as providing interpreters free of charge. These actions have gone a long way towards combating discrimination and disparities in health care.

Nevertheless, further work is needed to address discrimination and reduce these disparities. Older adults are no exception to the stark health disparities that persist across race, national origin, gender, sexual orientation, and poverty lines. For example, a larger share of Black and Hispanic Medicare beneficiaries report fair or poor health status than white beneficiaries.[4] Similarly, Black and Hispanic adults age 65 and older are almost twice as likely as white older adults to develop diabetes.[5] Older adults who are limited English proficient (LEP), including over four million Medicare beneficiaries,[6] face difficulties finding providers, especially for in-home supports and services, who speak their preferred language and often are forced to rely on family members to interpret for them. Lesbian, gay and bisexual older adults face higher rates of disability and mental health challenges; older bisexual and gay men face higher rates of physical health challenges; bisexual and lesbian older women have higher obesity rates and higher rates of cardiovascular disease; and transgender older adults face greater risk of suicidal ideation, disability, and depression compared to their peers.[7] HIV disproportionately impacts the LGBTQ community, and it is affecting an increasing number of older adults.[8]

However, the expansion of religious refusals under the proposed rule would only make these disparities worse by disproportionately harming communities that already face barriers to care: women, people of color, people living with disabilities, people with limited English proficiency, and Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) individuals, as well as people living in rural communities. The harmful effects would be compounded for individuals who hold multiple disadvantaged identities. For example, an older adult who is gay might also have limited English proficiency, or a physical or mental disability, and may not have a choice of providers and therefore nowhere to go if they are refused care in the rural community where they live.

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[4] Kaiser Family Foundation, *Profile of Medicare Beneficiaries by Race and Ethnicity*, (March 9, 2016), *available at* http://kff.org/medicare/report/profile-of-medicare-beneficiaries-by-race-and-ethnicity-a-chartpack/.

[5] Centers for Disease Control and Prevention, *The State of Aging and Health in America*, (2013) at Figure 2, *available at* www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf

[6] CMS Office of Minority Health, Understanding Communications and Language Needs of Medicare Beneficiaries, at 8 (April 2017), *available at* www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf

[7] Fredriksen-Goldsen et al., *The Aging And Health Report: Disparities And Resilience Among Lesbian, Gay, Bisexual, And Transgender Older Adults* (Nov. 2011), *available at* www.lgbtagingcenter.org/resources/resource.cfm?r=419

[8] *See* Ctrs. for Disease Control & Prevention, HIV in the United States: At a Glance (June 2017), available at www.cdc.gov/hiv/statistics/overview/ataglance.html; Ctrs. for Disease Control & Prevention, HIV and Transgender Communities (2016), www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf.

A. The proposed rule would harm LGBTQ older adults who continue to face widespread discrimination and health disparities.

We are particularly concerned that the proposed rule would exacerbate the barriers to care that LGBTQ older adults face and the effects of ongoing and pervasive discrimination by potentially allowing providers to refuse to provide services and information vital to LGBTQ health. In addition to experiencing the health disparities described above, LGBT elders are more likely to be single, childless, estranged from their biological family, and reliant on families of choice, such as friends and other loved ones. Because they do not have traditional support systems in place, many LGBT elders rely on nursing homes or other long-term care facilities to receive needed services.[9] Results of a recent survey by AARP show that at least a third of LGBT adults are worried about having to hide their LGBT identity in order to have access to housing options that are suitable for older adults.[10] Over half of LGBT adults fear discrimination in health care as they age and are especially concerned about neglect, abuse, and verbal or physical harassment in long-term care facilities.[11] These concerns are even greater among Black and Latino LGBT adults and individuals who identify as non-binary.[12]

Unfortunately, these fears are a reality for many LGBT older adults. In a survey of LGBT seniors reported in our publication, *Stories from the Field*, we found numerous cases where LGBT older adults experienced discrimination in long-term care facilities ranging from verbal and physical harassment, to visiting restrictions and isolation, to being denied basic care such as a shower or being discharged or refused admission.[13] In addition to being denied care or provided inadequate care, LGBT older adults and their loved ones may be afraid to seek care because they are not treated with dignity and respect. Several LGBT older adults reported being "prayed over" without their consent or being told they would go to hell—violating their right to practice their own beliefs.[14] These discriminatory actions by facility staff could be protected under this ill-advised rule.

As proposed, the rule could allow individuals and facilities to not only refuse to provide treatment for LGBTQ individuals, but to also deny doctors and other professionals the ability to provide that treatment in their facilities. Such refusals implicate standards of care that are vital to LGBTQ health. Medical professionals are expected to provide LGBTQ individuals with the same quality of care as they would anyone else. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and

[9] SAGE (Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders) and Movement Advancement Project, *Improving the Lives of LGBT Older Adults,* (March 2010), *available at* www.sageusa.org, www.lgbtmap.org.
[10] Houghton, Angela, AARP, *Maintaining Dignity: Understanding and Responding to the Challenges Facing Older LGBT Americans.* (Mar. 2018), *available at* https://doi.org/10.26419/res.00217.001.
[11] *Id.*
[12] *Id.*
[13] Justice in Aging et al., *LGBT Older Adults In Long-Term Care Facilities: Stories from the Field* (updated June 2015), *available at* www.justiceinaging.org.customers.tigertech.net/wp-content/uploads/2015/06/Stories-from-the-Field.pdf
[14] *Id*. at 11.

competency with LGBTQ issues as they pertain to any health services provided.[15] The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.[16] The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.[17] The proposed rule would interfere with the ability of providers to meet these standards since they would not be able to rely on the consistent support of the facilities and care teams where they practice.

B. The proposed rule will harm older adults and people living with disabilities who rely on long-term services and supports.

Many older adults and people with disabilities receive long-term services and supports, including home and community-based services (HCBS), from religiously-affiliated providers. However, some people who rely on these services have faced discrimination, exclusion, and a loss of autonomy due to provider objections to providing specified care. For example, individuals with HIV–a recognized disability under the ADA–have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. One man with HIV was refused care by six nursing facilities before his family was finally forced to relocate him to a facility 80 miles away.[18]

Older adults and people with disabilities often live or spend much of their day in provider-controlled settings where they receive supports and services. They may rely on a case manager to coordinate necessary services, a transportation provider to get them to community appointments, or a personal care attendant to help them take medications and manage their daily activities. Under this broad new proposed language, any of these providers could believe they are entitled to object to providing a service covered under the regulation and not even tell the individual where they could obtain that service, how to find an alternative provider, or even that the service is available to them. In these cases, a denial based on a provider's personal moral objection can potentially impact every facet of life for an older adult or person with disabilities – including visitation rights, autonomy, and access to the community. For example,

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[15] Gay Lesbian Bisexual & Transgender Health Access Project, *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, *available at* www.glbthealth.org/documents/SOP.pdf; A.M.A., *Creating an LGBTQ-friendly Practice*, *available at* www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice .

[16] World Prof. Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (2011), *available at* https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf.

[17] Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 512: Health Care for Transgender Individuals*, (Dec. 2011), *available at* www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals.

[18] Nat'l Women's Law Ctr., *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS,* (May 2014), *available at* https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf.

could a case manager ignore an individual's request to see an HIV specialist? Could a group home refuse to allow a same-sex couple who are residents to live together in the group home?

Finally, due to limited provider networks, older adults and people with disabilities living in rural areas may have particular difficulty finding an alternate provider. For example, home care agencies and home-based hospice agencies in rural areas are facing significant financial difficulties staying open. Seven percent of all zip codes in the United States do not have any hospice services available to them.[19] Finding providers competent to treat people with certain disabilities increases the challenge, and adding in the possibility of a case manager or personal care attendant who objects to serving the individual under this proposed rule could make the barrier to accessing these services insurmountable. Moreover, older adults and people with disabilities who identify as LGBTQ or who belong to a historically disadvantaged racial or ethnic group may be both more likely to encounter service refusals and also face greater challenges to receive (or even know about) accommodations.

III. The proposed rule undermines longstanding ethical and legal principles of informed consent and would undermine effective provider-patient communication

The proposed rule undermines informed consent, a necessary principle of person-centered decision making and a critical component of quality of care. Informed consent relies on providers disclosing medically accurate information so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[20]

The proposed rule purports to improve communication between patients and providers, but instead, will deter open, honest conversations that are vital to ensuring that patients are able to be in control of their medical care. For example, the proposed rule suggests that a provider could refuse to offer information, if that information might be used to obtain a service to which the refuser objects. By undermining informed consent, the proposed rule could result in providers withholding information far beyond the scope of the underlying statutes and violate medical standards of care.

Additionally, while virtually every state already provides for a conscience objection and a provider's right to refuse to comply with a patient's directive, state laws also impose an obligation on providers to inform patients of their objection and to make some level of effort to transfer the patient to another provider or facility that will comply with the patient's wishes. This proposed rule appears to require neither and may even preempt these state laws which protect patients' rights. If this rule is finalized, which we oppose, HHS should clarify that state conscience rule procedural requirements are not preempted.

In particular, the principles of informed consent, respect for autonomy, and self-determination are important when individuals are seeking end-of-life care or have diminishing capacity. These

[19] Julie A. Nelson & Barbara Stover Gingerich, *Rural Health: Access to Care and Services*, 22 HOME HEALTH CARE MGMT. PRAC. (2010), *available at* http://globalag.igc.org/ruralaging/us/2010/access.pdf.

[20] Tom Beauchamp & James Childress, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); Charles Lidz et al., INFORMED CONSENT: A STUDY OF DECISION MAKING IN PSYCHIATRY (1984).

patients should be the center of health care decision-making and they or their representatives should be fully informed about their treatment options. Under the proposed rule, however, providers who object to various procedures could withhold vital information about treatment options— including options such as palliative sedation or declining artificial nutrition and hydration—and refuse to provide a referral to a provider who would honor the patient's wishes. For patients who cannot currently make health care decisions, their advance directives should be honored, regardless of the physician's personal objections, either through immediate assistance or through transfer to another facility. The blanket refusals permissible under this proposed rule would violate informed consent principles by ignoring patients' needs, desires, and autonomy and self-determination at critical times in their lives.

IV. Conclusion

Justice in Aging is deeply concerned that the proposed rule's expansion of conscience protections and religious refusals would be detrimental to older adults' health and well-being and greatly harm communities who already lack access to care and endure discrimination. HHS must ensure that all consumers are protected from discrimination and that all providers treat every patient whom they serve with dignity and respect. The proposed rule would give carte blanche to any provider to withhold care on the basis of prejudice cloaked as "moral conviction." Therefore, we strongly urge HHS not to finalize the proposed rule.

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Directing Attorney

EXHIBIT T

March 27, 2018

Secretary Alex Azar
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on HHS proposed rule on Protecting Statutory Conscience Rights in Health Care, HHS–OCR–2018–0002, RIN 0945-ZA03

Dear Secretary Azar:

The co-chairs of the Consortium for Citizens with Disabilities (CCD) Rights Task Force submit these comments in response to HHS's proposed rule interpreting religious refusal laws. CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society.

As advocates for the rights of individuals with disabilities to full and equal participation in all aspects of our society, we have serious concerns about the vagueness and breadth of the proposed rule's provisions and the potential impact that it may have on the application of disability and civil rights laws, such as the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. For example, the proposed provisions at 45 C.F.R. §§ 88.3(a)(2)(v) and 88.3(a)(2)(vi) seem to allow health care providers and staff extremely broad latitude in refusing to perform or assist in the provision of any lawful health service on the ground that doing so would be contrary to his or her religious beliefs. The proposed rule fails to discuss how these broad interpretations of religious refusal laws would interact with civil rights laws. To the extent that its provisions may be interpreted to limit the rights of people with disabilities under the ADA, Section 504, or other civil rights laws to receive health care services, however, we strongly object to them.

Congress provided a "broad mandate" in the ADA and Section 504 "to remedy widespread

discrimination against disabled individuals."[1] The ADA was designed "to provide clear, strong, *consistent, enforceable* standards addressing discrimination against individuals with disabilities."[2] Religious beliefs, regardless of the sincerity with which they are held, cannot be used as a shield for discrimination in contravention of disability rights mandates.

Discrimination in the provision of health care based on religious grounds presents particular concerns for people with disabilities because many people with disabilities rely heavily on religiously affiliated service providers for daily supports. In fact, many people with disabilities have little choice but to receive needed services from such service providers. And those service providers—particularly residential providers—are frequently responsible for assisting with many aspects of a person's life.

People with disabilities have sometimes been excluded from needed services or faced barriers to receiving those services due to service provider objections. For example, group homes have sometimes refused to allow people with disabilities to live with their spouses or romantic partners - even in the case of a heterosexual married couple.[3] Recent federal regulations concerning Medicaid home and community-based services now more clearly require residential service providers for people with disabilities to allow choice of roommate and overnight visitors.[4] Allowing religiously-affiliated service providers to deny residential services to people with disabilities based on a religious objection such as this could dramatically undermine their clients' right to pursue relationships and exercise fundamental rights of association.

The broad language of the proposed rule might also be interpreted to mean that the service providers on whom people with disabilities rely to coordinate necessary services or to provide transportation, personal care services, or other key services could refuse to provide these services, even if the person is entitled to receive them through Medicaid, Medicare, or another program. For example, these provisions might permit a case manager to refuse to set up a medical appointment for a person with a disability to see a gynecologist if contraceptives might be discussed, might permit a personal care services provider to refuse to assist a person with a disability in performing parenting tasks because the person was married to someone of the same gender, might permit a mental health service provider to refuse to provide needed treatment to an individual based on the fact that the individual was transgender, and might permit a sign language interpreter to refuse to help a person communicate with a doctor about sexual health. As these examples demonstrate, a denial of service based on a provider's personal moral

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[1] *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 674 (2001).
[2] 42 U.S.C. § 12101(b)(2) (emphasis added). Section 504 contains virtually identical requirements.
[3] *See Forziano v. Independent Grp. Home Livin Prog.*, No. 13-cv-00370 (E.D.N.Y. Mar. 26, 2014) (dismissing lawsuit against group homes, including a religiously affiliated group home, that refused to allow married couple with intellectual disabilities live together).
[4] 42 C.F.R. §§ 441.710(a)(vi)(B)(2), 441.710(a)(vi)(D).

objection can potentially impact every facet of life for a person with disabilities – including autonomy, parental rights, and access to the community.

In addition, individuals with particular disabilities have historically faced discrimination on the basis of religious beliefs.[5] Cases abound where religious scruples have been invoked to deny services to HIV-infected people; as recently as 2009, pharmacists unsuccessfully challenged a Washington law prohibiting pharmacies from refusing to deliver lawfully prescribed or approved medicines.[6] This is also an extremely relevant issue for the disability community since 4.6 percent of Deaf people are infected with HIV/AIDS, four times the rate for the African-American population,[7] the most at-risk racial group in the U.S.[8]

People with disabilities not only experience health disparities themselves, but those disparities are compounded by the health disparities that they face as members of other demographic groups such as women, people of color, and LGBTQ people. While disability affects people of all races, ethnicities, genders, languages, sexual orientations, and gender identities, disability does not occur uniformly among racial and ethnic groups. Disability prevalence is highest among African Americans, who report disability at 20.5 percent compared to 19.7 percent for non-Hispanic whites, 13.1 percent for Hispanics/Latinos and 12.4 percent of Asian Americans.[9] Disability prevalence among American Indians and Alaskan Natives is 16.3 percent.[10] An Institute of Medicine report has already observed that there are "clear racial differences in medical service utilization rates of people with disabilities that were not explained by socioeconomic variables," and "persistent effects of race/ethnicity [in medical service utilization] could be the result of culture, class, and/or discrimination."[11] These compounded disparities place people with disabilities at greater risk of denials of needed health care.

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[5] National Women's Law Center, *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS*, (May 2014), *available at* https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf.

[6] *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1116 n.7 (9th Cir. 2009)

[7] Disability Policy Consortium, Seth Curtis and Dennis Heaphy, *Disabilities and Disparities: Executive Summary* 3 (March 2009).

[8] *Id*.

[9] U.S. Census Bureau, Matthew Brault, *Americans With Disabilities: 2005, Current Population Reports* 117 (2008). Many of the differences between the disability rates by race and Hispanic origin can be attributed to differences in the age distributions of their populations. For example, Hispanics are predominantly younger than non-Hispanic whites.

[10] U.S. Census Bureau, *2009 American Community Survey, S1810, Disability Characteristics 1 year estimates* (2009) http://factfinder.census.gov/servlet/STTable?_bm=y&¬qr_name=ACS_2009_1YR_G00_S1810&-geo_id=01000US&¬ds_name=ACS_2009_1YR_G00_&-_lang=en&- format=&-CONTEXT=st.

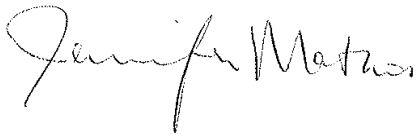
[11] Institute of Medicine, *The Future of Disability in America* 92 (2007).

Finally, we note that Title III of the ADA already exempts from coverage "religious entities or entities controlled by religious organizations, including places of worship."[12] The sweeping language of the proposed rule has the potential to create conflicts with Title III and to preempt enforcement of similar state and local laws protecting people with disabilities.

For the foregoing reasons, we urge you to revise the proposed rule to ensure that the religious refusal provisions are not interpreted to preempt civil rights protections.

Sincerely,

CCD Rights Co-Chairs
On behalf of CCD Rights Task Force



Jennifer Mathis
Bazelon Center for Mental Health Law

Dara Baldwin
National Disability Rights Network

Mark Richert
American Foundation for the Blind

Heather Ansley
Paralyzed Veterans of America

Samantha Crane
Autistic Self Advocacy Network

[12] 42 U.S.C. § 12187.

EXHIBIT U

Disability Rights Education & Defense Fund

DREDF

March 27, 2018 *Via Electronic Submission* (www.regulations.gov)

Secretary Alex Azar
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on HHS proposed rule on Protecting Statutory Conscience Rights in Health Care, HHS–OCR–2018–0002, RIN 0945-ZA03

Dear Secretary Azar:

Disability Rights Education and Defense Fund (DREDF) thanks you for the opportunity to submit comments on the Department of Health and Human Services' proposed rule on Protecting Statutory Conscience Rights in Health Care (proposed rule). DREDF is a national cross-disability law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. We are committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives.

Healthcare is not simply a consumer good. Everyone needs some degree of healthcare at some point in their lives. Disabilities and health conditions that affect functional ability arise from every facet of human interaction, or the mere reality of aging. People with disabilities and chronic conditions require equal access to quality healthcare in their communities to exercise their civil right to fully participate in all aspects of American society. As longtime advocates for the disability community in the arena of healthcare, we are alarmed by the vagueness and potential reach of the proposed rule's provisions as they intersect with civil rights laws including the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504), and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557). The proposed broadly requirements and prohibitions of 45 C.F.R. □88.3 prioritize the rights of personnel and entities involved with any health-related service, from research to insurance to third-party administration, to refuse to perform or assist with any lawful health service for "religious, moral, ethical or other reasons."

DREDF appreciates the proposed rule's argument on behalf of the conscience rights of

healthcare entities, but emphasizes that those rights must be read in concert with this country's commitment to the right of people with disabilities, across a full range of race, ethnicity, age, sexual orientation and gender identity, to receive health care services free of discrimination. Congress provided a "broad mandate" in the ADA and Section 504 "to remedy widespread discrimination against disabled individuals."[1] The ADA was designed "to provide clear, strong, *consistent, enforceable* standards addressing discrimination against individuals with disabilities."[2] The ADA unquestionably applies to the private offices of healthcare provides, hospitals, and any state or locally operated healthcare entity, and Section 504 applies to all entities that receive federal financial assistance or are federally operated. Section 1557 broadly extended Section 504's non-discrimination mandate to private insurers. Conscience rights, regardless of the sincerity with which they are held, cannot be used as a shield for discrimination that would deprive people with disabilities of equal access to healthcare.

Discrimination in the provision of health care based on religious grounds presents particular concerns for people with disabilities for both historic and practical reasons. Historically, people with disabilities have been subject to many stereotypes including religious beliefs that disability arises from demonic possession or a curse.[3] Those early stereotypes gave way to assumptions eugenic assumptions about who was "fit" to reproduce and many state laws that sterilized people with disabilities without their consent; California's eugenics laws stayed on the books until 1979.[4] While hopefully few current healthcare providers may hold overt beliefs about demonic possession or eugenics, different religious beliefs can easily influence assumptions about the "childlike nature" and capacities of people with disabilities, their quality of life, their ambitions, and their freedom and capacity to make autonomous choices and take risks.

Practically, people with disabilities as a group are subject to higher unemployment and lower socio-economic status. Many people with disabilities rely heavily on religiously affiliated service providers for daily supports as well as ongoing healthcare services. In fact, many people with disabilities have little choice but to receive needed services from such service providers. And those service providers—particularly residential providers—are frequently responsible for assisting with many aspects of a person's life and the activities to which they have access.

People with disabilities have sometimes been excluded from needed services or faced barriers to receiving those services due to service provider objections. For example, group homes have sometimes refused to allow people with disabilities to live with their spouses or romantic partners - even in the case of a heterosexual married couple.[5] Recent federal regulations concerning Medicaid home and community-based services now more clearly require residential service providers for people with disabilities that

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[1] *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 674 (2001).
[2] 42 U.S.C. 12101(b)(2) (emphasis added). Section 504 contains virtually identical requirements.
[3] Chomba Wa Munyi, "Past and Present Perceptions Towards Disability: A Historical Perspective," Disability Studies Quarterly 32:2 (2012), available at: http://dsq-sds.org/article/view/3197/3068.
[4] A. M. Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America*, American Crossroads (2015).
[5] *See Forziano v. Independent Grp. Home Livin Prog*., No. 13-cv-00370 (E.D.N.Y. Mar. 26, 2014) (dismissing lawsuit against group homes, including a religiously affiliated group home, that refused to allow married couple with intellectual disabilities live together).

receive federal funds to allow choice of roommate and overnight visitors.[6] Allowing religiously-affiliated service providers to deny residential services to people with disabilities based on a religious objection such as this could dramatically undermine their clients' right to pursue relationships and exercise fundamental rights of association.

The breadth of application of the proposed rule might also be interpreted to mean that the service providers on whom people with disabilities rely to coordinate necessary services or to provide transportation, personal care services, or other key services could refuse to provide these services, even if the person is entitled to receive them through Medicaid, Medicare, or another program. For example, these provisions might permit a case manager to refuse to set up a medical appointment for a person with a disability to see a gynecologist if contraceptives might be discussed, might permit a personal care services provider to refuse to assist a person with a disability in performing parenting tasks because the person was married to someone of the same gender, might permit a mental health service provider to refuse to provide needed treatment to an individual based on the fact that the individual was transgender, and might permit a sign language interpreter to refuse to help a person communicate with a doctor about sexual health. As these examples demonstrate, a denial of service based on a provider's personal moral objection can potentially impact every facet of life for a person with disabilities – including autonomy, parental rights, and access to the community.

Since the proposed rule encompasses referral and the giving of information, people with disabilities can be denied both the option of assistance finding needed healthcare services somewhere else, or left not even knowing that they have been given incomplete information. In many rural areas, and even in some urban areas of the country that have a very high cost of living, it can be extremely difficult for people with disabilities to find personal care assistants. Will a personal care assistant, or a care agency, with sincerely held religious beliefs be able to refuse to assist their client with activities that the assistant disapproves of, such as watching certain movies or meeting with certain friends because they believe such activities are morally wrong If a person with a disability attempts to find another care assistant, can the current assistant choose to simply not communicate the fact that other applicants are seeking the position The department's failure to specify in the proposed rule that healthcare entities cannot exercise their conscience rights over a disabled person's right to receive healthcare services free of discrimination leaves people with disabilities in an extremely vulnerable situation, potentially unable to rely on the very agency, HHS Office for Civil Rights,that should be protecting them from discrimination.

In addition, individuals with particular disabilities have historically faced particular discrimination on the basis of religious beliefs.[7] Cases abound where religious scruples have been invoked to deny services to HIV-infected people; as recently as 2009, pharmacists unsuccessfully challenged a Washington law prohibiting pharmacies from refusing to deliver lawfully prescribed or approved medicines.[8] This is also an extremely

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[6] 42 C.F.R. 441.710(a)(vi)(B)(2), 441.710(a)(vi)(D).
[7] National Women's Law Center, *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS,* (May 2014), *available at* https://nwlc.org/wp-content/uploads/2015/08/lgbt refusals factsheet 05-09-14.pdf.
[8] *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1116 n.7 (9th Cir. 2009)

relevant issue for the disability community since 4.6 percent of Deaf people are infected with HIV/AIDS, four times the rate for the African-American population,[9] the most at-risk racial group in the U.S.[10]

People with disabilities not only experience health disparities themselves, but those disparities are compounded by the health disparities that they face as members of other demographic groups such as women, people of color, and LGBTQ people. While disability affects people of all races, ethnicities, genders, languages, sexual orientations, and gender identities, disability does not occur uniformly among racial and ethnic groups. Disability prevalence is highest among African Americans, who report disability at 20.5 percent compared to 19.7 percent for non-Hispanic whites, 13.1 percent for Hispanics/Latinos and 12.4 percent of Asian Americans.[11] Disability prevalence among American Indians and Alaskan Natives is 16.3 percent.[12] One Institute of Medicine report has already observed that there are "clear racial differences in medical service utilization rates of people with disabilities that were not explained by socioeconomic variables," and "persistent effects of race/ethnicity [in medical service utilization] could be the result of culture, class, and/or discrimination."[13] Another recent paper commissioned by the National Academies of Sciences, Engineering and Medicine found that "[c]onscious and unconscious biases and stereotypes among health care providers and public health practitioners about specific racial and ethnic groups, and people with disabilities, contribute to observable differences in the quality of health care and adverse health outcomes among individual within those groups."[14] These compounded disparities place people with disabilities at greater risk of denials of needed health care.

Title III of the ADA already exempts from coverage "religious entities or entities controlled by religious organizations, including places of worship."[15] The sweeping language of the proposed rule has the potential to create conflicts with Title III and to preempt enforcement of similar state and local laws protecting people with disabilities.

Finally, we note that the proposed rule provides HHS OCR with the following authority:

> (c) Periodic compliance reviews. OCR may from time to time conduct compliance reviews or use other similar procedures as necessary to permit OCR to

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[9] Disability Policy Consortium, Seth Curtis and Dennis Heaphy, *Disabilities and Disparities: Executive Summary* 3 (March 2009).
[10] *Id*.
[11] U.S. Census Bureau, Matthew Brault, *Americans With Disabilities: 2005, Current Population Reports* 117 (2008). Many of the differences between the disability rates by race and Hispanic origin can be attributed to differences in the age distributions of their populations. For example, Hispanics are predominantly younger than non-Hispanic whites.
[12] U.S. Census Bureau, *2009 American Community Survey, S1810, Disability Characteristics 1 year estimates* (2009) http://factfinder.census.gov/servlet/STTable□□bm□y□amp;□qr□name□ACS □2009□1YR□G00□S1810□amp;-geo□id□01000US□amp;□ds□name□ACS□2009□1YR□G00□□amp;- □lang□en□amp;- format□□amp;-CONTEXT□st.
[13] Institute of Medicine, *The Future of Disability in America* 92 (2007).
[14] S. Yee, M. L. Breslin, T. D. Goode, S.M. Havercamp, W. Horner-Johnson, L. I. Iezzoni, G. Krahn, *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*; commissioned by the National Academy of Medicine of the National Academies of Sciences, Engineering and Medicine (2017).
[15] 42 U.S.C. □ 12187.

> investigate and review the practices of the Department, Department components, recipients, and subrecipients to determine whether they are complying with Federal health care conscience and associated antidiscrimination laws and this part. OCR may conduct these reviews in the absence of a complaint.

DREDF strongly submits that that HHS OCR's authority to conduct compliance reviews in the absence of a complaint must be available not only when OCR enforces conscience rights on behalf of providers and other healthcare entities, but equally available to those groups which are protected from non-discrimination in healthcare, including people with disabilities.

For the foregoing reasons, DREDF urges you to revise the proposed rule to ensure that the religious refusal provisions are not interpreted to preempt civil rights protections. Please feel free to contact me if you have any questions or comments concerning the above.

Sincerely,

Silvia Yee
Senior Staff Attorney

EXHIBIT V

THE DISABILITY COALITION
A Coalition of Persons with Disabilities, Family Members, and Advocates

In Santa Fe:
P.O. Box 8251
Santa Fe, New Mexico 87504-8251
Telephone: (505) 983-9637

In Albuquerque:
3916 Juan Tabo Boulevard, NE
Albuquerque, NM 87111
Telephone: (505) 256-3100

Reply to: Santa Fe office

March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building – Room 509F
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Department of Health and Human Services, Office for Civil Rights RIN 0945–ZA03, Proposed Regulation on "Protecting Statutory Conscience Rights in Health Care", Docket No. HHS-OCR-2018-0002

The Disability Coalition of New Mexico is a broad coalition of persons with disabilities, family members and advocates for the rights of people with disabilities of all kinds, including physical, mental, developmental, intellectual, and sensory. We submit these comments in opposition to the proposed rule on "Protecting Statutory Conscience Rights in Health Care" ("the Proposed Rule") published in the Federal Register by the Department of Health and Human Services (DHHS) on January 26, 2018. 83 Fed.Reg. 3880.

Our central concern is that the Proposed Rule will allow or even promote discrimination specifically on the basis of disability. However, we note that persons with disabilities would also be subject to increased discrimination on non-disability-specific bases that they share with other individuals, such as discrimination related to reproductive health services or end-of-life care, or that based on sexual orientation or gender identity.

People with disabilities already face significant barriers to obtaining the health care they need, in the form of such obstacles as inaccessible medical offices and equipment, providers who do not understand or address the needs of persons living with disabilities, or those who do not value the lives of individuals with disabilities to the same degree as those of the "able-bodied". The Proposed Rule would compound those problems by giving license to an extremely broad range of people involved – however tangentially – in the provision of health care services to impose their individual beliefs on patients, to the extent of entirely depriving them of access to necessary services.

Refusals to provide care are often based on subjective beliefs about the quality of life that a person with a disability experiences – or will experience if allowed to live. For example, life-saving care may be denied to a newborn because treating providers believe that the child's quality of life as an individual with a disability is not worth saving. Or care may be withheld from someone who has been severely injured in an automobile accident based on the belief that his quality of life going forward does not merit providing life-saving services. Or a person with an intellectual disability may be denied services based on a belief that the person does not deserve the same access to services that a person with "normal" functional capacity would receive. The Proposed Rule would give free rein to providers to impose these beliefs on their patients, exacerbating the already difficult situation that people with disabilities face in obtaining health care services.

Health care providers already enjoy ample protection from being forced to participate in services that violate their religious beliefs. The Proposed Rule would constitute an enormous broadening of those protections, to the detriment of patients in need of care.

1. The Proposed Rule would allow any person's individual belief to be the basis of an exemption from providing needed care to a patient, regardless of whether the belief is based on religious precepts.

2. The exemption would extend well beyond clinicians directly involved in the provision of health care services, and allow anyone with any "articulable connection" to service provision to refuse participation. 83 Fed.Reg. at 3892 (preamble) and 3923 (proposed 45 CFR §88.2). For example, a hospital administrator could refuse to process paperwork to admit a patient for a procedure disfavored by that employee, a cafeteria worker could refuse to bring a meal to a patient receiving services the worker does not agree with, or a technician could refuse to prepare equipment to be used in a procedure.

3. The "health care entities" protected under the Proposed Rule would include an extremely broad range of organizations beyond those directly engaged in the provision of health care services. The proposed definition expressly includes, for example, research organizations, insurance plans, and "plan sponsor[s]" such as employers, and goes on to state that the proposed list is intended to be merely illustrative and is not exhaustive. 83 Fed.Reg. at p. 3893 (preamble) and 3924 (proposed 45 CFR §88.2). The extent to which entities or individuals with only the most tangential tie to the care would be permitted to block provision of that care is breath-taking.

4. A provider refusing to participate would be under no obligation to give the patient information on or referral to alternate sources of care that would enable the individual to obtain needed services, or to facilitate the patient's transfer to such a provider. Withholding such information from a patient is a gross violation of the trust relationship that should exist between provider and patient and could lead to serious harm to a patient who is thereby prevented from accessing needed care from an alternative source after a "conscience-based" refusal.

In addition to its extremely broad scope, we have many other concerns about the Proposed Rule, including the following:

1. The Proposed Rule would improperly give the religious, moral or ethical beliefs of health care providers (or other individuals distantly associated with the provision of care) primacy over those of the patient. The Proposed Rule goes well beyond protecting the religious

and moral beliefs of health care providers and allows those providers (and others with even a tenuous connection to provision of services) to impose their beliefs on their patients and other third parties.

2. The Proposed Rule would improperly give the religious, moral or ethical beliefs of providers primacy over medical standards of care. All patients have the right to expect that they will be treated in accordance with such generally accepted standards and should not be deprived of that appropriate treatment based on individual provider beliefs.

3. The Proposed Rule would protect the rights of providers to refuse to provide care, but does nothing to protect providers whose consciences call on them to provide services. For example, a physician would have the right to refuse to provide abortion services, but another physician whose moral convictions called for her to provide an abortion as a necessary service for a patient would not have the same protection for her beliefs and could be subjected to retaliation, disciplinary action or outright denial of her right to act on her beliefs by providing appropriate medical care. In so doing, the Proposed Rule appears to privilege some moral convictions as worthy of protection over others that are deemed to be unworthy of such safeguards.

4. The disclosure requirements in the Proposed Rule are inadequate. While it would require health care entities to notify patients of the provider's right to refuse services, it requires no notification of the types of care or services that will be denied. This could lead to a patient unknowingly finding herself in a position where she will be denied services, to her detriment. For example, a patient may mistakenly believe that a full-service hospital offers sterilization services, only to find out that she cannot obtain a tubal ligation at the time she delivers her baby but must instead undergo a second surgical procedure at a separate facility at another time.

5. The Proposed Rule goes beyond protecting the religious and moral beliefs of providers and would constitute government authorization for discrimination.

6. The Proposed Rule would conflict with existing law and does not clarify how its provisions would interact with those other provisions.

a) The Proposed Rule would create a conflict with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1295dd. That statute requires that a hospital must screen patients to determine the existence of an emergency condition and must provide necessary services to stabilize the individual's condition or, in appropriate cases, transfer the patient to another provider for care. The Proposed Rule appears to encourage providers to flout EMTALA by denying care, disregarding the requirements to screen and stabilize, and refusing to arrange for transfer to an appropriate provider. The Proposed Rule (including the preamble) published in the Federal Register makes neither any mention of EMTALA or any attempt to clarify the intended interaction of the Proposed Rule's provisions with statutory obligations under EMTALA.

b) Title VII of the 1964 Civil Rights Act requires reasonable accommodations for the religious beliefs or practices of employees, including those of health care entities, unless the accommodation imposes a undue burden on the entity's operations. The Proposed Rule would go well beyond such accommodations and thereby put employers in the position of operating within two different and inconsistent sets of rules. As with EMTALA, the Proposed Rule published in the Federal Register neither mentions nor addresses Title VII.

Finally, the Proposed Rule appears to authorize an unconstitutional establishment of religion. Freedom of religion, as enshrined in the U.S. Constitution, is the right to free exercise of one's own religion and is not a license to impose one's religious beliefs on others or to engage in

discrimination against others based on one's own beliefs. The U.S. Supreme Court has warned that accommodation of religious beliefs may, if taken too far, become an "unlawful fostering of religion", *Corp. of Presiding Bishop v. Amos*, 483 U.S. 327, 334-35 (1987), and that religious accommodations that unduly burden others are not protected by the Constitution's Establishment Clause. See *Sherbert v. Verner*, 374 U.S. 398 (1963); see also *Burwell v. Hobby Lobby*, 573 U.S. ___,134 S. Ct. 2751 (2014). The Proposed Rule would authorize individuals and institutions involved in the provision of health care to impose their private beliefs on others who do not share those beliefs and thus unduly burden those other persons, and is therefore unconstitutional.

We strongly urge the Department to withdraw the Proposed Rule. Thank you for your consideration of these comments.

Sincerely,

Ellen Pinnes
for The Disability Coalition
EPinnes@msn.com

EXHIBIT W

National Organization for Women

March 27, 2018

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

ATTN: Conscience NPRM RIN 0945-ZA03

To Whom It May Concern:

The National Organization for Women (NOW) strongly believes that a health care provider's personal beliefs cannot be allowed to impede or alter the treatment of patients. For this reason, we oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule") and the establishment of the "Conscience and Religious Freedom Division" within the Office of Civil Rights (OCR). This Rule and this Division legalize discrimination in health care via the expansion of refusal procedures, including religious and moral convictions as reasonable bases for refusal of care.[1] Such an act undermines the separation of church and state, allowing any individuals and health care entities receiving federal funding to refuse *any* part of a health service or program to an individual based on subjective convictions, which additionally may be used to mask bigotry and prejudice. In this manner, the Department plans to utilize OCR resources to allow institutions, insurance companies, and anyone involved in patient care, including "volunteers, trainees, contractors…and providers holding admitting privileges" to use their personal beliefs to deny treatment to those desperately needing it. This opens the door to widespread discrimination based on a patient's race, gender identity, and/or sexual orientation. **For these reasons, NOW calls on the Department and OCR to withdraw the Proposed Rule.**

The Department and OCR specifically attempt to require a broad swath of entities to permit individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[2] Read alongside the rest of the Proposed Rule, it is clear this allows any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care. Consequently, it is not only patient interactions with immediate providers that will be affected, but with any personnel involved, directly or indirectly, in their care.

By expanding the reach of existing refusal of care laws, which already harm those seeking care, and creating a right to new refusals, this Rule will exacerbate health inequities in the denial of critical services, such as abortion and transition-related care. Already, the Ethical and Religious Directives (ERDs) followed by Catholic and Catholic-affiliated hospitals allow providers to deny reproductive

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (*to be codified at* 45 C.F.R. pt. 88) [*hereinafter* Rule].
[2] *See id.* at 12.

health services to patients, with providers in one 2008 study disclosing that they could not provide the standard of care for managing miscarriages at Catholic hospitals.[3] As a result, women were delayed care or transferred to other facilities at great risk to their health [4]. One patient in Arkansas endured several pregnancy complications and, knowing she could not risk another pregnancy, requested a sterilization procedure at her Cesarean delivery which was refused by her Catholic hospital provider.[5] Under this proposed rule, similar denials of care, along with resulting emotional and physical distress, will become commonplace.

The Proposed Rule also broadens the Church Amendments, which in their current form, allow individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions related to the service or research activity to which they object.[6] The Proposed Rule expands this provision by allowing individuals to refuse to perform aspects of their jobs based on reference to religious or moral belief, whether or not the refusal relates to the specific biomedical, behavioral service, or research activity they are working on.[7] This expansion goes beyond the statute enacted by Congress.

Such overstepping, however, is a consistent theme with regards to this Proposed Rule. In addition to expanding the breadth of existing refusal laws, the Proposed Rule redefines phrases and words used in existing refusals of care laws and civil rights laws to further stretch and expand their intended meaning. For example, the definition of "assist in the performance" in the Proposed Rule indicates that the types of services which may be refused include "making arrangements for the procedure" no matter how tangential such arrangements are to the procedure.[8] As such, individuals not "assisting in the performance" of a procedure in the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, now possess a new "right" to refuse. The Proposed Rule's definition of "referral" also goes beyond any recognized understanding, allowing providers and personnel to refuse to provide any additional information, including location or funding, that could help an individual to get the care they need, denying patients knowledge concerning their full and complete options for care.[9] Furthermore, the Proposed Rule's newly expanded definitions often exceed, or are not in accordance with, existing definitions within the statutes the Proposed Rule seeks to enforce. Under the Coats and Weldon Amendments "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.[10] The Proposed Rule, however, attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad

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[3] Lori R. Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.
[4] Id.
[5] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.
[6] The Church Amendments, 42 U.S.C. § 300a-7 (2018).
[7] *See* Rule *supra* note 1, at 185.
[8] *Id.* at 180.
[9] *Id.* at 183.
[10] The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018).

term.[11] This attempt to expand the meaning of a statutory term already defined by Congress fosters confusion and goes against congressional intent. By defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert into the definition.[12]

When these broad definitions are combined with expansive interpretations of the underlying statutes, they expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, another way the Weldon Amendment is expanded under the Proposed Rule is through the definition of "discrimination."[13] The Proposed Rule defines "discrimination" against a health care entity broadly, including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[14] In a Rule that seeks to protect those who want to discriminate, such a broad definition is inappropriate. Furthermore, the definition itself is so vague that it provides no functional guidance on how to comply with its requirements, fostering confusion.

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have potentially harmful consequences for those denied care. When women and families are uninsured, locked into managed care plans that do not meet their needs, or cannot afford to pay out of pocket and/or travel to another location, refusals bar access to care.[15] This is especially true for immigrants, who often lack transportation and may have to travel great distances to get required care.[16] In rural areas there may be no other sources of health and life preserving medical care.[17] When these individuals encounter refusals of care, they may have nowhere else to go. The same holds true for members of the LGBTQ+ community, who have often faced discrimination with regards to healthcare. This is evidenced by the fact that 8% of lesbian, gay, bisexual and queer respondents to a survey by the Center for American Progress indicated that a provider had refused to see them based on their sexual orientation, 16% reporting that they had experienced verbal, physical and/or sexual abuse at the hands of their providers[18]. For trans individuals, the statistics are still more alarming. 29% of trans people surveyed indicated that a healthcare provider had refused to see them and 50% stated that their providers

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[11] *See* Rule *supra* note 1, at 182.
[12] The doctrine of expression unius est exclusion alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[13] *See* Rule *supra* note 1, at 180.
[14] *Id.*
[15] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. *Women's Health Insurance* Coverage, KAISER FAMILY FOUND. 1, 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.
[16] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health & Ctr. For Reproductive Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: the Fight for Women's Reproductive Health in the Rio Grande Valley* 1, 7 (2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf.
[17] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
[18] Percentages of those experiencing verbal, physical and/or sexual abuse are the result of the addition of percentages reporting verbal abuse and percentages reporting unwanted sexual/physical contact. For a summary of survey results, see: Shabab Ahmed Mirza and Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*. *Center for American Progress* (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/

had verbally, physically or sexually abused them as they sought care [19]. With such reported instances of discrimination and harm done while seeking treatment, it is sadly unsurprisingly that, according to the 2015 U.S. Transgender Survey, nearly 1 in 4 trans people avoided seeking necessary health care in the year prior due to a fear of discrimination, a fear, which given reported instances thereof, cannot be considered unreasonable [20]. And yet, like immigrant populations, the LGBTQ+ community often has nowhere else to go, those surveyed indicating in high amounts that it would be "very difficult" or "not possible" for them to find the services needed either at a different hospital, pharmacy or clinic, trans people once again reporting higher rates of difficulty as compared to cisgender LGBTQ+ individuals[21]. LGBTQ+ people living in non-metropolitan areas also report high rates of difficulty finding a new provider, a situation that is likely the result of increased transportation costs and distance[22].

The Proposed Rule and the Division become still more troubling when one considers that individuals who face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, research shows that women of color disproportionately receive their care at Catholic hospitals and that, (in) nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[23] This puts them at greater risk of being denied appropriate reproductive healthcare, such as miscarriage management and treatment for pregnancy complications, relative to white women, simply due to the supposed religious preferences of these institutions.

In this manner, by expanding and creating new methods by which providers and personnel associated with healthcare services – however tangentially – may refuse to perform services for any patient, the Proposed Rule opens the doors to federally-sanctioned, legalized discrimination in healthcare, something that will cost lives and endanger the health and safety of many, especially those whose identities mark them as part of one or more marginalized populations. **For this reason, NOW reiterates, this Proposed Rule cannot be permitted to stand, and must be withdrawn, so as not to cause irreparable harm to prospective patients, all of whom are owed treatment in keeping with the recognized full and complete standard of care**.

Regards,

Toni Van Pelt

Toni Van Pelt, President
National Organization for Women
1100 H St., NW, Suite 300
Washington, D.C.20005

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[19] Id.
[20] Id.
[21] Id.
[22] Id.
[23] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

EXHIBIT X

OFFICE OF THE COUNTY COUNSEL
COUNTY OF SANTA CLARA

County Government Center
70 West Hedding Street
East Wing, 9th Floor
San Jose, California 95110-1770

(408) 299-5900
(408) 292-7240 (FAX)

James R. Williams
COUNTY COUNSEL

Greta S. Hansen
CHIEF ASSISTANT COUNTY COUNSEL

Winifred Botha
Robert M. Coelho
Steve Mitra
ASSISTANT COUNTY COUNSEL

March 22, 2018

Submitted electronically through www.regulations.gov

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

Attn: Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)
Re: Protecting Statutory Conscience Rights in Health Care

Dear Secretary Azar:

The County of Santa Clara ("County") submits these comments in response to the Department of Health and Human Services' (HHS) proposed rule, Protecting Statutory Conscience Rights in Health Care.[1]

The County, established in 1850, is a charter county and political subdivision of the State of California. Its mission is to protect the health, safety, and welfare of 1.9 million County residents. The County owns and operates Santa Clara Valley Medical Center ("SCVMC"), a fully integrated and comprehensive public health care delivery system that provides critical health care to residents of Santa Clara County regardless of their ability to pay. SCVMC, which includes a 574-bed tertiary care hospital with a Level 1 trauma center and 11 ambulatory care clinics, is the only public safety-net health care provider in Santa Clara County, and the second largest such provider in California. SCVMC provides the vast majority of the health care services available to poor and underserved patients in the County. The County also owns and operates Valley Health Plan ("VHP"), which participates in California's health insurance marketplace under the Affordable Care Act.

[1] 83 Fed. Reg. 3880 (proposed Jan. 26, 2018).

As set forth below, the proposed regulation: (1) improperly attempts to broaden the substantive scope of statutory conscience-based protections; (2) if adopted, may be improperly interpreted to invite discrimination against patients who face significant barriers to care; and (3) if adopted, will impose unnecessary burdens on safety-net providers such as the County.

A. The Proposed Regulation Improperly Attempts to Broaden the Substantive Scope of Statutory Conscience-Based Protections

Existing law provides an adequate framework for the enforcement of conscience-based protections, which protect under certain circumstances health care workers who refuse to participate in certain procedures or services based on their religious beliefs or "moral convictions." In addition, Title VII of the Civil Rights Act of 1964 provides an employment law framework for religious accommodations. The proposed regulation is not only unnecessary in light of the current framework, but it also improperly attempts to legislate heightened conscience-based protections that Congress has not recognized. Through its "further definition of Federal health care conscience and associated anti-discrimination laws," the proposed regulation seeks to vastly expand the scope of conscience-based protections in a way that substantially increases the likelihood that already-marginalized patients will face additional barriers in accessing health care.[2] Such an effect on patients seeking care undermines HHS's mission "to enhance and protect the health and well-being of all Americans."[3]

1. *The proposed regulation improperly broadens the meaning of "referral or refer for," which may result in health care workers turning patients away from a facility when others at the facility are willing to provide care.*

The proposed regulation's broad definitions of "assist in the performance" and "referral or refer to" in sections 88.3(a)(2)(v) and 88.2 sweep beyond the statutory language and may be improperly interpreted as permitting individual health care workers to turn patients away from a facility, without providing *any* information, when the objected-to services are in fact provided at that facility.[4] The definition in Section 88.2 of "refer or refer to" as including "the provision of any information . . . by any method" goes beyond the County's understanding of what a referral is.[5] The County is concerned that individual health care workers might improperly interpret the proposed regulation as permitting them to refuse *any* form of patient assistance, including notifying them that such services are provided by the County at that facility. For example, a provider might interpret the proposed regulation as allowing her, based on "moral convictions," to turn away, without providing *any* information, a patient at SCVMC experiencing abdominal pain related to an intra-uterine device, when there are many other providers at SCVMC who are

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[2] *Id.* at 3891.

[3] *Introduction: About HHS*, HHS, https://www.hhs.gov/about/strategic-plan/introduction/index.html, attached as Exhibit 1.

[4] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3925 (§ 88.3(a)(2)(v)); *id.* at 3924 (§ 88.2).

[5] *Id.*

willing to treat that patient. Health care professionals are obligated to provide their patients with complete and accurate information about their treatment options. Failure to do so could result in liability for the providers, incomplete or deficient treatment of patients, and violation of ethical and legal principles.

Nothing in the proposed regulation supports HHS's conclusion that Congress intended such a broad extension of statutory conscience-based protections. HHS contends in the commentary to the proposed regulation that because the statutes use the terms "make arrangements for" and "refer for" services, Congress intended a broad definition of "referrals."[6] But this is not persuasive evidence that Congress intended the definition of "referral or refer to" to be as broad as it is in the proposed regulation: "provision of *any information. . . by any method*."[7] Stating that the County provides the requested services, even if the particular health care worker objects to providing them, is not "making arrangements for" a service that the provider has a religious objection to performing. In particular, the conscience-based protections must be read in light of Congress's robust, generally applicable non-discrimination statutes, including Section 1557 of the Affordable Care Act, Titles II and III of the Americans with Disabilities Act, and Title VI of the Civil Rights Act of 1964, that apply in certain health care settings.

Although HHS states that its proposed definition of "referral or refer to" will "address confusion the Department perceives among the public about what sorts of actions may be properly regarded as referrals for the purposes of protecting rights of conscience under the statutes at issue in this proposed rule,"[8] the substantive rewriting of statutory rights will result in greater confusion, because patients will not know whether they are getting complete information or a full range of treatment options. In delegating to the Office of Civil Rights (OCR) enforcement authority over the conscience-based protection statutes, Congress did not delegate the authority to transform the statutes into a broad license to discriminate and to provide patients with incomplete, deficient, or no treatment options based on a boundless array of "moral convictions," some of which may be contrary to non-discrimination statutes, and many more of which may conflict with HHS's mission to improve the health care of *all* Americans.

2. *The proposed regulation's reinterpretation of the Weldon Amendment is likely to limit access to comprehensive health insurance options.*

As applied to the Weldon Amendment,[9] the proposed regulation's definition of "health care entity" is likely to create additional barriers to accessing care, because it will likely limit

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[6] *Id.* at 3895.

[7] *Id.* (emphasis added).

[8] *Id.*

[9] The Weldon Amendment, incorporated in the HHS appropriations acts, provides that "[n]one of the funds made available in this Act may be made available to a Federal agency or program, or to a state or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."

access to health insurance with comprehensive coverage of reproductive services. The proposed regulation adds "a plan sponsor" to the definition of "health care entity" under the Weldon Amendment.[10] This would greatly expand the universe of entities permitted to challenge a state's requirement to "provide, pay for, provide coverage of, or refer for, abortion."[11] HHS's proposed justification for expanding the definition of "health care entity"—that "[t]he amendment's broad and non-exhaustive definition indicates that the amendment takes an inclusive approach with respect to the health care entities it protects and should not be interpreted narrowly,"[12]—is not based on any legislative history, nor is it a license to go beyond the plain meaning of the statute. Congress did not delegate authority to HHS to expand the scope of the Weldon Amendment.

It is even more problematic that the proposed regulation attempts to reinterpret the Weldon Amendment to broadly allow health care entities to refuse to "provide, pay for, provide coverage of, or refer for abortions,"[13] regardless of whether entities have a conscience-based objection to doing so. HHS offers no evidence that refusals unrelated to conscience-based objections—such as financial or operational motivations—are intended to be protected under the Weldon Amendment. Rather, both the legislative history of the Weldon Amendment, and judicial interpretations of it, compel the contrary conclusion.[14] And even though economically or operationally driven refusals to provide abortion-related services or referrals have nothing to do with civil rights, the proposed regulation would make OCR's enforcement authority available to entities that merely have an economic or operational objection to providing such services. Contrary to HHS's mission, such a delegation would likely serve only to decrease the availability of health insurance options that provide comprehensive coverage of reproductive services.

B. The Proposed Regulation, If Adopted, May Be Improperly Interpreted as Inviting Discrimination Against Patients Who Already Face Significant Barriers to Care

If adopted, the proposed regulation will likely invite discrimination against patients who already face significant barriers to accessing care, such as lesbian, gay, bisexual, transgender, or queer (LGBTQ) people. Although a full discussion of the myriad of health care consumers who may be affected by the proposed regulation is beyond the scope of this comment, the proposed

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Consolidated Appropriations Act, 2017, Public Law 115-31, § 507(d)(1), 131 Stat. 135. It defines "health care entity" to include "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." *Id.* at § 507(d)(2).

[10] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3890–91, 3924 (§ 88.2).

[11] *Id.* at 3925–26 (§ 88.3(c)(2)).

[12] *Id.* at 3890.

[13] *Id.* at 3925–26 (§ 88.3(c)(2)).

[14] *See* Letter from Jocelyn Samuels, Director, OCR, to Catherine W. Short, Vice President, Life Legal Def. Found., et al. (June 21, 2016) (citing *California ex rel. Lockyer v. United States*, 450 F.3d 436, 441 (9th Cir. 2006); 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004)).

regulation's likely effect on LGBTQ people, who frequently encounter discrimination and other barriers to accessing medical care, serves as an example of the harmful impact the regulation is likely to have.

Discrimination against LGBTQ people in health care settings is well documented. In one study, more than half of all respondents had experienced at least one of the following when seeking health care: refusals of needed care, providers refusing to touch them or using excessive precautions, harsh or abusive language, providers blaming them for their health status, or physically rough or abusive conduct.[15] In that study, eight percent of lesbian, gay, or bisexual respondents reported they had been refused needed health care because of their sexual orientation, and nearly 27 percent of transgender respondents reported being refused care because of their transgender status.[16] The percentages of LGBT people of color and low-income LGBT people who reported being refused care are much higher than the percentages for survey respondents as a whole.[17]

One respondent to a survey of transgender people reported, "I have been refused emergency room treatment even when delivered to the hospital by ambulance with numerous broken bones and wounds."[18] Another study, based on a review of complaints filed with OCR, describes a situation in which a transgender woman was recovering from an appendectomy, and the treating doctor, who "does not deal with 'these kinds' of patients," refused to call her by the correct pronouns.[19] Some medical providers have explicitly asserted religious-based reasons for denying care to LGBTQ people or their families, such as a pediatrician who refused to treat the newborn daughter of a lesbian couple.[20]

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[15] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 10 (2010), *available at* https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf, attached as Exhibit 2.

[16] *Id.*

[17] *Id.* at 12. The County generally uses the acronym LGBTQ but uses "LGBT" when referring to the cited study, which uses that acronym.

[18] Jaime Grant et al., Nat'l Center for Transgender Equality & Nat'l Gay and Lesbian Task Force, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* 73 (2011), *available at* http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf, excerpt attached as Exhibit 3.

[19] Sharita Gruberg & Frank J. Bewkes, Ctr. for Am. Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (Mar. 7, 2018), *available at* https://cdn.americanprogress.org/content/uploads/2018/03/06122027/ACAnondiscrimination-brief2.pdf, attached as Exhibit 4.

[20] Abby Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents and There's Nothing Illegal about It*, Washington Post (Feb. 19, 2015), https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it/?utm_term=.a59cf2f3df0a, attached as Exhibit 5.

Refusing to provide medical care to consumers based on sex, sexual orientation, or gender identity is a form of sex discrimination prohibited by federal law. As an entity covered by the Affordable Care Act, the County complies with the ACA's non-discrimination protections in Section 1557, 42 U.S.C. § 18116(a), which prohibits discrimination based on sex and other protected characteristics in health programs and activities. In addition, as a local government that seeks to ensure the health, safety, and welfare of its 1.9 million residents, the County has a significant interest in eliminating discrimination and barriers to health care for *all* of its residents. To understand the health needs of the County's LGBTQ residents, the County's Public Health Department performed an LGBTQ Health Assessment in 2013.[21] Among other things, the study showed that 12 percent of LGBTQ survey respondents were "denied or given lower quality health care" in the 12 months preceding the survey due to their sexual orientation and/or gender identity.[22]

The County is concerned that the proposed regulation, if adopted, will invite medical providers to discriminate against LGBTQ health care consumers, among others, in violation of federal non-discrimination law. Not only does the proposed regulation appear to invite discriminatory conduct by expanding the reach of statutory conscience-based protections as discussed above, but it also oversimplifies them in the language it proposes to use to raise awareness among providers. The Notice in Appendix A tells providers they "have the right to decline to participate in, refer for, undergo, or pay for certain health care-related treatments, research, or services . . . which violate your conscience, religious beliefs, or moral convictions under Federal law."[23] This is not limited to the types of procedures contemplated in the statutory provisions discussed in the proposed rule. Such notice might encourage a provider, for example, to refuse to treat a transgender patient who comes to the emergency room seeking care for a broken arm based on the provider's "moral convictions," even though such refusal of service would violate federal non-discrimination law and the Emergency Medical Treatment and Labor Act.[24] And, if the notice is seen by a patient, this might discourage open communication with the provider, for fear that services will be denied. If HHS adopts the proposed regulation, it must address the empirical evidence which strongly suggests that marginalized patients will face heightened barriers in accessing care. And the notice must be compliant with all other applicable laws.

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[21] Santa Clara Cnty Pub. Health Dep't, *Status of LGBTQ Health: Santa Clara County 2013* (2013), *available at* https://www.sccgov.org/sites/phd/hi/hd/Documents/LGBTQ%20Report%202012/LGBT%20Health%20Assessment.pdf, attached as Exhibit 6.

[22] *Id.*

[23] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3931.

[24] 42 U.S.C. § 18116(a); 42 U.S.C. § 1395dd.

C. The Proposed Regulation, If Adopted, Would Be an Unnecessary Burden to Safety-Net Providers Such as the County of Santa Clara

The proposed regulation's projected costs, which HHS states will be $815 million over the course of five years, far outweigh any expected benefits that could possibly stem from the expected increase in the supply of health care providers who maintain conscience-based objections. As a result, the proposed regulation, if adopted, would be an unnecessary burden to safety-net providers such as the County, which rely on limited public funds to provide essential health care services to *all* patients on a non-discriminatory basis. As illustrated above, an effect of the proposed regulation will likely be increased discrimination against patients who already face barriers in accessing care.

The proposed regulation's discussion of "ancillary benefits for patients," such as "assist[ing] patients in seeking counselors who share their deepest held convictions,"[25] ignores the much more substantial harm that the proposed regulation will likely cause to patients who are refused medical services, referrals to services, information about such services or referrals, or even information about where such information might be obtained, based on the religious beliefs or "moral convictions" of providers. The proposed regulation asserts that "[f]acilitating open communication between providers and their patients also helps to eliminate barriers to care, particularly for minorities."[26] But providers may interpret the regulation as allowing them to refuse to communicate *any* information to patients based on the provider's "moral convictions."

Surprisingly, the proposed regulation's cost-benefit analysis does *not* consider the potential impact or costs directly impacting patients, including costs resulting from "health outcomes or other effects of protecting conscience rights."[27] Studies show that discrimination, and the potential for discrimination, deter marginalized populations such as LGBTQ people from seeking medical care.[28] And discrimination negatively impacts health outcomes. As HHS's HealthyPeople 2020 initiative has noted, LGBTQ people "face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[29]

In addition, the proposed regulation vastly underestimates the costs of compliance for safety-net providers such as the County. Because the proposed regulation vastly expands the

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[25] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3916–17.

[26] *Id.* at 3917.

[27] *Id.* at 3916, 3918.

[28] Shabab Ahmed Mirza & Caitlin Rooney, Ctr. for Am. Progress, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018), *available at* https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/, attached as Exhibit 7.

[29] HHS Office of Disease Prevention & Health Promotion, *Lesbian, Gay, Bisexual, and Transgender Health*, HealthyPeople 2020, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, attached as Exhibit 8.

substantive scope of statutory conscience-based protections, the projected estimate of *one* attorney hour to review the final rule[30] grossly underestimates the time that would be required to fully examine the rule's implications for existing County policies and practices related to conscience-based protections, as well as applicable non-discrimination policies at the federal, state, and local level. Similarly, the projected estimate for time required to post approximately five notices[31] ignores the reality of large health and hospital systems like the one operated by the County, which encompasses many facilities in many locations. The burden of this requirement is particularly unnecessary for entities like the County, which already ensures that employees are provided notice of their right to assert conscience-based protections through robust policies that allow employees to opt-out of participation in certain services in advance if those services conflict with a staff member's cultural values, ethics, or religious beliefs.[32]

D. Conclusion

As discussed above, the proposed regulation is an unlawful and unnecessary burden on providers and may invite discrimination against vulnerable populations who already face barriers to health care. The County urges HHS to rescind the proposed regulation.

Very truly yours,

JAMES R. WILLIAMS
County Counsel

Julie Wilensky
Deputy County Counsel

Adriana Benedict
Social Justice and Impact Litigation Fellow

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[30] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3912.

[31] *Id.* at 3914.

[32] *See, e.g.*, Memorandum from Paul Lorenz to SCVMC Employees, Non-Participation in Certain Patient Care (Aug. 9, 2017); Memorandum from Paul Lorenz to SCVMC Employees, Medically Ineffective Interventions, Requests Concerning (May 8, 2015); Agreement Between Cnty. of Santa Clara & Registered Nurses Prof'l Ass'n (Nov. 10, 2014 through Oct. 20, 2019).

EXHIBIT 1

Introduction: About HHS

Mission Statement

The mission of the U.S. Department of Health and Human Services (HHS) is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

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Organizational Structure

HHS is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS accomplishes its mission through programs and initiatives that cover a wide spectrum of activities, serving and protecting Americans at every stage of life, from conception. HHS is responsible for almost a quarter of all Federal outlays and administers more grant dollars than all other Federal agencies combined.

Eleven operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies, administer HHS's programs. While HHS is a domestic agency working to protect and promote the health and well-being of the American people, the interconnectedness of our world requires that HHS engage globally to fulfill its mission. In addition, staff divisions provide leadership, direction, and policy guidance to the Department.

The organizational chart for HHS and a description of the Agencies and Offices can be found on the Department's website at http://www.hhs.gov/.

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Cross-Agency Collaborations

Improving health and human services outcomes cannot be achieved by the Department on its own; collaborations are critical to achieve our goals and objectives.

HHS collaborates closely with other Federal departments and agencies on cross-cutting topics. For example, through the President's Management Council, the Department engages with other Federal departments to identify and adopt best practices on performance and management initiatives. Another example, focused on mission-critical efforts, is the Federal Interagency Workgroup that led the Healthy People 2020 development effort, bringing together Federal staff from the Department with partners in the U.S. Departments of Agriculture and Education.

Federal Advisory Committees enable the Department to collaborate with other Federal departments and agencies, as well as members of the public, on high-priority issues. For example, the Interdepartmental Serious Mental Illness Coordinating Committee, established by the 21st Century Cures Act of 2016 (Pub. L. 114–255), convenes senior leaders from 10 Federal agencies including HHS; the Departments of Justice, Labor, Veterans Affairs, Defense, Housing and Urban Development, and Education; and the Social Security Administration, along with 14 non-Federal public members, to improve Federal coordination of efforts to address the needs of adults with serious mental illness and youth with serious emotional disturbance.

Importantly, the Federal Government has a unique legal and political government-to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments. Executive Order 13175, *Consultation and Coordination with Indian Tribal Governments*, requires consultation with Indian Tribal governments when considering policies that affect Tribal communities. The Department's Tribal Consultation Policy - PDF, first developed with Tribal participation in 2004, was updated in 2010. HHS works with Tribal governments, Indian organizations, and other Tribal organizations to facilitate greater consultation and coordination between States and Tribes on health and human services issues.

HHS works closely with State, local, and U.S. territorial governments, providing funding for program operations and technical assistance. HHS also fosters critical global relationships, coordinates international engagement across HHS and the U.S. Government, and provides leadership and expertise in global health diplomacy and policy to contribute to a safer, healthier world.

In addition, HHS has strong partnerships with the private sector, academia, research institutions, and nongovernmental organizations, including religious and faith-based organizations. The Department partners with the private sector, such as regulated industries, academic institutions, trade organizations, and advocacy groups. The Department leverages resources from these organizations to enable HHS to

accomplish its mission through strategies that minimize the burden on, and increase the benefits to, the American public. This effort occurs through Tribes and faith-based and community initiatives as well as grantees in the private sector, such as academic and research institutions, and community-based nonprofit organizations, which provide many services at the local level.

The narrative and strategies listed under the Strategic Goals and Objectives in this document provide additional descriptions of how the Department collaborates with governmental and nongovernmental groups.

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Content created by Assistant Secretary for Planning and Evaluation (ASPE)

Content last reviewed on February 28, 2018

EXHIBIT 2

When Health Care Isn't Caring

Lambda Legal's Survey on Discrimination Against
LGBT People and People Living with HIV

Lambda Legal
making the case for equality

TABLE OF CONTENTS

Lambda Legal is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those with HIV through impact litigation, education and public policy work.

This project was directed by Lambda Legal's Director of Community Education and Advocacy Beverly Tillery

Research design and data analysis by Somjen Frazer Consulting (www.somjenfrazer.com)

Additional drafting by Rhea Hirshman

For more information on the National Health Care Fairness Survey and to view the original survey, visit www.lambdalegal.org/health-care-fairness.

When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV (New York: Lambda Legal, 2010). Available at www.lambdalegal.org/health-care-report

EXECUTIVE SUMMARY

Many of us are vulnerable when we are ill or seeking health care services. For lesbian, gay, bisexual and transgender (LGBT) people and those living with HIV, that vulnerability is often exacerbated by disrespectful attitudes, discriminatory treatment, inflexible or prejudicial policies and even refusals of essential care. These barriers, in turn, can result in poorer health outcomes and often have serious and even catastrophic consequences.

This survey is the first to examine refusal of care and barriers to health care among LGBT and HIV communities on a national scale. We hope that these data will influence decisions being made about how health care is delivered in this country now and in the future.

In spring 2009, Lambda Legal and over 100 partner organizations distributed the survey to LGBT people and people living with HIV nationwide. The information in this report is gleaned from 4,916 respondents.

The respondents were not drawn from a random sample, but instead are people who chose to respond to the survey after it was promoted online and at events. The results are a rich and informative picture of the experiences of thousands of LGBT people and people living with HIV, but cannot be used to draw conclusions about the proportion of all LGBT people and people living with HIV who have had similar experiences. The data are powerful because they represent a diverse sampling of the LGBT and HIV communities with respect to sexual orientation, gender identity, HIV status, race and ethnicity, age and geography.

Discrimination and Barriers to Care

The results of this survey highlight enormous challenges that remain for LBGT communities and those living with HIV in accessing quality, non-discriminatory health care services. More than half of all respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive. **Almost 56 percent of lesbian, gay or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and nearly 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care.**

- **LGBT people and people living with HIV are too often denied the care they need because of their sexual orientation, gender identity and/or HIV status.** Almost 8 percent of LGB respondents reported that they had been denied needed health care outright. Over a quarter of all transgender and gender-nonconforming respondents (almost 27 percent) reported being denied care and 19 percent of respondents living with HIV also reported being denied care.

- **LGBT people and people living with HIV are frequently treated in a discriminatory manner while trying to obtain care, including providers using harsh language, refusing to touch patients and blaming them for their health status.**

  - Just over 10 percent of LGB respondents reported that health care professionals used harsh language toward them; 11 percent reported that health professionals refused to touch them or used excessive precautions; and more than 12 percent of LGB respondents reported being blamed for their health status.

  - Almost 36 percent of respondents living with HIV reported that health care professionals refused to touch them or used excessive precautions and nearly 26 percent were blamed for their own health status.

  - Nearly 21 percent of transgender and gender-nonconforming respondents reported being subjected to harsh or abusive language from a health care professional, and almost 8 percent

reported experiencing physically rough or abusive treatment from a health care professional. Over 20 percent of transgender and gender-nonconforming respondents reported being blamed for their own health conditions.

- **In almost every category measured in this survey, transgender and gender-nonconforming respondents reported experiencing the highest rates of discrimination and barriers to care.** Transgender and gender-nonconforming respondents reported facing barriers and discrimination as much as two to three times more frequently than lesbian, gay or bisexual respondents.

- **In nearly every category, a higher proportion of respondents who are people of color and/or low-income reported experiencing discriminatory and substandard care.** For example, close to 33 percent of low-income transgender and gender-nonconforming respondents reported being refused care because of their gender identity and almost a quarter of low-income respondents living with HIV reported being denied care.

- **Respondents reported a high degree of anticipation and belief that they would face discriminatory care and such concerns were a barrier to seeking care.** Overall, 9 percent of LGB respondents are concerned about being refused medical services when they need them, and 20 percent of respondents living with HIV and over half of transgender and gender-nonconforming respondents share this same concern.

Survey respondents were somewhat more privileged than the LGBT population as a whole, with higher proportions having obtained advanced degrees, reporting higher household incomes and having better health insurance coverage. **Since these factors tend to improve access to care, this report likely *understates* the barriers to health care experienced by all LGBT people and those living with HIV.**

Key Recommendations

Health care institutions should:

- Establish nondiscrimination, fair visitation and other policies that prohibit bias and discrimination based on sexual orientation, gender identity and expression and HIV status, recognize families of LGBT people and their wishes and provide a process for reporting and redressing discrimination if it occurs.

- Develop and implement goals and plans to ensure that LGBT people and people living with HIV are treated fairly.

- Require health profession students and health professionals to undergo significant cultural competency training about sexual orientation, gender identity and expression and HIV status.

- Include training about the specific ways LGBT people and people living with HIV who are also people of color, low-income, seniors or members of other underserved populations may experience discrimination in health care settings and establish policies to prevent them.

- Advocate for laws and accreditation standards that require all providers to deliver to LGBT people and people living with HIV the same level of high-quality care afforded others.

Our federal, state and local governments should:

- Include coverage of LGBT people and those living with HIV in all antidiscrimination and equal opportunity mandates.

- Require all health care facilities and education programs that receive government funding to develop and implement goals, policies and plans to ensure that LGBT people and people living with HIV are treated fairly and provide ongoing cultural competency training for all health care profession students and staff.

- Change laws to require recognition of the families of LGBT people, including those who live within less common family structures, and require health care providers to do the same.

- Eliminate overly broad religious exemptions that purport to exempt medical care from nondiscrimination laws.

- Prohibit discriminatory practices by insurance providers that deny or limit coverage for needed care by LGBT people and people living with HIV.

- Ensure that government-funded health research and surveys include sexual orientation and gender identity issues and demographic analysis so that more can be known about the health care discrimination experienced by our communities as well as about our communities' health care needs.

Individuals and organizations should:

- Educate themselves, each other and, when possible, health care providers about the rights and needs of LGBT patients and those living with HIV.

- Advocate for improved laws and policies.

- Use existing mechanisms that are appropriate — such as medical powers of attorney and other legal documents as well as formal legal relationships where that is a couple's choice — to create as much protection as possible for themselves and their loved ones.

- Fight back when discrimination occurs, including reporting discriminatory practices, sharing stories and contacting Lambda Legal and other advocacy organizations and/or attorneys.

About Lambda Legal and the Study

Lambda Legal is the oldest and largest national legal organization committed to achieving the full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those living with HIV. This survey was designed as part of Lambda Legal's national Health Care Fairness Campaign launched in 2009. The goals of the campaign are to bring together advocates, partners and consumers to educate policy-makers, health care providers and the general public about the need for health care fairness and to advocate for reforms that address the issues of greatest concern to LGBT people and people living with HIV. Chronicling the types and prevalence of barriers to care faced by the range of groups in our communities is a vital part of helping to address and eliminate them.

For more information about Lambda Legal, visit www.lambdalegal.org

HEALTH CARE FAIRNESS:
A PERSONAL ISSUE, A NATIONAL CAMPAIGN

Lambda Legal has been advocating for health care fairness through impact litigation, education and public policy work to make sure that LGBT people and those living with HIV have full and equal access to all medically appropriate health care without discrimination based on sexual orientation, gender identity or expression, HIV or family status. Some of the key components of health care fairness we have outlined include:

- privacy and confidentiality for all, including LGBT people and those living with HIV;
- recognition and respect for all families including same-sex couples and their children;
- equal access to affordable health care insurance for same-sex spouses, partners and their children, and elimination of discriminatory insurance policy exclusions for transgender care, reproductive health care or care based on HIV status;
- fair and comprehensive health care services for LGBT youth and adults in custody as well as those living with HIV;
- informed consent for HIV testing;
- protection of the rights of LGBT patients and those living with HIV to seek and obtain all medically appropriate care without restrictions based on the personal or religious views of providers;
- equal access to mental health and substance abuse treatment and services for LGBT people and people with living with HIV; and
- fair and compassionate services for LGBT seniors and older people living with HIV.

Because issues of health care access and fairness are so critical to the well-being of the LGBT and HIV communities, Lambda Legal made health care fairness one of our ten priority issue areas and in 2009 we chose to highlight these issues with a national **Health Care Fairness Campaign.** The goals of the campaign are to bring together advocates, partners and consumers to educate policy-makers, health care providers and the general public about the need for health care fairness and to advocate for reforms that address the issues of greatest concern to LGBT people and people living with HIV.

Why This Survey?

Anecdotal evidence suggests that LGBT individuals and people living with HIV in the United States — from all backgrounds — have less access to health care and face greater obstacles to navigating health care systems than do heterosexual people. For over three decades, Lambda Legal has been at the forefront of establishing recognition of the legal rights of LGBT people and people living with HIV. The organization's impact litigation cases present examples of the kinds of challenges many LGBT people and people living with HIV experience while trying to receive needed health care services every day. Our Legal Help Desk also consistently receives calls from LGBT people and people living with HIV with questions and concerns about how they have been treated by health care and health insurance providers.

Although there have been studies finding health disparities by sexual orientation in cancer screening, mental illness, substance abuse, smoking and some other commonly measured health status indicators, there are very few, if any, survey reports about the types of health care-related discrimination LGBT people and those living with HIV face, how common such experiences are and what impact this discrimination has on their care. Designed as part of Lambda Legal's national Health Care Fairness Campaign, this survey is the first to examine experiences with refusal of care and barriers to health care access among LGBT and HIV communities on a national scale.

With the nation in the midst of a vigorous debate about reforming the way health care is delivered, we at Lambda Legal and our partners want to ensure that the needs of LGBT people and those living with HIV are an integral part of the discussion. Chronicling the barriers to care faced by the range of groups in our communities and the scope of these problems is a vital part of helping to address these needs. We hope that these data will influence decisions being made now and in the future.

WHAT WE FOUND:
WHEN HEALTH CARE ISN'T CARING

Enormous challenges remain for lesbian, gay, bisexual and transgender (LGBT) communities and people living with HIV. Experiences of bias and outright hostility remain common in all areas of our lives. When those experiences occur in the context of obtaining health care, they are not only deeply distressing but potentially life-threatening.

The essential bond of trust between clinician and patient that many in the United States take for granted is not a given for LGBT people or people living with HIV. Whether because of prejudices, ignorance, outdated systems or short-sighted policies, many people across our communities are not receiving the health care they need.

The tables on the following pages, which present data from our health care fairness survey, illustrate this problem from two perspectives. Tables 1 to 5 show **patterns of discrimination and substandard care** experienced in specific interactions with medical providers. Table 6 deals with personal fears and alienation from the health care system. Such prevalent fears and alienation are **barriers to care.**

Discrimination and Substandard Care

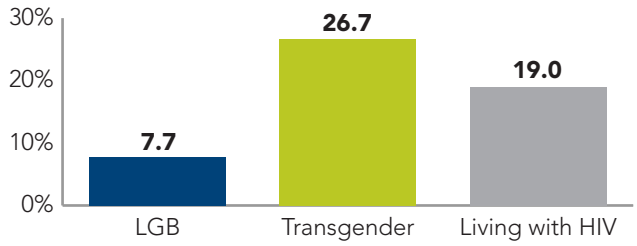
The responses we received are disturbing and require action. Respondents were asked to report whether they believed they received discriminatory care because of their sexual orientation, gender identity or HIV status. All the data reported below represent experiences that respondents felt were motivated by prejudice against lesbian, gay, bisexual, transgender people or people living with HIV. (Please note that the "transgender" category in the following charts includes both transgender and gender-nonconforming respondents because of the high visibility that puts both groups at a high risk for discrimination based on gender identity.)

More than half of all respondents reported that they have experienced at least one of the following types of

In 2008, Janice Langbehn (second from left) and Lisa Pond were about to depart from Miami on a family cruise with their three children. Pond suddenly collapsed and was rushed to Jackson Memorial Hospital. Janice was informed that she was in an antigay city and state, and she could expect to receive no information or acknowledgment as Lisa's partner or family. Hospital personnel would not allow Janice or their children to see Lisa until nearly eight hours after their arrival as Lisa slipped into a coma, even though Lisa's sister was allowed to visit as soon as she arrived. The next day, Lisa died. In 2008, Lambda Legal filed a lawsuit on behalf of the family. The court dismissed the case, agreeing with Jackson Memorial that the hospital has no obligation to allow their patients' visitors in their trauma unit. Lambda Legal and our partners continue to fight for fair visitation policies.

Langbehn v. Jackson Memorial Hospital

Table 1: I was refused needed health care



Guadalupe "Lupita" Benitez (left) was denied infertility treatment by the North Coast Women's Care Medical Group because she is a lesbian. Her former doctors are conservative Christians who claimed their religious beliefs gave them a right to withhold care from Benitez that they routinely provide to heterosexual patients. In 2001, Lambda Legal filed a lawsuit on behalf of Benitez fighting for the basic right of LGBT people to receive equal access to treatment from health care providers and tackling the issue of religiously motivated discrimination. In 2008, the California Supreme Court unanimously ruled in favor of Benitez, making clear that California's state law prohibiting discrimination must be followed.

Benitez v. North Coast Women's Care Medical Group

discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive. **Almost 56 percent of lesbian, gay or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and almost 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care.**

Almost 8 percent of LGB respondents reported that they had been denied needed health care because of their sexual orientation. Over a quarter of all transgender respondents (nearly 27 percent) reported being denied care and 19 percent of respondents living with HIV also reported being denied care because of their transgender or HIV status, respectively.

Many of our survey respondents also reported that they have been treated in a discriminatory manner while trying to receive care. Nearly 11 percent of LGB respondents have interacted with health care professionals who have used harsh language. That same percentage have encountered health care professionals who refused to touch them or used excessive precautions. More than 12 percent of LGB respondents were blamed for their health status.

Our survey showed that persons living with HIV are still facing ignorance, lack of respect and overt discrimination when accessing health care, with 19 percent of respondents reporting being refused needed health care. **Respondents living with HIV were most likely to report that health care professionals refused to touch them or used excessive precautions (nearly 36 percent) and blamed them for their own health status (nearly 26 percent).** And over 4 percent of respondents living with HIV reported being treated in a physically rough or abusive manner by health care providers.

The picture is even more disturbing for transgender and gender-nonconforming respondents, who experienced

Table 2: Health care professionals refused to touch me or used excessive precautions

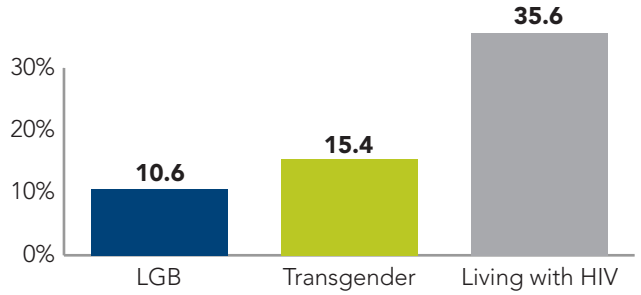


Table 4: Health care professionals blamed me for my health status

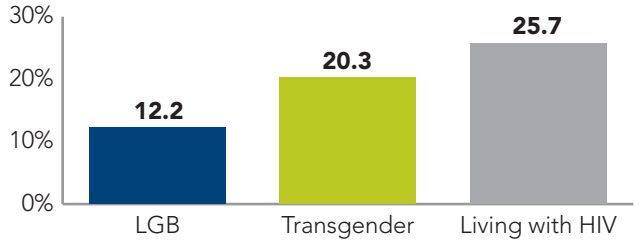


Table 3: Health care professionals used harsh or abusive language

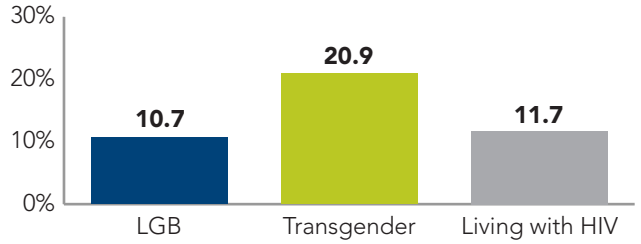
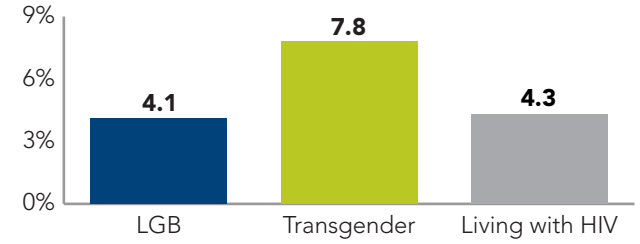


Table 5: Health care professionals were physically rough or abusive



the highest rates of being refused care (nearly 27 percent), being subjected to harsh language (nearly 21 percent) and experiencing physically rough or abusive treatment (nearly 8 percent). Over 20 percent of transgender and gender-nonconforming respondents reported being blamed for their own health problems and illnesses.

In addition to the overall rates of substandard care, respondents of color and low-income respondents (defined in this survey as having a household income under $20,000) in nearly every category experienced higher rates of discrimination and substandard care. For example, while transgender respondents as a whole reported a care-refusal rate of almost 27 percent, low-income transgender respondents reported a rate of almost 33 percent. Over a quarter of low-income respondents living with HIV were refused care compared to 19 percent of respondents living with HIV overall. Almost 11 percent of low-income LGB respondents and LGB respondents of color were refused care compared to almost 8 percent of LGB people overall.

Nearly half of low-income respondents living with HIV reported that medical personnel refused to touch them while the overall rate among those with living with HIV was nearly 36 percent. Over 35 percent of low-income respondents living with HIV were blamed for their health status, in contrast to about a quarter of those living with HIV overall.

Low-income respondents and respondents of color often reported harsh language by medical providers. Almost 17 percent of low-income LGB respondents and 14 percent of LGB respondents of color reported experiencing harsh language compared to almost 11 percent of LGB respondents overall. Over a quarter of transgender respondents of color and 28 percent of low-income

transgender respondents reported harsh language compared to 21 percent of transgender respondents overall. And nearly 13 percent of respondents of color living with HIV and 19 percent of low-income respondents living with HIV experienced harsh language compared to almost 12 percent of respondents living with HIV overall.

People of color living with HIV and LBG people of color were at least twice as likely as whites to report experiencing physically rough or abusive treatment by medical professionals. Of the LGB respondents, 3 percent of whites and almost 7 percent of people of color reported experiencing such treatment; among those living with HIV, the figures were just over 3 percent for whites and nearly 8 percent for people of color.

Barriers to Care

In addition to asking about specific encounters with health care providers and systems, the Lambda Legal health care fairness survey also asked respondents about their fears and concerns about obtaining health care. Personal beliefs and perceptions about whether one can access quality health care have been shown to strongly affect whether and how individuals seek medical care and interact with medical professionals. Past experiences of bias, humiliation, harsh treatment and isolation as well as perceived bias by health care providers can cause LGBT people and people living with HIV to become alienated from the health care system and even reluctant to seek care. Such reluctance can in turn result in poorer health outcomes because of delays in diagnosis, treatment or preventive measures.

Overall bias and stigma in our society — conveyed through negative family, community, institutional and cultural messages about our lives, combined with discriminatory policies and practices — can result in unwillingness for LGBT people and people living with HIV to disclose to clinicians personal information that can be essential to proper diagnosis and/or treatment. At times, disclosure can be a catch-22 — that is, lack of disclosure about one's sexual orientation or gender identity can lead to inadequate care, while disclosure can make LGBT people more vulnerable to discrimination and denial of care. For transgender individuals, disclosing one's gender identity may result in discriminatory practices by insurance companies who refuse to cover necessary cross-gender health care, such as pap smears for transgender men or prostate screenings for transgender women.

Table 6: Fears and concerns about accessing health care

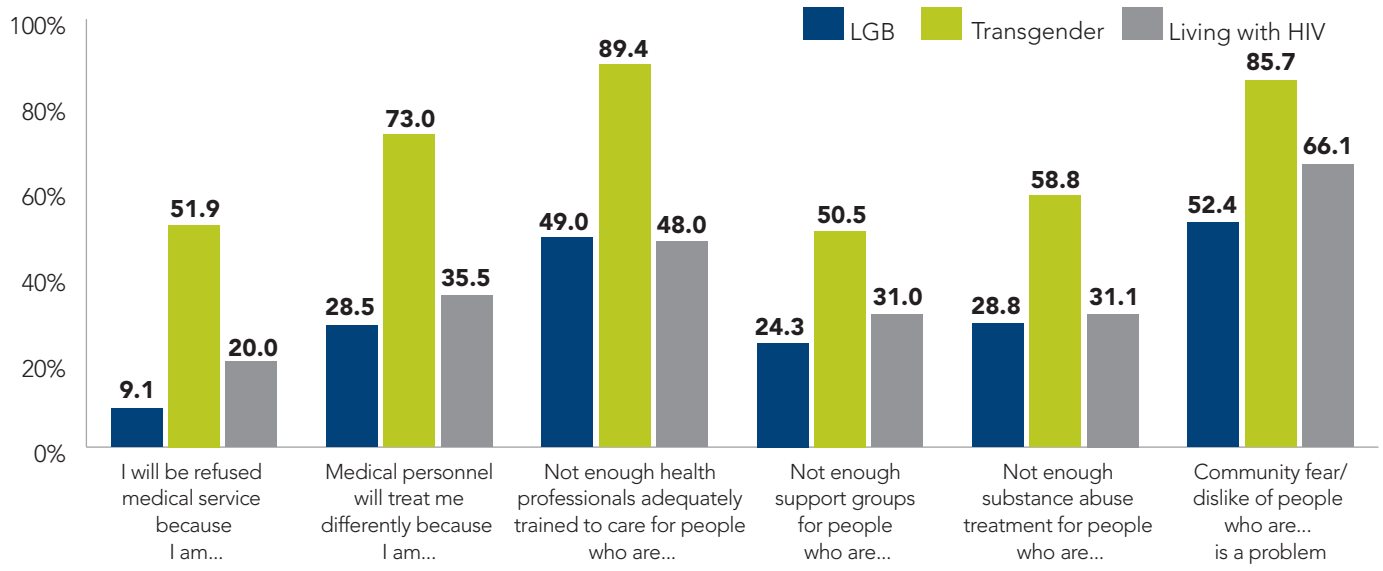


Table 6 shows the depth of the need for greater cultural competency throughout our health care systems to reduce serious barriers to care.

Survey respondents were asked to rate how much various factors make it hard for them to receive the care they need. Percentages reflect how many respondents designated each factor as "somewhat of a problem" or a "major problem" and indicate alarming amounts of perceived bias and barriers to care for LGB people and even greater alienation for people living with HIV and transgender people. (Please note: Only the responses from members of each group were counted in these statistics. For instance, the transgender group only includes responses from people who are transgender and gender non-conforming.)

Overall, nine percent of LGB respondents are concerned about being refused medical services when they need them. Over half of transgender respondents and 20 percent of respondents living with HIV share this concern. When asked about more specific concerns, the reports of perceived bias are even more disturbing. **For instance, nearly half of LGB respondents and respondents living with HIV and almost 90 percent of transgender respondents believe there are not enough medical personnel who are properly trained to care for them.** Mental health issues were also of particular concern to LGB people, transgender people and those living with HIV, with almost 28 percent of the respondents concerned that not enough mental health professionals are available to help them. **Over half of LGB respondents, two-thirds of respondents living with HIV and almost 86 percent of transgender respondents indicated that overall community fear or dislike of people like them is a barrier to care.**

In this survey, we also examined barriers to care based on gender expression. Regardless of their sexual orientation or gender identity, people who are gender-nonconforming— men who appear more feminine, women who appear more masculine and people who have a more androgynous appearance — often face bias, harassment and discrimination in our society. In fact, one of the common ways many LGBT people experience discrimination in our society is based on their gender expression. This was a particular concern for the people who answered our survey. **Thirty percent of all respondents stated that they fear medical personnel will treat them differently based on their gender expression and presentation.**

I called a gynecologist's office tying to schedule a hysterectomy. I told the receptionist that I was a transgender male. Two days later, I received a phone call telling me that the doctor did not take cases like mine and referring me to a hospital. I remember feeling like a freak. I called the second number. The receptionist told me they didn't deal with transgender men either. After I got over the hurt, I called another doctor's office. The receptionist told me that their office welcomed transgender clients. I told the doctor that I wanted a full hysterectomy. She performed an exam, Pap smear and ultrasound. She told me that the results showed that I was fine. I asked her again about the hysterectomy, this time telling her I would pay for it out of pocket. She continued to say that it would be unethical because there was nothing wrong with me. She was hiding her transphobia behind a bogus argument and dismissing a very real medical need. I told her that there *was* something wrong: "I am a man with a uterus. I need to have all female reproductive parts removed. I AM A MAN!" She refused. I left her office feeling like a freak again, vulnerable and depressed.

Tony Ferraiolo/ New Haven, CT

THE PATH TO HEALTH CARE FAIRNESS:
RECOMMENDATIONS FOR PROVIDERS, POLICY-MAKERS AND COMMUNITY MEMBERS

The findings in this survey raise serious concerns about the state of health care for the lesbian, gay, bisexual and transgender (LGBT) and HIV communities that must be addressed. Remedying the problems outlined in this report requires systemic change: an integrated combination of enforcement of legal protections that already exist, progressive legislation, thoughtful policy-making and ongoing education and training, all carried out with opportunities for community input.

The Critical Role of Cultural Competency

Increasing cultural competency should be one of the main methods for health care providers to address the discrimination experienced by LGBT people and people living with HIV and to close the gap in access to health care. Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of health care, thereby producing better health outcomes.[1] According to the U.S. Department of Health and Human Services' Office of Minority Health, "It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it."[2]

Policies about discrimination, visitation, patients' rights, employment and other matters should clearly communicate that bias and discrimination of LGBT people and people living with HIV will not be tolerated. Policies should also outline a grievance process and provide access to redress if the policies are violated. Health care providers should also recognize and honor the wishes of the families of LGBT people. Even though our survey did not ask about discriminatory behavior and attitudes towards the families of LGBT people (questions were about individual interactions with health care systems and providers), such attitudes contribute significantly to creating an unwelcoming environment for all LGBT people.

Institutions should also clearly inform patients of their policies and practices and regularly solicit input from the LGBT and HIV communities.

Education is another important component to cultural competency. Institutions should provide initial training as a part of orientation for new staff and require ongoing education for all staff. The optimal provision of health care and prevention services to sexual and gender minorities requires providers to be sensitive to historical stigmatization, to be informed about continued barriers to care and to become aware of the cultural aspects of their interactions with LGBT patients.[3]

Forms, questionnaires and other written materials should be sensitive to and inclusive of LGBT people and their families and communicate the institution's commitment to providing an environment that meets the needs of all patients including LGBT people and people living with HIV. Where appropriate, institutions should also provide and advertise LGBT and HIV-specific services and specialized care such as support groups or HIV prevention programs.

When fully implemented, cultural competency can reduce the systemic health care discrimination experienced by LGBT people and people living with HIV. The Mautner Project, a national lesbian health organization, has a training curriculum, "Removing the Barriers: Providing Culturally Competent Care to Lesbians and Women Who Partner with Women," that explains the benefits of culturally competent care as including: increased access to

1 In Diane L. Adams, ed., *Health Issues for Women of Color: A Cultural Diversity Perspective* (Thousand Oaks, CA: Sage, 1995).

2 U.S. Department of Health and Human Services, Office of Minority Health, "What is Cultural Competency," http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11 (accessed January 10, 2010).

3 K. H. Mayer, J.B. Bradford, H. J. Makadon, R. Stall, H. Goldhammer, and S. Landers, "Sexual and Gender Minority Health: What We Know and What Needs to be Done," *American Journal of Public Health,* 98, no. 6 (2008): 989-995.

services; improved prevention and early intervention; more accurate diagnoses; improved treatment adherence and compliance and increased patient retention.

By focusing on cultural competence for all LGBT people and people with HIV, providers, policy-makers and members of the community can begin taking steps to address substandard and discriminatory care as well as additional barriers that prevent LGBT people and people living with HIV from obtaining quality health care.

Our Recommendations

Health care institutions and providers should:

- **Establish nondiscrimination, fair visitation and other policies that:**
  - prohibit bias and discrimination based on sexual orientation, gender identity and expression and HIV status including refusal of care, disrespectful or abusive treatment, the use of excessive precautions and blaming patients for their health conditions;
  - convey a commitment to equally serve and provide culturally competent care to LGBT and HIV communities;
  - recognize families of LGBT people and their wishes; and
  - provide a process for reporting and redressing discrimination if it occurs.
- **Develop and implement goals and plans to ensure that LGBT people and people living with HIV are treated fairly, including strategies to maintain diverse staff, complete an initial assessment of services for LGBT patients, collaborate with LGBT and HIV community partners and implement culturally sensitive grievance procedures.**
- **Require health profession students and health professionals to undergo significant cultural competency training about sexual orientation, gender identity and expression and HIV status so they will be able to provide respectful and nondiscriminatory care to LGBT people and people living with HIV.**

  Cultural competency needs to be implemented at both an institutional and individual level. Unfortunately, many professional schools and continuing education programs do not provide the training needed to teach culturally competent care for LGBT people and those living with HIV.[4] Ensuring that all medical, nursing, dental and other health profession students are trained in these issues as a mandatory part of the curriculum will increase the likelihood that they will have a basic understanding of the needs of the LGBT and HIV communities. Making cultural competency a key part of ongoing staff training and continuing education programs is equally important for ensuring that the inclusive policies of institutions are carried out consistently and uniformly.
- **Include training about gender identity and expression to ensure that the unique needs of transgender and gender-nonconforming people are addressed.**

  In almost every category measured in this survey, proportionately more transgender respondents reported discrimination in care and barriers to care. Providers need to take particular care to address the issues of transgender and gender-nonconforming people.
- **Include training about the specific ways LGBT people and people living with HIV who are also people of color, low-income, seniors or members of other underserved populations may experience discrimination in health care settings and establish policies to prevent discrimination.**

  Providers must address the discrimination experienced by low-income people and people of color and ensure that care is delivered in a culturally competent way to people who are part of more than one marginalized community. (For more discussion about the impact of health care discrimination on low-income people and people of color and the intersectionality of multiple

4 Ibid., 989-995.

forms of oppression, see Lambda Legal's supplemental health care fairness survey fact sheets.)

- **Advocate for laws and accreditation standards that require all providers to deliver to LGBT people and people living with HIV the same level of high-quality care afforded others.** Laws and standards that mandate LGBT and HIV-inclusive practices are needed so that all providers will offer the same level of care.

Federal, state and local governments should:

- **Include coverage of LGBT people and those living with HIV in all antidiscrimination and equal opportunity mandates including laws related to employment discrimination, access to public accommodations, harassment and freedom of expression.**
- **Require all health care facilities and educational programs that receive government funding to develop and implement goals, policies and plans to ensure that LGBT people and people living with HIV are treated fairly and require that they provide ongoing cultural competence training for all health care profession students and staff.**
- **Change laws to require recognition of the families of LGBT people, including those who live within less common family structures, and require health care providers to do the same.**
- **Eliminate overly broad religious exemptions that purport to exempt medical care from nondiscrimination laws.**

  Although questions about religion were not part of the survey, we know that, in an increasingly worrisome trend, some health care providers have claimed that their religious beliefs or affiliations allow them to deny providing the same care to LGBT individuals that they routinely offer to others. Providers should not be allowed to use their religious views or affiliations to circumvent antidiscrimination laws, medical ethics rules and professional standards of care.
- **Prohibit discriminatory practices by insurance providers that deny or limit coverage for needed care by LGBT people and people living with HIV, such as basic and/or gender transition care for transgender individuals or reproductive health care for LGBT people.**
- **Ensure that government-funded health research and surveys include sexual orientation and gender identity issues and demographic analysis so that more can be known about the health care discrimination experienced by our communities as well as about our communities' health care needs.**

Individuals and organizations should:

- **Educate themselves and each other about LGBT rights, and when possible, educate health care providers about the needs of LGBT patients and those living with HIV.**
- **Advocate for improved laws and policies.**
- **Report unfriendly and discriminatory practices and share referrals to friendly providers and institutions.**
- **Share stories of health care discrimination with organizations like Lambda Legal, as well as with policy-makers, friends, relatives and trusted co-workers.**
- **Create as much protection as possible for themselves and their loved ones using appropriate, existing mechanisms such as advance directives, medical powers of attorney and other legal documents as well as formal legal relationships such as domestic partnerships, civil unions and marriage, where that is a couple's choice.**
- **Fight back when discrimination occurs and contact Lambda Legal, other legal and advocacy organizations or a local attorney.**
- **Continue to fight attempts to roll back LGBT rights.**

METHODOLOGY:
HOW WE CONDUCTED THE SURVEY

In the spring and summer of 2009, Lambda Legal invited lesbian, gay, bisexual and transgender (LGBT), HIV and other partner organizations to join the national Health Care Fairness Campaign, asking them to promote the health care fairness survey and encouraging their participation in other aspects of this initiative. With the help of over 100 such organizations located in 35 states, the survey was distributed to LGBT people and people living with HIV nationwide. Participants included 25 national organizations and 75 local, state and regional organizations. Thirteen groups were specifically people of color organizations and 12 specifically focused on people living with HIV. Groups promoted the survey in various ways, including email requests to members and supporters; posting survey links on their websites and their social networking sites and distributing and collecting paper surveys where feasible.

Lambda Legal sent survey announcements and reminders to our email list, featured the survey on our web page and publicized the survey in Lambda Legal's *Impact* magazine and monthly eNews. Ads were placed on various LGBT blogs, web sites and in a few LGBT newspapers, and the survey was promoted on Facebook and Twitter. Wallet cards announcing the survey were distributed at 15 Pride festivals and several other LGBT events around the country. In a few cities, Lambda Legal staff and/or interns collected surveys at locations in the LGBT community. All survey promotional and informational materials were available in both English and Spanish, as was the survey itself. The survey was not based on a random sample, but used "convenience sampling" and "snowball sampling," which means that responses came from those who chose to take the survey and many learned about it through e-mails and blog posts.

A total of 5,941 people took the survey from June 10 to July 14, 2009. The information in this report is gleaned from the 4,916 surveys that remained after invalid surveys (postal codes outside the U.S., missing key demographic info, not LGBT or living with HIV) were excluded from the sample.

WHO RESPONDED

The tables below provide demographic information about the 4,916 individuals whose responses are reflected in this report. Because of the complexity of our communities, checking more than one category was an option for several of the demographic questions, so that some results add up to more than 100 percent.

Sexual Orientation

Slightly over half the respondents, or 2,727 people, identified as gay, with just fewer than 30 percent, or 1,453 people identifying as lesbian. The categories of queer (nearly 16 percent or 774 people) and same-gender loving (just over 5 percent or 261 people) include both women and men, as does the bisexual category (just over 11 percent percent or 542 people). A very small number of responses came from heterosexuals (just over 1 percent or 66 people), who are either living with HIV or transgender.

Gender Identity

Table 8 shows that almost 56 percent of all respondents identified as male and almost 38 percent of all respondents identified as female. These numbers include transgender and nontransgender respondents. Almost 53 percent (2,593 people) identified as non-transgender male and nearly 33 percent (1,614) as non-transgender female; 8 percent (397) as transgender (either transfeminine or transmasculine); just over 4 percent (220) as gender-nonconforming; and almost 2 percent (83) as two-spirit.

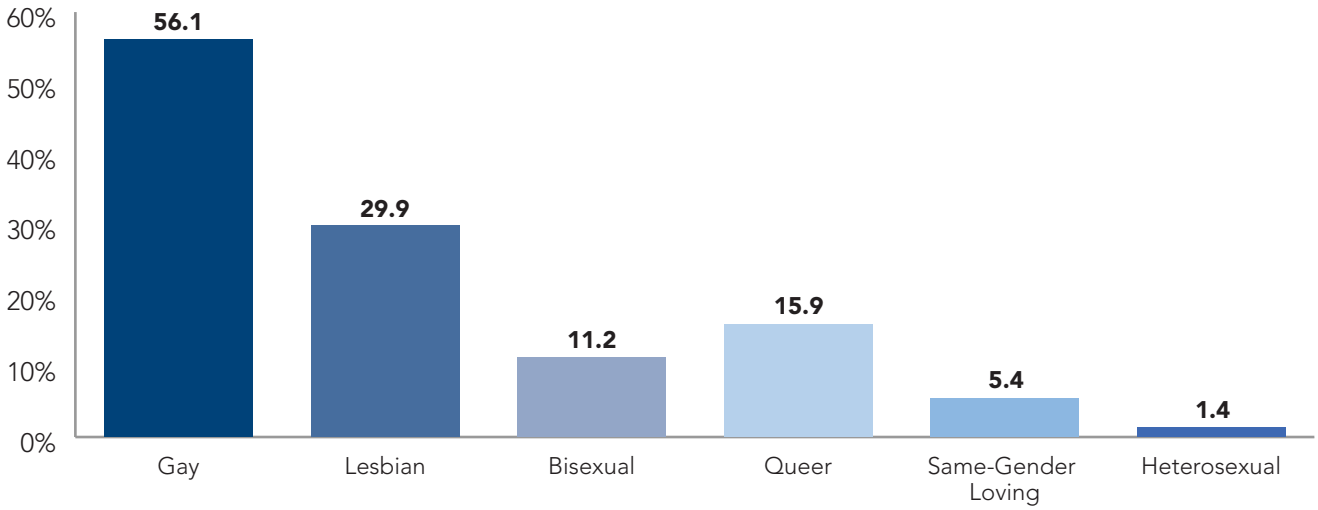
"Transgender" is an umbrella term that refers to people whose gender identity and/or gender expression differs from the sex they were assigned at birth. In general use, the term may include but is not limited to transsexuals, cross-dressers and other gender-variant people. In the related chart (Table 8), transgender respondents are listed as either "transmasculine" (individuals who were assigned the sex "female" at birth, but whose gender identity is along the masculine spectrum of gender) or "transfeminine" (individuals who were assigned the sex "male" at birth, but whose gender identity is along the feminine spectrum of gender). "Gender-nonconforming" (GNC) refers to individuals whose external manifestation of their gender identity does not conform to society's expectations of gender roles. A gender-nonconforming person may or may not identify as transgender, gay, lesbian or bisexual but may identify as gender-free, androgynous or moving back and forth between gender identities. The term "two-spirit" is a culturally specific category related to traditions among Native Americans/American Indians.

Race and Ethnicity

Eighty-six percent of all respondents or 4,241 people identified as White and slightly over 18 percent or 892 people identified as people of color – meaning that they selected a racial/ethnic category other than or in addition to White. These numbers add up to more than 100 percent because some of the multiracial people selected white and another race or ethnicity.

Table 9 displays the racial and ethnic distribution of the people of color who completed the survey. Of the total survey respondents, almost 8 percent or 373 people were Latina/o; close to 5 percent or 231 people were Black; almost 4 percent or 176 people were American Indian; 3 percent or 153 people were Asian; and 1 percent or 48 people were Middle Eastern. Again, the numbers add up to more than 100 percent because respondents could choose more than one category. Almost 6 percent of all survey respondents, or 285 people, identified as multiracial. While Asians and American Indians who responded to the survey were proportionately represented compared to the overall population in the United States, Blacks, Latina/os and Middle Eastern respondents were underrepresented compared to their representation in the U.S. population as a whole. This underrepresentation indicates an ongoing need for more consistent and better-targeted outreach to communities of color.

Table 7: Sexual orientation



Totals more than 100% because respondents could select more than one category.

Table 8: Current gender identity

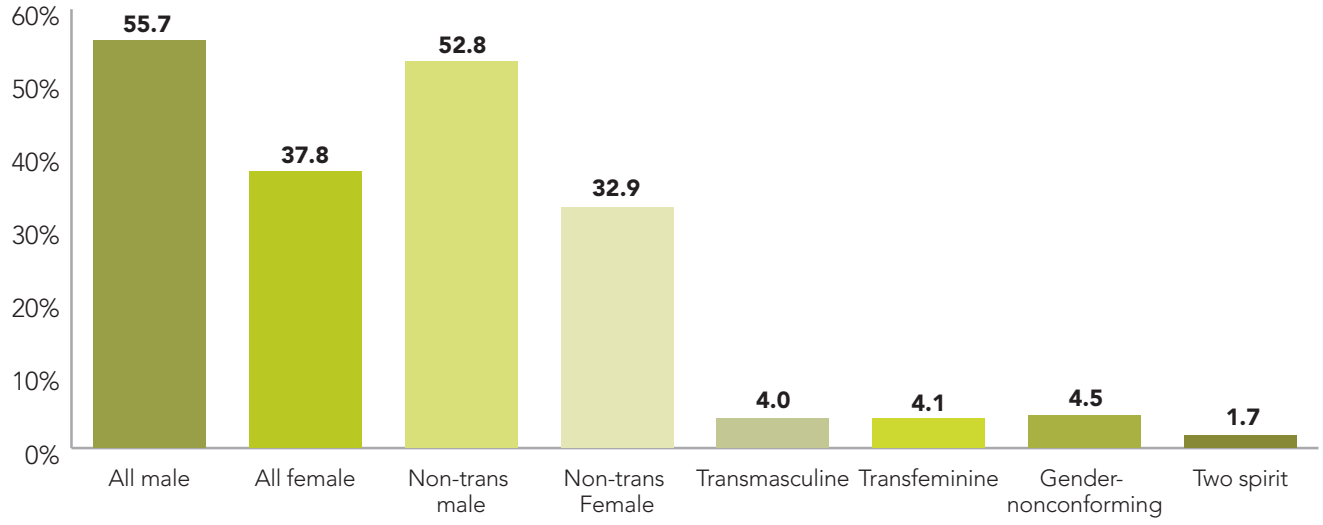
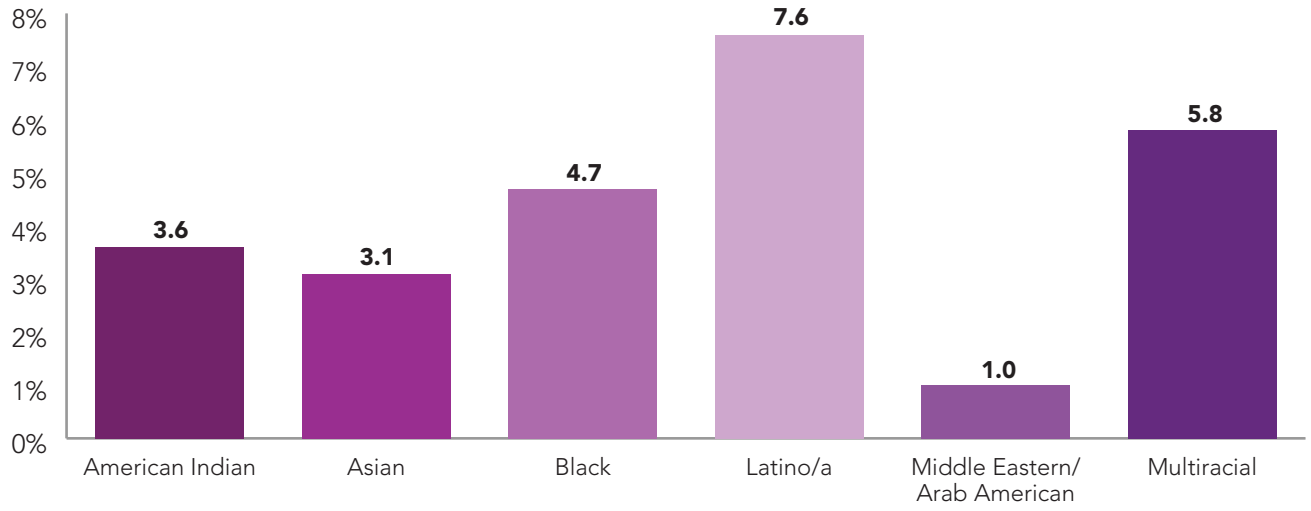


Table 9: Race and ethnicity of people of color respondents



Other Demographics

All age groups are represented in the survey with responses somewhat skewed towards the 25-44 age group.

The survey generally achieved geographic distribution, with respondents from all fifty states and Washington, DC, although California provided a disproportionate number of respondents (nearly 21 percent or 985 people).

Individuals living with HIV were over 13 percent of the sample, or 662 people.

An important fact to note is that survey respondents were somewhat more privileged than the LGBT population as a whole, with higher proportions having obtained college, graduate and professional degrees; reporting higher household incomes and having better health insurance coverage. According to a groundbreaking study by the Williams Institute of the University of California School of Law, the stereotype of LGBT people as an affluent elite with high levels of education and income is debunked by more than a decade of research showing that LGBT people actually have lower incomes than comparable heterosexual individuals and households and that existing research strongly hints at a sizable presence of LGBT people among the low end of the income distribution in the United States.[5] A recent study conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force also found that transgender respondents experience poverty at a much higher rate than the general population, with more than 15 percent reporting incomes of $10,000 or lower, double the rate of the general population.[6]

Since people who are affluent, educated and insured are more likely to be well-served by health care systems, this report likely *understates* the barriers to health care experienced by LGBT people and those with living with HIV.

5 R. Albeda, M. V. L. Badgett, A. Schneebaum, and G. J. Gates, "Poverty in the Lesbian, Gay, Bisexual and Transgender Community," http://www.law.ucla.edu/WilliamsInstitute/pdf/LGBPovertyReport.pdf (accessed November 23, 2009).

6 National Center for Transgender Equality and National Gay and Lesbian Task Force, "National Transgender Discrimination Survey," http://www.thetaskforce.org/downloads/release_materials/tf_enda_fact_sheet.pdf (accessed December 28, 2009).

Table 10: Age

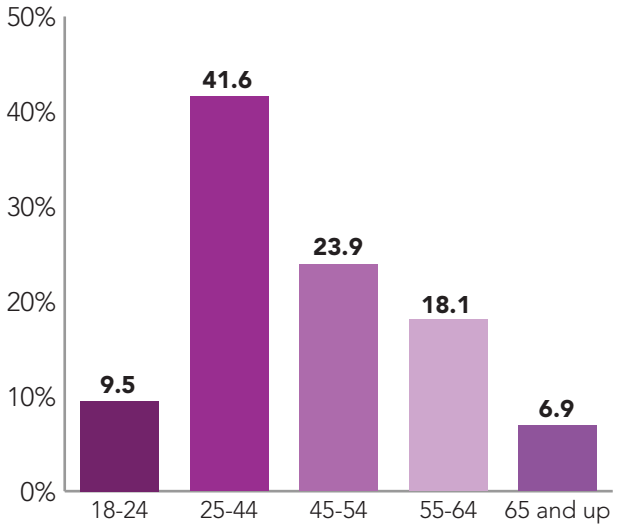


Table 11: HIV status

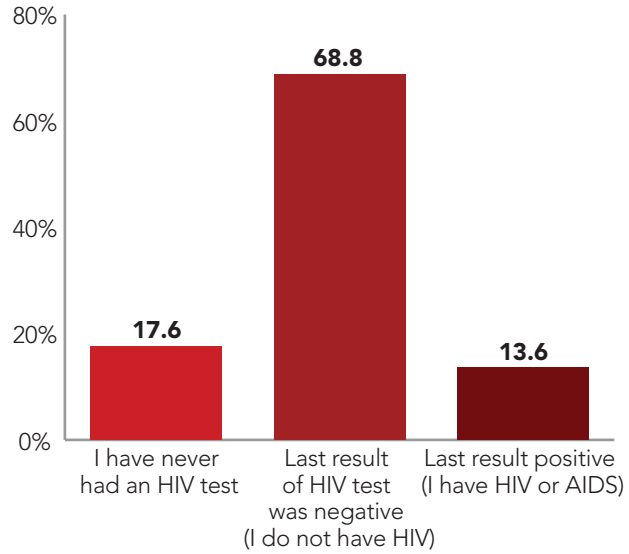


Table 12: Employment status

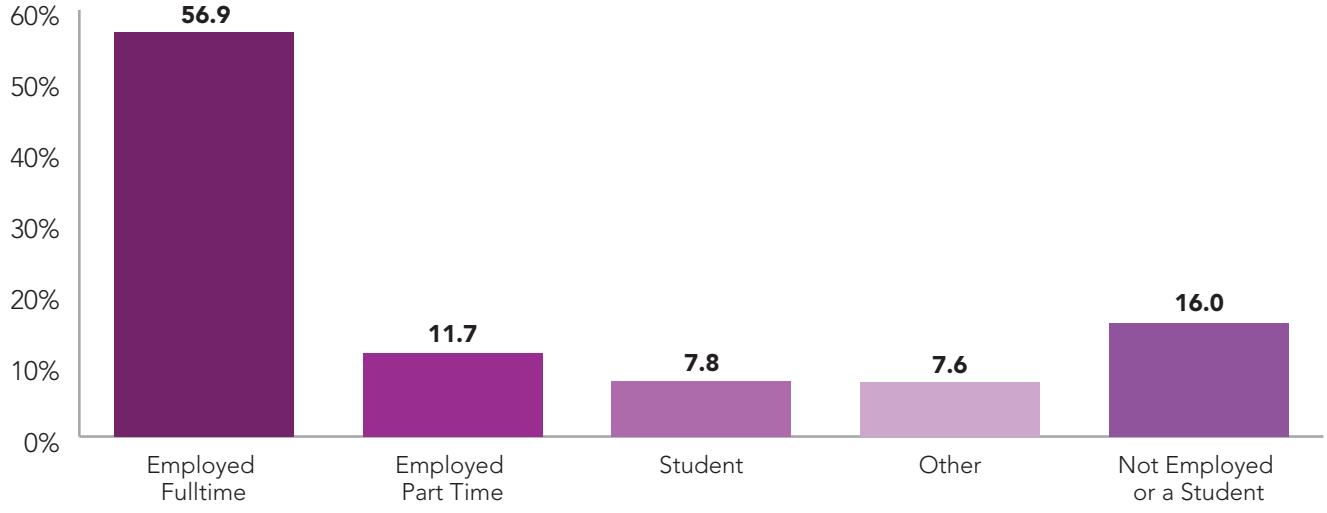


Table 13: Household income

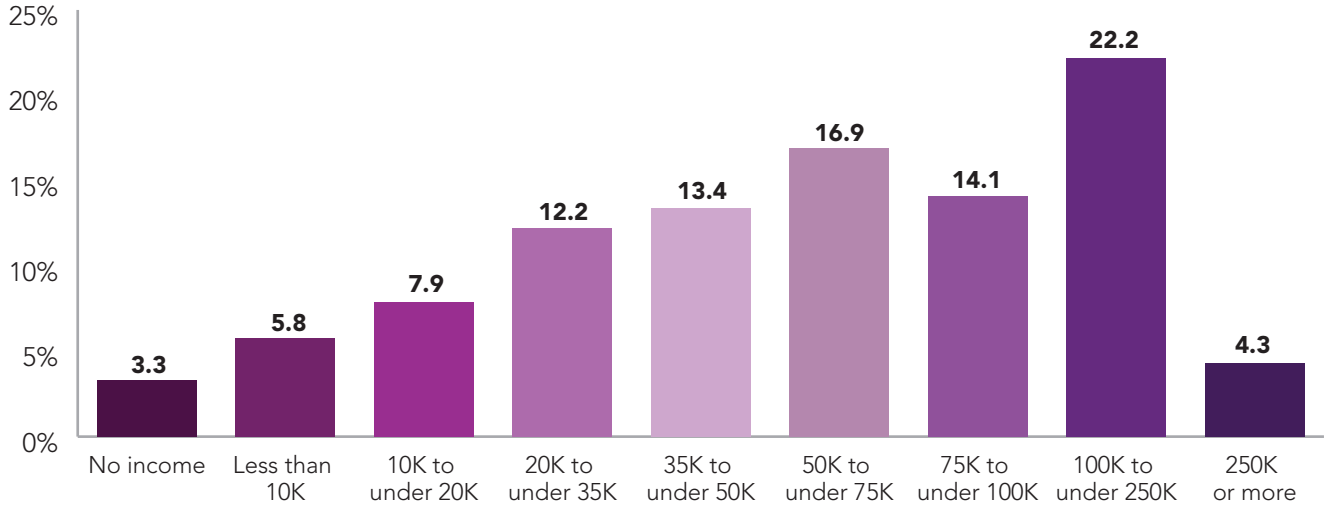
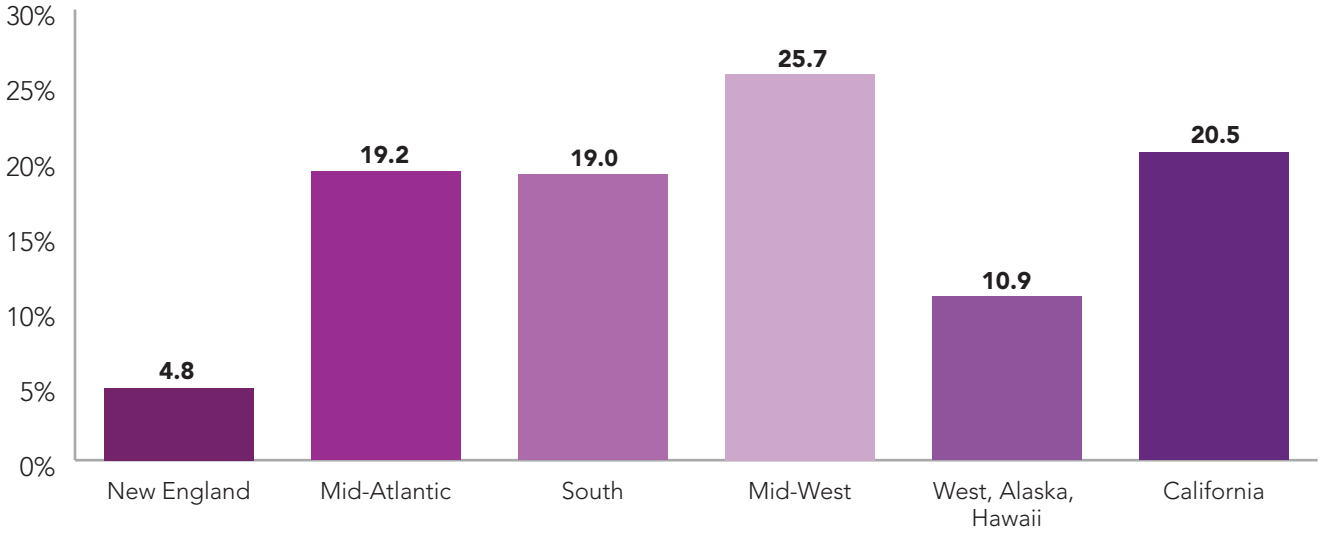


Table 14: Geographic distribution of responses



GLOSSARY:
EXPLANATION OF SURVEY TERMS

This section was created to enhance understanding of the terms in this report. However, it's important to remember that people defy labels. Identity is fluid and self-defined. Not everyone will fit into a definition, label or box, no matter how large we make it.

Advance directive, also known as a living will, is a legal document that gives instructions specifying what medical actions should be taken in the event that a person is no longer able to make decisions due to illness or incapacity.

AIDS or Acquired Immune Deficiency Syndrome is generally used to refer to the most advanced stages of HIV progression in which the human immune system becomes compromised, leaving the body susceptible to opportunistic infections it could otherwise defeat. There is some debate among medical professionals as to what actually constitutes a progression to AIDS and whether the term should continue to be used at all.

Bisexual people are attracted to and/or sexually active with people regardless of gender.

Convenience sampling is a technique for developing a research sample which involves drawing from that part of the population which is close to hand, readily available or convenient. This technique is different from random sampling.

Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings – in the context of this study, to increase the quality of health care, thereby producing better health outcomes.

Gay people are people who are romantically and/or sexually attracted to and/or sexually active with people of the same gender. "Gay" can refer either to women or men, but for the purposes of this report refers to men unless otherwise specified.

Gender expression refers to the way a person expresses gender through dress, grooming habits, choice of name and pronoun, mannerisms, activities, etc.

Gender identity is an individual's emotional and psychological sense of being male or female. Gender identity is not necessarily the same as an individual's biological identity. In this survey, when the terms "male" and "female" are used alone, they refer to people who do not have transgender and gender-nonconforming identities, while transgender and gender-nonconforming people are identified by their current gender and the terms "transgender" and/or "gender non-conforming."

Gender-nonconforming (GNC) refers to individuals whose external manifestation of their gender identity does not conform to society's expectations of gender roles. A gender-nonconforming person may or may not identify as transgender, gay, lesbian or bisexual.

HIV or human immunodeficiency virus (HIV) is a retrovirus that targets the human immune system. Progression of HIV infection can lead to a serious compromise of immune system function, leaving the body open to opportunistic infections against which it could normally defend.

HIV positive people are living with HIV, although they might not have AIDS.

Homophobia refers to hatred, fear of or discrimination against lesbian, gay or bisexual people based on their sexual orientation.

Lesbians are people who are romantically and/or sexually attracted to and/or sexually active with people of the same gender. "Lesbian" refers exclusively to women while "gay" can refer either to women or men.

LGBT stands for lesbian, gay, bisexual or transgender.

Low-income is defined for the purposes of this report as having an annual household income of less than $20,000.

Medical power of attorney is a legal document that gives someone the legal authority to act on an individual's behalf regarding health care decisions if they ever become incapacitated or unable to communicate.

People living with HIV includes all people who are infected with HIV, including people who have been diagnosed with AIDS and those who are HIV positive.

Queer is an identity used by people who reject conventional categories such as "LGBT" or embrace a political identity as 'queer' in addition to being LGB and/or T. It also may include heterosexuals who embrace a non-normative or counter-normative sexual identity.

Same-gender loving is a term most often used in communities of color to describe people with same-sex attractions since gay, homosexual, bisexual or lesbian can carry negative connotations to some people.

Sexual orientation generally refers to people's sexual behavior or attraction.

Snowball sampling is a technique for developing a research sample where existing study subjects recruit future subjects from among their acquaintances. Thus the sample group appears to grow like a rolling snowball. As the sample builds up, enough data is gathered to be useful for research. This sampling technique is often used in hidden populations which are difficult for researchers to access.

Transexual is an older term which originated in the medical and psychological communities. Many transgender people prefer the term "transgender" to "transexual." Some transexual people still prefer to use the term to describe themselves. However, unlike transgender, transexual is not an umbrella term, and many transgender people do not identify as transexual.

Transfeminine is a broad term used to describe individuals who were assigned the sex "male" at birth, but whose gender identity is along the feminine spectrum of gender. This can encompass those who have medically transitioned and those who have not, and may include (but is not limited to) those who identify as transwomen, MTF (male-to-female), transgender female, transexual female, genderqueer, etc.

Transgender is a word commonly used to describe people who live in a gender different from the one assigned to them at birth. People often use this word to describe not only people who have changed their gender through surgery or cross-gender hormone treatment, but also people who have non-medical gender transitions or identify as transgender but do not seek to change their gender legally or medically. For the purposes of this report, "transgender" categories include people who self-identified as transgender and those who indicated a current gender identity that is different from what they stated was the sex on their birth certificate.

Transmasculine is a broad term used to describe individuals who were assigned the sex "female" at birth, but whose gender identity is along the masculine spectrum of gender. This can encompass those who have medically transitioned and those who have not, and may include (but is not limited to) those who identify as transmen, FTM (female-to-male), transgender male, transexual male, genderqueer, etc.

Transphobia refers to hatred, fear of or discrimination against transgender people based on their gender identity or expression.

Two-spirit is a culturally-specific gender-nonconforming identity within the culture and heritage of American Indian/Native American.

OUR PARTNERS

We'd like to thank the following groups that have joined as partners in Lambda Legal's national Health Care Fairness Campaign for helping to promote the health care fairness survey and disseminate and utilize these findings. We would not have been able to collect responses from such a large and diverse group of people without their help and support. It should be noted that our partners did not participate in the writing of this report nor the development of the policy recommendations.

9 to 5 California
9 to 5 National Association of Working Women
Adolescent AIDS Program
Aeromestiza
Affirmations
AIDS Legal Referral Panel
AIDS Project El Paso
Al Gamea
Allgo
Alliance for Full Acceptance
American Friends Service Committee
Asian Pacific Islander Coalition on HIV/AIDS (APICHA)
Atlanta Lesbian Health Initiative
Basic Rights Oregon
BCC (Beth Chayir Chadoshim)
Best Koeppel APLC
BGLAD @ SCU Law
Bienestar
Boston Alliance of LGBT Youth, Inc. (BAGLY)
Bronx Pride
Brothas & Sistas, Inc.
CAEAR Foundation
Cascade AIDS Project
Center for Medicare Advocacy, Inc.
Centerlink
Circle of Voices
COLAGE
Community HIV/AIDS Mobilization Project (CHAMP)
Crossdressers International
Dr. Maxwell Anderson & Associates
Emotional Healing and Empowerment Center
Entre Hermanos
Equality North Carolina
Equality Texas
Family Equality Council
Feminist Health Center
Gay & Lesbian Center of South Nevada
Gay and Lesbian Medical Association
Gay, Lesbian and Straight Education Network
Gender Just
Gender Rights Advocacy Association of New Jersey
Georgia Equality
Giovanni's Room
Glory To God Christian Church
Human Rights Campaign
Identity, Inc
Indiana Equality
International Federation for Gender Education
International Gay & Lesbian Human Rights Commission
Kentucky Fairness Alliance

Knoxville/Knox County, Department of Air Quality Management

Latino Commission on AIDS

Legal Voice

LGBT Center New Orleans

LGBT Community Center of Greater Cleveland

LGBT Center, UCSF

Life Healing Center

Lighthouse Community Center

Love Makes a Family

Lotus Monk

Mautner Project

Metropolitan Community Church of Louisville

Missoula AIDS Council

Mocha Center

More Light Presbyterians

National Coalition for LGBT Health

National Gay & Lesbian Task Force

National Senior Citizens Law Center

National Youth Advocacy Coalition

Nevada Association of Latin Americans (NALA)

NIA Collective

New York Association for Gender Rights Advocacy

Northern Colorado AIDS Project

One Iowa

Our House

OUTLaw

Palm Beach County Human Rights Council

PFLAG National

PFLAG Bozeman

PFLAG Omaha

PFLAG Tulsa

Planned Parenthood of Southern Finger Lakes

Pride Collective & Community Center

Pro Latino

PROMO

Public Health - Seattle & King County

Rainbow Access Initiative

Rainbow Center

Rainbow Community Center

Raising Women's Voices for the Health Care We Need

Tennessee Transgender Political Coalition

The Butch/Femme Society

The MergerWatch Project

The Sperm Bank of California

The Wall - Las Memorias

Tomboy Magazine

Topeka AIDS Project

Transgender Individuals Living Their Truth (TILTT)

Transgender Legal Defense Fund

Triangle Foundation

Tri-City Health Center

Two Spirit Society of Denver

UCC Coalition for LGBT Concerns

Utah Pride Center

Ventura County Rainbow Alliance (VCRA)

Whitman-Walker Clinic

Wilson Resource Center

Workmen's Circle, So California Arberter Ring Edcuation Center

Zuna Institute

Contact Lambda Legal

NATIONAL HEADQUARTERS
120 Wall Street
Suite 1500
New York, NY 10005-3904
tel 212-809-8585
fax 212-809-0055

WESTERN REGIONAL OFFICE
3325 Wilshire Boulevard
Suite 1300
Los Angeles, CA 90010-1729
tel 213-382-7600
fax 213-351-6050

MIDWEST REGIONAL OFFICE
11 East Adams
Suite 1008
Chicago, IL 60603-6303
tel 312-663-4413
fax 312-663-4307

SOUTHERN REGIONAL OFFICE
730 Peachtree Street, NE
Suite 1070
Atlanta, GA 30308-1210
tel 404-897-1880
fax 404-897-1884

SOUTH CENTRAL REGIONAL OFFICE
3500 Oak Lawn Avenue
Suite 500
Dallas, TX 75219-6722
tel 214-219-8585
fax 214-219-4455

www.lambdalegal.org

Lambda Legal is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those with HIV through impact litigation, education and public policy work.

If you feel you have been discriminated against, please call Lambda Legal's Help Desk at (866) 542-8336 or visit www.lambdalegal.org/help/online-form

Lambda Legal
making the case for equality

EXHIBIT 3

Injustice at Every Turn

A Report of the National Transgender Discrimination Survey

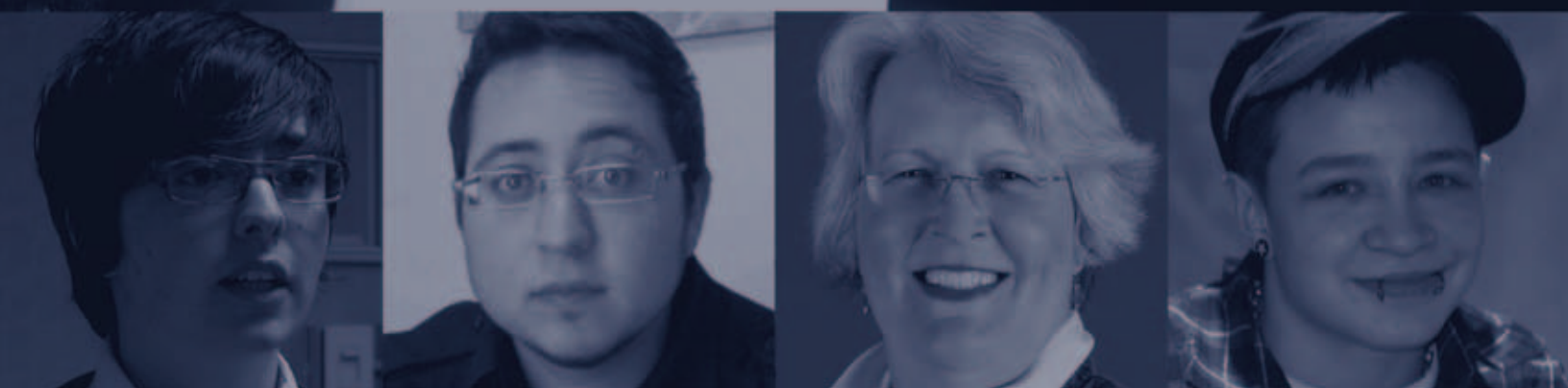
Lead authors in alphabetical order:

Jaime M. Grant, Ph.D.
Lisa A. Mottet, J.D.
Justin Tanis, D.Min.

with Jack Harrison
Jody L. Herman, Ph.D.
and Mara Keisling

National Center for TRANSGENDER EQUALITY

National Gay and Lesbian Task Force



INJUSTICE AT EVERY TURN:

A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY

Lead authors in alphabetical order:

Jaime M. Grant, Ph.D.
Lisa A. Mottet, J.D.
Justin Tanis, D.Min.

with Jack Harrison, Jody L. Herman, Ph.D., and Mara Keisling

About the National Center for Transgender Equality

The National Center for Transgender Equality is a national social justice organization devoted to ending discrimination and violence against transgender people through education and advocacy on national issues of importance to transgender people. By empowering transgender people and our allies to educate and influence policymakers and others, NCTE facilitates a strong and clear voice for transgender equality in our nation's capital and around the country.

About the National Gay and Lesbian Task Force

The mission of the National Gay and Lesbian Task Force is to build the grassroots power of the lesbian, gay, bisexual and transgender (LGBT) community. We do this by training activists, equipping state and local organizations with the skills needed to organize broad-based campaigns to defeat anti-LGBT referenda and advance pro-LGBT legislation, and building the organizational capacity of our movement. Our Policy Institute, the movement's premier think tank, provides research and policy analysis to support the struggle for complete equality and to counter right-wing lies. As part of a broader social justice movement, we work to create a nation that respects the diversity of human expression and identity and creates opportunity for all.

RECOMMENDED CITATION

Grant, Jaime M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.

TABLE OF CONTENTS

HEALTH

Access to health care is a fundamental human right that is regularly denied to transgender and gender non-conforming people.

Transgender and gender non-conforming people frequently experience discrimination when accessing health care, from disrespect and harassment to violence and outright denial of service. Participants in our study reported barriers to care whether seeking preventive medicine, routine and emergency care, or transgender-related services. These realities, combined with widespread provider ignorance about the health needs of transgender and gender non-conforming people, deter them from seeking and receiving quality health care.

Our data consistently show that racial bias presents a sizable additional risk of discrimination for transgender and gender non-conforming people of color in virtually every major area of the study, making their health care access and outcomes dramatically worse.

KEY FINDINGS IN HEALTH

- Survey participants reported that when they were sick or injured, they **postponed medical care** due to discrimination (28%) or inability to afford it (48%).
- Respondents faced **serious hurdles to accessing health care**, including:
  - **Refusal of care**: 19% of our sample reported being refused care due to their transgender or gender non-conforming status, with even higher numbers among people of color in the survey.
  - **Harassment and violence in medical settings**: 28% of respondents were subjected to harassment in medical settings and 2% were victims of violence in doctor's office.
  - **Lack of provider knowledge**: 50% of the sample reported having to teach their medical providers about transgender care.
- The **majority of survey participants have accessed some form of transition-related medical care** despite the barriers; the majority reported wanting to have some type of surgery but have not had any surgeries yet.
- **If medical providers were aware of the patient's transgender status, the likelihood of that person experiencing discrimination increased**.
- Respondents reported **over four times the national average of HIV infection**, 2.64% in our sample compared to .6% in the general population, with rates for transgender women at 4.28%, and with those who are unemployed (4.67%) or who have done sex work (15.32%) even higher.[1]
- Over a quarter of the respondents **misused drugs or alcohol specifically to cope with the mistreatment** they faced due to their gender identity or expression.
- A staggering **41% of respondents reported attempting suicide** compared to 1.6% of the general population, with unemployment, bullying in school, low household income and sexual and physical associated with even higher rates.

Access to Healthcare

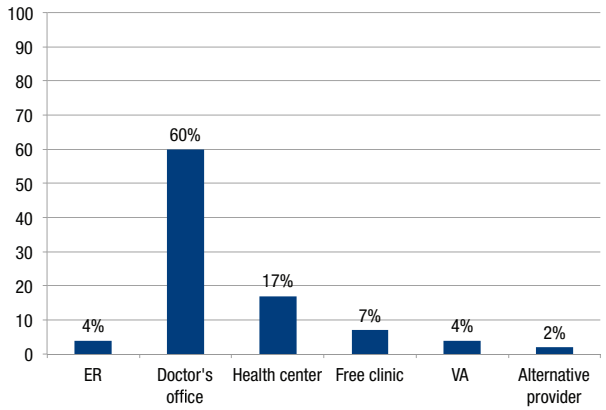
HEALTH CARE SETTINGS

A majority of study participants sought care ("when you are sick or need advice about your health") through a doctor's office (60%); however a sizable minority used health centers and clinics (28%). Four percent (4%) of respondents primarily used emergency rooms for care. Several studies have shown that individuals who use emergency rooms for primary care experience more adverse health outcomes than those who regularly see a primary physician.[2] Factors that correlated with increased use of emergency rooms (ERs) among our respondents were:

- Race—17% of African-Americans used ERs for primary care, as did 8% of Latino/a respondents;
- Household income—8% of respondents earning under $10,000 per year used ERs for primary care;
- Employment status—10% of unemployed respondents and 7% of those who said they had lost their jobs due to bias used ERs for primary care;
- Education—13% of those with less than a high school diploma used ERs for primary care.

Visual conformers and those who had identity documents that matched their presentation had high rates of using doctor's offices for their care.

Primary Source of Medical Care for Respondents



Health Care Experiences

DISCRIMINATION BY MEDICAL PROVIDERS

Denial of health care and multiple barriers to care are commonplace in the lives of transgender and gender non-conforming people. Respondents in our study seeking health care were denied equal treatment in doctor's offices and hospitals (24%), emergency rooms (13%), mental health clinics (11%), by EMTs (5%) and in drug treatment programs (3%).[3] Female-to-male respondents reported higher rates of unequal treatment than male-to-female respondents. Latino/a respondents reported the highest rate of unequal treatment of any racial category (32% by a doctor or hospital and 19% in both emergency rooms and mental health clinics).

19% of our sample reported being refused care altogether, due to their gender identity or expression, with even higher numbers among people of color in the survey.

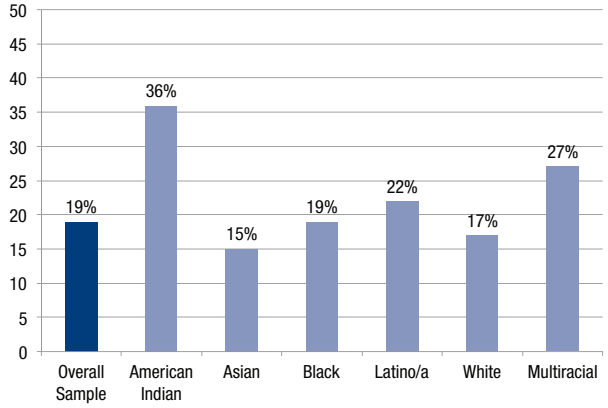
We also asked whether respondents had been ***denied service altogether*** by doctors and other providers.[4] Nineteen percent (19%) had been refused treatment by a doctor or other provider because of their transgender or gender non-conforming status.

Twenty-four percent (24%) of transgender women reported having been refused treatment altogether and 20% of transgender men did. Respondents who reported they had lost jobs due to bias (36%); American Indians (36%); those who worked in the underground economy (30%); those on public insurance (28%); and those who transitioned (25%) experienced high occurrence of refusal to treat.

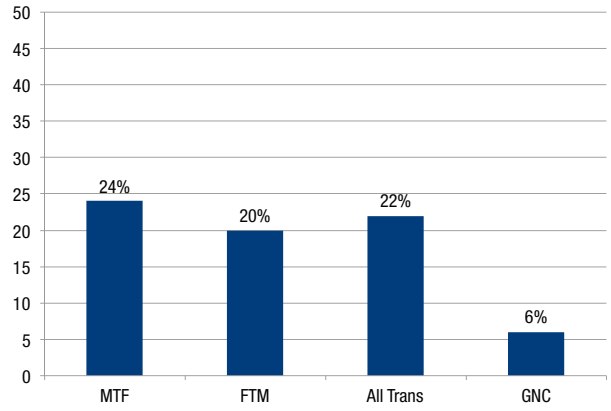
"After an accident on ice, I was left untreated in the ER for two hours when they found my breasts under my bra while I was dressed outwardly as male."

"I have been refused emergency room treatment even when delivered to the hospital by ambulance with numerous broken bones and wounds."

Refusal to Provide Medical Care by Race



Refusal to Provide Care by Gender Identity/Expression



"I have had general practitioners refuse to accept me as a patient on the basis of having a history of gender identity disorder."

VIOLENCE AND HARASSMENT WHEN SEEKING MEDICAL TREATMENT

Doctors' offices, hospitals, and other sources of care were often unsafe spaces for study participants. Over one-quarter of respondents (28%) reported verbal harassment in a doctor's office, emergency room or other medical setting and 2% of the respondents reported being physically attacked in a doctor's office.

2% of respondents reported being physically attacked in a doctor's office.

28% reported being verbally harassed in a medical setting.

Those particularly vulnerable to physical attack in doctors' offices and hospitals include those who have lost their jobs (6%); African-Americans (6%); those who done sex work, drug sales or other work in the underground economy (6%); those who transitioned before they were 18 (5%); and those who are undocumented non-citizens (4%).

In emergency rooms, 1% reported attack. Those more vulnerable to attack include those who are undocumented (6%); those who have worked in the underground economy (5%); those who lost their jobs (4%); and Asian respondents (4%). Obviously, harassment and physical attacks have a deterrent effect on patients seeking additional care and impact the wider community as information about such abuses circulates.

"My experiences in dealing with hospital personnel after my rape was not pleasant and lacked a lot of sensitivity to trans issues."

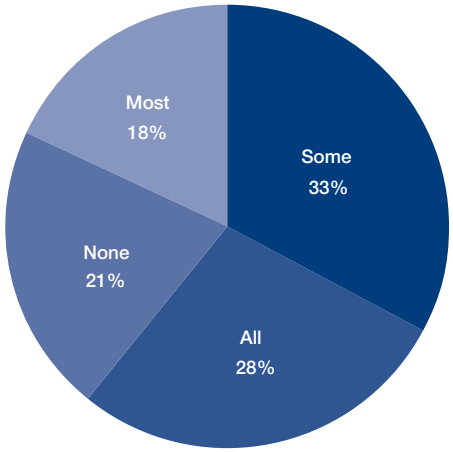
"When I tried to kill myself and was taken to a suicide center, I was made fun of by staff and treated roughly."

"I was forced to have a pelvic exam by a doctor when I went in for a sore throat. The doctor invited others to look at me while he examined me and talked to them about my genitals."

OUTNESS AND DISCRIMINATION

Twenty-eight percent (28%) of respondents said they were out to all their medical providers. Eighteen percent (18%) said they were out to most, 33% said some or a few, and 21% were out to none.

When Seeking Medical Care, How Many People Know or Believe You Are Transgender or Gender Non-Conforming?



Doctors can provide more effective care when they have all medically relevant information about their patients. Unfortunately, our data shows that doctors' knowledge of a patient's transgender status increases the likelihood of discrimination and abuse. Medical professionals' awareness of their patient's transgender status ***increased experiences of discrimination*** among study participants up to eight percentage points depending on the setting:

- **Denied service altogether:** 23% of those who were out or mostly out to medical providers compared to 15% of those who were not out or partly out
- **Harassment in ambulance or by EMT**: 8% of those who were out or mostly out to medical providers compared with 5% of those who were not out or partly out
- **Physically attacked or assaulted in a hospital**: 2% of those who were out or mostly out to medical providers compared with 1% of those who were not out or partly out

"I have been harassed and physically assaulted on the street. One time, I didn't go the hospital until I went home, changed [out of feminine] clothes, and then went to the emergency room in male mode. I had a broken collar bone as a result of that attack."

"I rarely tell doctors of my gender identity. It just seems so hard to explain what "genderqueer" means in a short doctor's appointment. I also am reluctant to take the risk of discrimination; I need to be healthy more than I need to be out to my doctors. I hate making this compromise. But I'm not quite that brave yet."

"Denial of health care by doctors is the most pressing problem for me. Finding doctors that will treat, will prescribe, and will even look at you like a human being rather than a thing has been problematic. Have been denied care by doctors and major hospitals so much that I now use only urgent care physician assistants, and I never reveal my gender history."

MEDICAL PROVIDERS' LACK OF KNOWLEDGE

50% of the sample reported having to teach their medical providers about transgender care.

When respondents saw medical providers, including doctors, they often encountered ignorance about basic aspects of transgender health and found themselves required to "teach my provider" to obtain appropriate care. Fully 50% of study respondents reported having to teach providers about some aspect of their health needs; those who reported "teaching" most often include transgender men (62%), those who have transitioned (61%) and those on public insurance (56%).

"I have several health issues and have been refused care by one doctor who 'suggested' that I go someplace else because she could not treat me since she 'did not know anything about transgender people.' "

POSTPONEMENT OF NECESSARY AND PREVENTIVE MEDICAL CARE

One fourth of study participants reported delaying needed care because of disrespect and discrimination from medical providers.

We asked respondents whether they postponed or did not try to get two types of health care: preventive care "like checkups" and necessary care "when sick or injured." We found that many postponed care because they ***could not afford it*** and many postponed care because of ***discrimination and disrespect from providers***.

A large number of study participants postponed necessary medical care due to inability to afford it, whether seeking care when sick or injured (48%), or pursuing preventive care (50%). Transgender men reported postponing any care due to inability to afford it at higher rates (55%) than transgender women (49%).

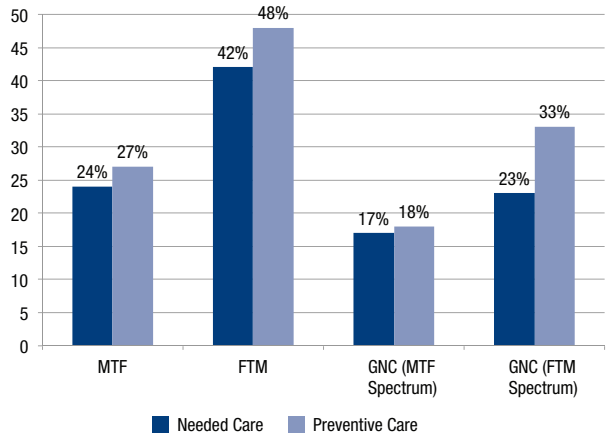
Insurance was a real factor in delayed care: those who have private insurance were much less likely to postpone care because of inability to afford it when sick or injured (37%) than those with public (46%) or no insurance who postponed care (86%).

In terms of preventive care, those without insurance reported delaying care due to inability to afford it much more frequently (88%) than those with private insurance (39%) or public insurance (44%). Failing to obtain preventive care is known to lead to poor long-term health outcomes.

Due to discrimination and disrespect, 28% postponed or avoided medical treatment when they were sick or injured and 33% delayed or did not try to get preventive health care. Female-to-male transgender respondents reported postponing care due to discrimination and disrespect at a much higher frequency (42%, sick/injured; 48% preventive) than male-to-female transgender respondents (24%, sick/injured; 27% preventive). Those with the highest rates of postponing care when sick/injured included those who have lost a job due to bias (45%) and those who have done sex work, sold drugs, or done other work in the underground economy for income (45%). Twenty-nine percent (29%) of respondents who were "out" or "mostly out" to medical providers reported they had delayed care when ill and 33% postponed or avoided preventive care because of discrimination by providers.

"The transition and health care has been expensive, all at a time where my main source of income (my law practice) deteriorated. I have exhausted my savings and the equity from selling my home just to pay medical and living expenses."

Postponement Due to Discrimination by Providers



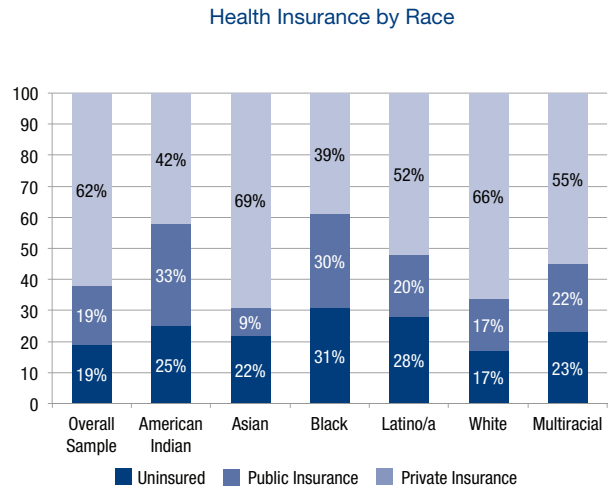
ACCESS TO INSURANCE

Study participants were less likely than the general population to have health insurance, more likely to be covered by public programs such as Medicare or Medicaid, and less likely to be insured by an employer.

Nineteen percent (19%) of the sample lacked any health insurance compared to 17% of the general population.[5] Fifty-one percent (51%) had employer-based coverage compared to 58% of the general population.[6]

African-American respondents had the worst health insurance coverage of any racial category: 39% reported private coverage and 30% public. Thirty-one percent (31%) of Black respondents reported being uninsured; by contrast 66% of white respondents reported private insurance, 17% public insurance and 17%

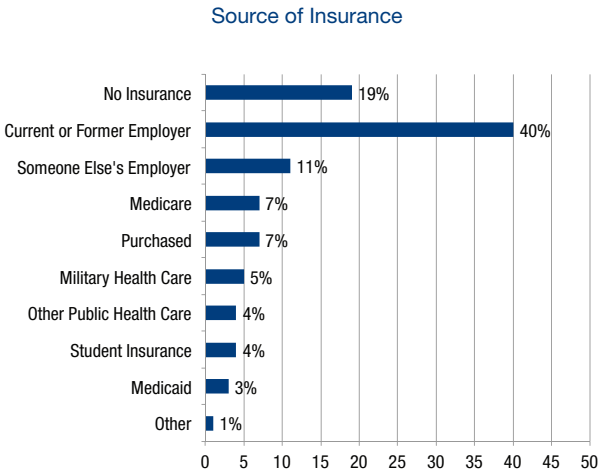
uninsured. In the general population, 68% have private insurance and 28% have public insurance.[7]



Undocumented non-citizens had very low rates of coverage: 26% reported private insurance, 37% public insurance, and 36% no insurance. The South was the worst region for coverage where 59% of respondents reported private insurance, 17% public insurance and 25% no insurance.

Transgender women reported private insurance at 54%, public insurance at 24% and 22% were uninsured. Transgender men reported private insurance at 68%, public insurance at 13% and 19% with no insurance. Transgender respondents, overall, reported private insurance at 60%, public insurance at 20% and 20% had no insurance. Gender non-conforming respondents were insured at higher rates than their transgender counterparts, with 73% reporting private insurance, 11% public insurance, and 17% uninsured.

"I have been living with excruciating pain in my ovaries because I can't find a doctor who will examine my reproductive organs." (from a transgender man)



Transition-related Care

The majority of survey participants have accessed some form of transition-related medical care despite the barriers.

Most survey respondents had sought or accessed some form of transition-related care. Counseling and hormone treatment were notably more utilized than any surgical procedures, although the majority reported wanting to "someday" be able to have surgery. The high costs of gender-related surgeries and their exclusion from most health insurance plans render these life-changing (in some cases, life-saving) and medically necessary procedures inaccessible to most transgender people.

Throughout this section, we focus primarily on transgender people rather than on gender non-conforming people, though they too may also desire and sometimes use various forms of gender-related medical care.

The World Professional Association for Transgender Health (WPATH) publishes Standards of Care[8] which are guidelines for mental health, medical and surgical professionals on the current consensus for providing assistance to patients who seek transition-related care. They are intended to be flexible to assist professionals and their patients in determining what is appropriate for each individual. The Standards of Care are a useful resource in understanding the commonly experienced pathways through transition-related care.

"My choices for health coverage at my employer all exclude any treatment for transgender issues, even though they cover things like hormones for other people."

COUNSELING

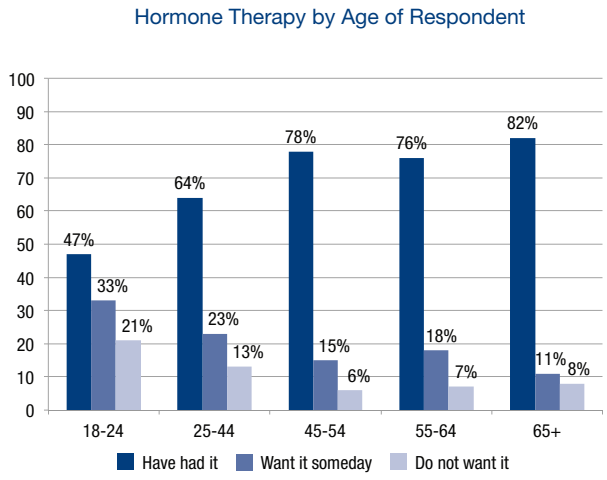
Counseling often plays an important role in transition. Because of the WPATH Standards of Care, medical providers often require a letter from a qualified counselor stating that the patient is ready for transition-related medical care; transgender people may seek out counseling for that purpose. Counseling may also play a role in assisting with the social aspects of transition, especially in dealing with discrimination and family rejection.

Seventy-five percent (75%) of respondents received counseling related to their gender identity and an additional 14% hoped to receive it someday. Only 11% of the overall sample did not want it. Those who identified as transgender were much more likely to have had counseling (84%) than those who are gender non-conforming (48%). Eighty-nine percent (89%) of those who medically transitioned have received counseling, as have 91% of those who had some type of surgery.

Part of counseling can involve receiving a gender-related mental health diagnosis such as "Gender Identity Disorder." Many doctors require this diagnosis before providing hormones or surgical treatment, but the diagnosis itself is widely criticized for categorizing naturally occurring gender variance as pathological.[9] Fifty-percent (50%) of study participants have received a gender-related mental health diagnosis. Transgender women reported a higher rate of diagnosis (68%) than transgender men (56%); and transgender-identified participants had a substantially higher rate of diagnosis (63%) than gender non-conforming respondents (11%).

HORMONE THERAPY

Sixty-two percent (62%) of respondents have had hormone therapy, with the likelihood increasing with age; an additional 23% hope to have it in the future. Transgender-identified respondents accessed hormonal therapy (76%) at much higher rates than their gender non-conforming peers, with transgender women more likely to have accessed hormone therapy (80%) than transgender men (69%). Almost all respondents who reported undertaking transition-related surgeries also reported receiving hormone therapy (93%).

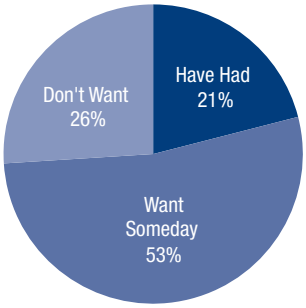


"I can no longer afford health care of any kind. I am fully transitioned and thus reliant upon estradiol as my body produces neither estrogens nor androgens in sufficient quantity. I am unable to go to the doctor for my prescriptions, and thus have been unable to buy my hormones for over one year. Thus I watch my hair falling out, my nails dissolve and am weak and tired like a far older lady than I am."

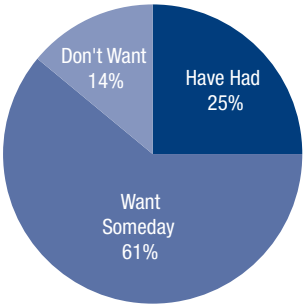
SURGERY—MALE-TO-FEMALE

Transgender women may elect to undertake a variety of surgeries, including breast augmentation, orchiectomy (removal of testes), vaginoplasty (creation of a vagina and/or removal of the penis), and facial feminization surgeries. We asked respondents to report on whether they had, or wanted, breast augmentation surgery, orchiectomies and vaginoplasties. As the charts below show, most transgender women reported wanting or having these surgeries. In addition, 17% reported having had facial surgery.[10] However, it is impossible to know how many others would desire or utilize surgery if it was more financially accessible.

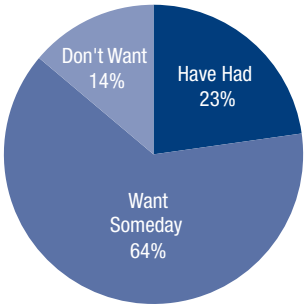
MTF Breast Augmentation Surgery



MTF Orchiectomy



MTF Vaginoplasty

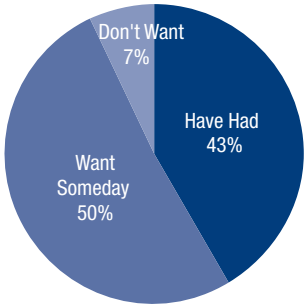


"I cannot afford gender reassignment surgery which is crucial to my mental well being and thoughts of suicide are always present."

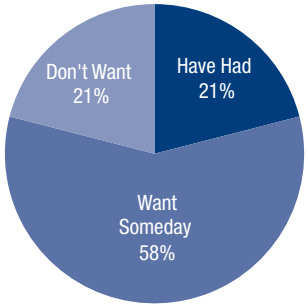
SURGERY—FEMALE-TO-MALE

Transgender men may elect to undertake a variety of surgeries, including chest reconstruction, hysterectomy, metoidioplasty and other genital surgeries. We asked respondents to report on chest surgery; hysterectomy; metoidioplasty, which releases the clitoris; surgeries that create testes; and phalloplasty, which surgically creates a penis and testes. The majority of FTM transgender-identified respondents wanted to have, or have already had, chest surgery and a hysterectomy. However, when it came to genital surgeries, very few reported having such surgeries; a slim majority (53%) reported desiring other genital surgery such as metoidioplasty in addition to the 3% that have had it; and one-quarter (27%) wanted to have a phalloplasty in addition to the 1% who have had it. It is impossible to know how these rates would change if these surgeries were more financially accessible.

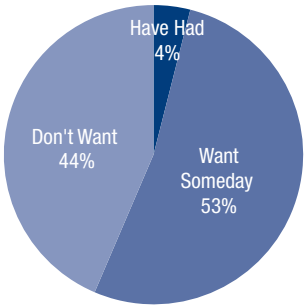
FTM Chest Surgery



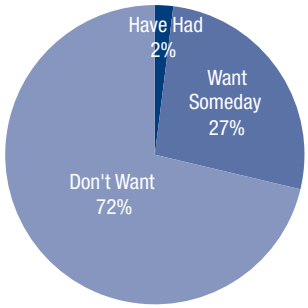
FTM Hysterectomy



FTM Metoidioplasty/ Creation of Testes



FTM Phalloplasty



"I have also have had several bouts with depression and anxiety disorders and once ended up in the emergency room for depression. I still bounce in and out of depression due to not being able to get the appropriate surgical procedures."

Health Vulnerabilities

Survey participants reported poorer health outcomes than the general population in a variety of critical health areas.

PHYSICAL VIOLENCE AND SEXUAL ASSAULT

"As a child because I acted "girly," I was a victim of severe child abuse, and was sexually assaulted. I avoided transitioning until I came to the point of suicide."

In questions related to experiences in educational settings, at work, in interactions with police and with family members, at homeless shelters, accessing public accommodations, and in jails and prisons, respondents were asked about physical violence or sexual violence, or both, committed against them because of their gender identity/expression. There was no *general question* asked about whether respondents had ever experienced any bias-motivated violence, and further, there was no question that asked to report on violence that was not *specifically motivated* by anti-transgender bias.

Twenty-six percent (26%) of respondents had been physically assaulted in at least one of these contexts because they were transgender or gender non-conforming. Ten percent (10%) of respondents were sexually assaulted due to this bias.

Having been physically or sexually assaulted aligned with a range of other negative outcomes, as described below in each relevant section.

HIV

Respondents reported over four times the national average of HIV infection.

Respondents reported an HIV infection rate of 2.64%,[11] over four times the rate of HIV infection in the general United States adult population (0.6%) as reported by the United Nations Programme on HIV/AIDS and the World Health Organization.[12] People of color reported HIV infection at substantially higher rates: 24.90% of African-Americans, 10.92% of Latino/as, 7.04% of American Indians, and 3.70% of Asian-Americans in the study reported being HIV positive. This compares with national rates of 2.4% for African Americans, .08% Latino/as, and .01% Asian Americans.[13] Non-U.S. citizens in our sample reported more than twice the rate of HIV infection of U.S. citizens (2.41%), with documented non-citizens at 7.84% and undocumented at 6.96%.

Doing sex work for income clearly was a major risk factor, with 61% of respondents who were HIV positive reporting they had done sex work for income. To consider this from a different angle, of all the people in our sample who had done sex work, 15.32% reported being HIV positive.

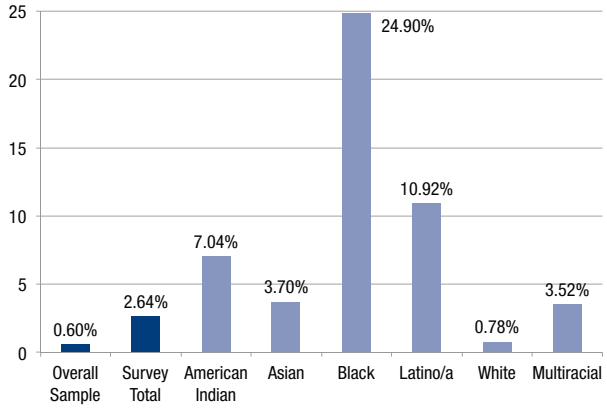
Among survey participants, 88% of those who reported being HIV positive identified as either MTF or gender non-conforming on the male-to-female spectrum. The reported rate of HIV infection for the MTF transgender respondents was 4.28%. The reported rate of HIV infection for FTM respondents was .51%, lower than the national average.

Other categories that reported substantially higher HIV rates than the sample as a whole were:

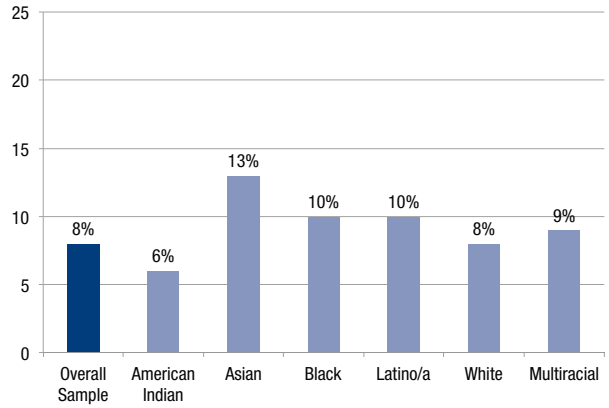
- Those without a high-school diploma (13.49%)
- Those who had been sexually assaulted due to bias (10.13%)
- Those with household income below $10,000 a year (6.40%)
- Those who had lost a job due to bias (4.59%) or reported being unemployed (4.67%)

Eight percent (8%) of our sample reported that they did not know their HIV status. Transgender women and transgender men had equal rates of not knowing, both 8%, with transgender respondents also at 8% and gender non-conforming respondents at 9%. Those most likely not to know their HIV status include undocumented non-citizens (17%), those with household incomes under $10,000/year (14%), and those with lower educational attainment (those with no high school diploma and high school diploma only, both at 13%).With regard to race, Asian respondents were least likely to know their status (13%).

HIV Infection By Race, Compared to U.S. General Population



HIV Status Unknown By Race



DRUG AND ALCOHOL USE

The National Institutes of Health (NIH) estimate that 7.3% of the general public abuses or is dependent on alcohol, while 1.7% abuses or is dependent on non-prescription drugs.[14] Eight percent (8%) of study participants reported currently using alcohol or drugs specifically to cope with the mistreatment that they received as a result of being transgender or gender non-conforming, while 18% said they had done so in the past but do not currently. We did not ask about general use of alcohol and drugs, only usage which the respondents described as a coping strategy for dealing with the mistreatment they face as transgender or gender non-conforming persons.

26% use or have used alcohol and drugs to cope with the impacts of discrimination.

Doing sex work, drug sales, and other work in the underground economy for income more than doubles the risk of alcohol or drug use because of mistreatment, with 19% of these respondents currently using alcohol and/or drugs while 36% reported that they had done so in the past. Those who have been the physically attacked due to bias also had a higher rate of current alcohol and drug misuse (15%) as did those who have been sexually assaulted due to bias (16%). Also at elevated risk were those who had lost a job due to discrimination; 12% reported currently using drugs and alcohol, while 28% have done so in the past.

"I do not use drugs but my drinking has increased over the past 3 years due to stress and loneliness."

"When I started coming out, I stopped the drinking and stopped the depression medicines. When I started living full time in my real gender, I blossomed into an outgoing, loving, giving person."

Alcohol and drug use decreased by age among our participants, as they did in studies of the general population,[15] with those 65 years and above reporting less than half the rate of use (4%) of those who are the 18-44 age range (9%). This contrasts with studies of LGBT populations that show a less dramatic decrease in use over the life cycle;[16] however, because our study only asked about use connected to mistreatment, the comparisons with both the general population and LGBT studies are not precise.

SMOKING

Thirty percent (30%) of our sample reported smoking daily or occasionally, compared to 20.6% of U.S. adults.[17] Studies of LGBT adults show similar rates to those in our study, with elevated rates of 1.1-2.4 times that of the general population,[18] and a 2004 California study found a 30.7% smoking rate for transgender people.[19] In the general population, men smoke at higher rates than women, but in LGBT studies, women smoke at higher rates than men. Our sample resembled the LGBT data regarding elevated smoking levels but differed in that more men than women in our sample smoke, a pattern that is closer to that of the general population. When asked if they would "like to quit," 70% of smokers in the study selected yes.

Comparative Smoking Rates from Other Studies,[20] Compared to Our Study

	General Population	Lesbian and Gay	Bisexual	Our Sample
Men	23.1%	26.5-30.9%	29.5-38.1%	33%
Women	18.3%	22.3-26%	30.9-39.1%	29%

Visual conformers were less likely to be current smokers (27%) than visual non-conformers (37%), suggesting that the stress caused by the additional mistreatment that visual non-conformers face may be involved in the development of an addiction to nicotine. Similarly, those who have been physically assaulted due to bias (40%) and sexually assaulted due to bias (45%) have higher smoking rates than their peers who were not assaulted.

SUICIDE ATTEMPTS

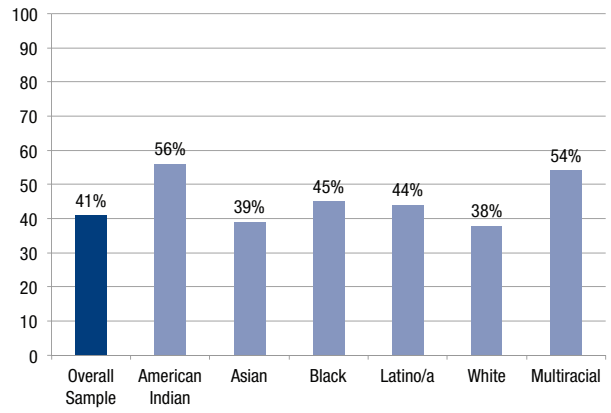
When asked "have you ever attempted suicide?" 41% of respondents answered yes. According to government health estimates, five million, or 1.6% of currently living Americans have attempted suicide in the course of their lives.[21] Our study asked if respondents had ever attempted suicide while most federal studies refer to suicide attempts within the last year; accordingly it is difficult to compare our numbers with other studies. Regardless, our findings show a shockingly high rate of suicidality.

41% of respondents reported attempting suicide.

The National Institute for Mental Health (NIMH) reports that most suicide attempts are signs of extreme distress, with risk factors including precipitating events such as job loss, economic crises, and loss of functioning.[22] Given that respondents in this study reported loss in nearly every major life area, from employment to housing to family life, the suicide statistics reported here cry out for further research on the connection between the consequences of bias in the lives of transgender and gender non-conforming people and suicide attempts.[23]

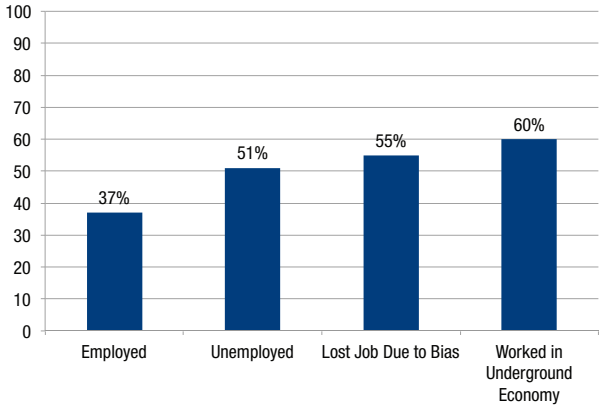
NIMH also reports that generally African-Americans, Latino/as and Asians have much lower suicide rates than whites and American Indians; our sample showed a different pattern of risk for suicide by race, with Black and Latino/a respondents showing dramatically elevated rates in comparison to their rates in the general population.

Suicide Attempt by Race



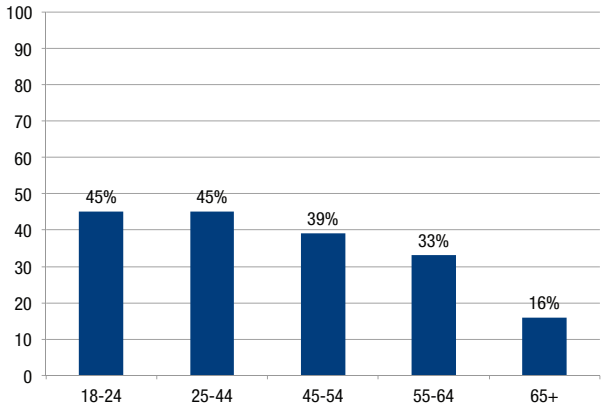
Respondents' work status and experiences of discrimination in employment also had a sizable impact on their likelihood of having attempted suicide.

Suicide Attempt by Employment



In terms of age group risk, the highest rates of suicide attempts in this study were reported among those in the 18-24 age group (45%) and 25-44 age group (45%), with only 16% of those over 65 reporting a suicide attempt. These rates are inverse to the general population, which shows a higher incidence of attempts among older Americans than youth.[24]

Suicide Attempts by Age



Our questionnaire did not ask at what age the respondents made suicide attempts and therefore it is difficult to draw conclusions about the risk of suicide over their life spans. However, there are a number of attributes that align with an increased rate of attempted suicide. High risk groups include visual non-conformers (44%) and those who are generally out about their transgender status (44%). Those who have medically transitioned (45%) and surgically transitioned (43%) have higher rates of attempted suicide than those who have not (34% and 39% respectively).

Over half of those bullied, harassed, assaulted, or expelled due to bias in school attempt suicide.

Those who were bullied, harassed, assaulted, or expelled because they were transgender or gender non-conforming in school (at any school level) reported elevated levels of suicide attempts (51% compared with 41% of our sample as a whole). Most notably, suicide attempt rates rise dramatically when teachers were the reported perpetrators: 59% for those harassed or bullied by teachers, 76% among those who were physically assaulted by teachers and 69% among those who were sexually assaulted by teachers. These numbers speak to the urgency of ending violence and harassment of transgender students by both their peers and their teachers.

Education and household income both align with suicide rates, with those earning $10,000 annually or less at extremely high risk (54%), while those making more than $100,000 are at comparatively lower risk (26%), while still tremendously higher than the general population. Those who have not completed college attempted suicide at higher rates (48% among those with no high school diploma, 49% for those with a high school diploma only, and 48% for those with some college education) while those have completed college (33%) or graduate school (31%) have lower rates.

Those who had survived violence perpetrated against them because they were transgender or gender non-conforming were at very high risk; 61% of physical assault survivors reported a suicide attempt, while sexual assault survivors reported an attempt rate of 64%.

"My suicide attempt had a lot to do with the fact that I felt hopeless and alone in regards to my gender identity."

CONCLUSIONS FOR HEALTH

Respondents reported serious barriers to health care and outrageous frequencies of anti-transgender bias in care, from disrespect to refusal of care, from verbal harassment to physical and sexual abuse. Transgender people of color and low-income respondents faced substantially elevated risk of abuse, refusal of care, and poor health outcomes than the sample as a whole.

The data gathered here speak to a compelling need to examine the connection between multiple incidences of discrimination, harassment and abuse faced by our respondents in the health care system and the high risk for poor health outcomes. Additionally, our data suggest that discriminatory events are commonplace in the daily lives of transgender people and that this has a cumulative impact—from losing a job because of bias to losing health insurance; from experiencing health provider abuse to avoiding health care; from long-term unemployment to turning to work on the streets. The collective impact of these events exposed our respondents to increased risk for HIV infection, smoking, drug/alcohol use, and suicide attempts.

It is important to note that the traumatic impact of discrimination also has health care implications. Transgender people face violence in daily life; when this risk is compounded by the high rates of physical and sexual assault they face while accessing medical care, health care costs increase, both to treat the immediate trauma as well as ongoing physical and psychological issues that may be created.

As we have seen across a number of categories in the survey, the ability to work substantially impacts transgender health. In particular, those who have been fired due to anti-transgender bias and those who have done sex work, drug sales, or other work in the underground economy are much more likely to experience health risks that are shown to lead to poorer health outcomes.

Discrimination in the health care system presents major barriers to care for transgender people and yet a majority of our survey participants were able to access some transition-related care, with 75% receiving counseling and 62% obtaining hormones. Genital surgery, on the other hand, remains out of reach for a large majority, despite being desired by most respondents. This is one important reason why legal rights for transgender people must never be determined by surgical status.

"I saw a doctor in New York and told her how I wanted [chest surgery]. She looked at me sternly and said, 'I can't believe you are wasting my time. Do you know what your problem is? You just want to be a boy. You want to be a boy and that's never gonna happen so just do yourself a favor and get over it.' Then she left the room abruptly. I grabbed my things and bolted down the street, feeling like the biggest freak in the world."

RECOMMENDATIONS FOR HEALTH

- Anti-transgender bias in the medical profession and U.S. health care system has catastrophic consequences for transgender and gender non-conforming people. This study is a call to action for the medical profession:
  - The medical establishment should fully integrate transgender-sensitive care into its professional standards, and this must be part of a broader commitment to cultural competency around race, class, and age;
  - Doctors and other health care providers who harass, assault, or discriminate against transgender and gender non-conforming patients should be disciplined and held accountable according to the standards of their professions.
- Public and private insurance systems should cover transgender-related care; it is urgently needed and is essential to basic health care for transgender people.
- Ending violence against transgender people should be a public health priority, because of the direct and indirect negative effect it has on both victims and on the health care system that must treat them.
- Medical providers and policy makers should never base equal and respectful treatment and the attainment of appropriate government-issued identity documents on:
  - Whether an individual has obtained surgery, given that surgeries are financially inaccessible for large majorities of transgender people because they are rarely covered by either public or private insurance;
  - Whether an individual is able to afford or attain proof of citizenship or legal residency.
- Rates of HIV infection, attempted suicide, drug and alcohol abuse, and smoking among transgender and gender non-conforming people speak to the overwhelming need for:
  - Transgender-sensitive health education, health care, and recovery programs;
  - Transgender-specific prevention programs.
- Additional data about the health outcomes of transgender and gender non-conforming people is urgently needed:
  - Health studies and other surveys need to include gender identity as a demographic category;
  - Information about health risks, outcomes and needs must be sought specifically about transgender populations;
  - Transgender people should not be put in categories such as “men who have sex with men” (MSM) as transgender women consistently are and transgender men sometimes are. Separate categories should be created for transgender women and transgender men so HIV rates and other sexual health issues can be accurately tracked and researched.

EXHIBIT 4

Center for American Progress

The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial

By Sharita Gruberg and Frank J. Bewkes March 7, 2018

After six years and nearly 25,000 public comments, the U.S. Department of Health and Human Services (HHS) issued a rule in May 2016 to implement Section 1557 of the Affordable Care Act (ACA), clarifying that discrimination based on sex stereotyping and gender identity is impermissible sex discrimination under the law.[1] This position was in line with growing case law to support prohibitions against sex discrimination covering LGBTQ people.[2]

In December 2016, however, the U.S. District Court for the Northern District of Texas issued a nationwide injunction prohibiting HHS from enforcing the regulation's prohibition on discrimination on the basis of gender identity, and, to date, the current administration has failed to defend the regulation.

Franciscan Health, formerly Franciscan Alliance Inc., is a religiously affiliated health care alliance. Along with eight states and two other private health care providers, it sued HHS over the regulation.[3] They alleged that doctors would be forced against their will to perform medical procedures that are contrary to their religious beliefs and that they believe are harmful to the patient. Most specifically, they objected to providing medical treatments related to gender transition, especially for children. The rule implementing Section 1557 requires providers to offer medically necessary health care services to transgender people if those services are within their scope of practice. Franciscan Alliance claimed that following their beliefs and performing procedures for some people, such as mastectomies for cancer patients, but not others, such as "top surgery" for transgender patients, would open them to liability. Due to this concern, they even went so far as to claim that doctors would be forced to cease providing certain medical care treatments for all patients in order to exempt themselves from providing transition-related care to which they have a religious objection.

To learn more about the nature of anti-LGBTQ discrimination in health care and HHS's enforcement of Section 1557's protections for LGBTQ people, the Center for American Progress conducted an analysis of closed complaints of discrimination based on sexual orientation, sex stereotyping related to sexual orientation, and gender identity. HHS received

these complaints prior to the injunction. The analysis revealed that the majority of patients who filed such complaints of discrimination with HHS had not been denied care related to gender transition. Rather, transgender patients who filed complaints were often denied in general, unrelated to transition-related treatments, solely because of their gender identity.

This finding is significant, because Franciscan Alliance's stated concern in *Franciscan Alliance v. Burwell* is that the implementation of Section 1557 would force its doctors to help patients with gender transition care. But the data show that health care providers most often discriminate against transgender people simply for being who they are—not based on the care they need. With the majority of discrimination complaints grounded in gender identity rather than gender transition, the desire of opponents—including Franciscan Alliance—to undo Section 1557's protections for transgender people would have sweeping consequences and possibly indicates an underlying animus toward transgender people generally. CAP's analysis of these claims indicates that, if successful for Franciscan Alliance, *Franciscan Alliance v. Burwell*'s attack on gender identity discrimination protections would allow many forms of discrimination against patients—such as refusing to use proper pronouns and to provide reproductive health care simply because a person's gender presentation does not match their ID or records—and undermine the quality of care for many people while increasing litigation costs for providers.

Thankfully, a different federal court ruled in September 2017 that discrimination on the basis of gender identity is sex discrimination prohibited under Section 1557 itself.[4] This ruling affirmed that transgender individuals can go directly to court, rather than file gender identity discrimination complaints through the administrative procedures of the Office of Civil Rights (OCR) at HHS.[5] Since gender identity discrimination is prohibited sex discrimination under the ACA itself, the administration should not amend the rule interpreting Section 1557 in response to *Franciscan Alliance*; to the contrary, it should continue to defend the rule and fight to overturn the injunction.

Section 1557's nondiscrimination protections

Section 1557 prohibits discrimination by any health program or activity receiving federal assistance; health programs and activities administered by HHS; and marketplaces under the ACA, on the basis of race, color, national origin, sex, age, or disability.[6] The definition of what constitutes sex discrimination in Section 1557 is informed by the prohibitions against sex discrimination in Title IX of the Education Amendments of 1972, as well as Title VII of the Civil Rights Act of 1964.[7] The courts have clarified that discrimination on the basis of gender identity is sex discrimination, despite the stance of the Trump administration.[8] In other words, as a federal court recently found, "Because Title VII, and by extension Title IX, recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex, the Court interprets the ACA to afford the same protections."[9] (see text box) The ACA offers protections regardless of the status of its implementing regulations.

Prescott v. Rady Children's Hospital-San Diego

In September 2017, the U.S. District Court for the Southern District of California ruled on *Prescott v. Rady Children's Hospital-San Diego*, a case brought by a mother on behalf of her deceased transgender son.[10] Kyler, her son, had battled with gender dysphoria, depression, and suicidal ideation. His mother sought help at Rady Children's Hospital-San Diego (RCHSD), where hospital staff proceeded to repeatedly misgender Kyler. Unfortunately, RCHSD did not correct the behavior after it was brought to light by Kyler's mother; instead, it discharged Kyler from psychiatric hold early. Kyler died by suicide a month later. The court's ruling in this case was in response to an order on a motion to dismiss, so the merits of Kyler's mother's claim that her son was discriminated against were not addressed. The court did, however, hold that the discrimination claim based on Kyler's transgender identity arose from the language of the ACA itself, rather than the implementing regulation, and that the claim was plausible.

To provide further clarity on the nature of the protections afforded by the ACA, HHS issued a rule that interpreted the sex discrimination prohibition in Section 1557 to prohibit discrimination based on sex stereotyping and gender identity.[11] There is growing case law to support prohibitions against sex stereotyping, including sexual orientation discrimination.[12] The rule specifies that insurers are prohibited from denying or limiting health insurance or coverage because of someone's gender identity; that there cannot be a categorical exclusion from insurance coverage for transition-related care; and that if health services are ordinarily available to individuals of a certain sex, they cannot be denied to a transgender person for whom they are medically relevant. For example, a gynecologist cannot refuse to perform a Pap test or mammogram on a transgender man. The rule is in line with what the vast majority of insurers have already done. A 2017 study of 71 insurers in 18 states found that 90 percent of insurers did not include transgender-specific exclusions and nearly one-third affirmatively stated that medically necessary treatment for gender dysphoria is covered.[13] The rule also clarifies that persistently and intentionally refusing to use a transgender person's correct name and gender pronoun constitutes impermissible harassment on the basis of sex and that transgender people must have access to facilities and programs consistent with their gender identity.

The OCR is charged with accepting and investigating complaints under Section 1557. The statute also provides a private right of action, allowing individuals who experience discrimination to file a lawsuit under Section 1557.

Even without a formal finding of discrimination, the OCR can work with health care providers to take proactive steps to ensure LGBTQ patients are protected from discrimination like it did with The Brooklyn Hospital Center. In July 2015, the OCR reached a voluntary settlement agreement with The Brooklyn Hospital Center after a transgender

woman filed a complaint with the office that the hospital violated Section 1557 when it assigned her to a double occupancy patient room with a man despite her gender identity.[14] The hospital agreed to adopt new nondiscrimination policies and train employees on compliance with those policies.[15]

Analysis of sexual orientation and gender identity discrimination complaints under Section 1557

On January 24, 2017, CAP submitted a Freedom of Information Act (FOIA) request to HHS for complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the ACA from March 23, 2010, to January 20, 2017. In response, CAP received information about a subset of complaints that were received by the agency and were closed—a total of 34 complaints from 2012 through 2016. Review of the documents, however, indicated that the Brooklyn Hospital Center case was not among the complaints provided. These FOIA data do not reflect complaints that remain open or that have been held without action based on the *Franciscan Alliance* litigation. In the final rule interpreting Section 1557, HHS estimated that, each year, it receives a total of 15 to 20 Section 1557 complaints that cannot be filed under other statutes. HHS, however, predicted this number would increase following publication of the proposed rule.[16] Among the complaints, which sometimes had more than one issue claim, there were 31 claims involving gender identity discrimination and six involving sexual orientation discrimination.[17] In two instances, HHS completed its investigation and found the complaints were substantiated; in other words, HHS issued actual findings of discrimination. Most of the closed complaints resulted in the subject of the complaint taking voluntary corrective action. In 22 cases, the covered entity worked with HHS to institute trainings or change policies or HHS provided technical assistance to address the complaint.

Most complaints involved denials of care or insurance coverage because of a person's gender identity

The most common complaints involved individuals being denied care because of their gender identity or transgender status. There were 13 such closed complaints among the 31 complaints involving gender identity discrimination that CAP reviewed. Complaints included a transgender woman being denied a mammogram because of her gender identity; transgender people being denied sexual assault medical forensic examinations; and a transgender man being refused a screening for a urinary tract infection because the clinic claimed it only provided those screenings to women.

One of the next most common complaints involved people being denied insurance coverage because of their gender identity. Five of these complaints were denials of coverage for transition-related care; however, there was one incident of an individual who was

refused insurance coverage for reproductive health care because of his gender identity and another because the insurer would only cover genetic testing for breast cancer for women and not for a transgender man—despite the fact that the testing was recommended by the complainant's doctor.

- Additional examples of discrimination in the complaints include:[18]

- A transgender woman went to the hospital with cold symptoms, but her care was delayed because of repeated questions about her gender identity and inappropriate questions about her anatomy at intake.

- A transgender woman with a disability was repeatedly harassed by the driver of a medical transport service that took her to and from her doctor's appointments.

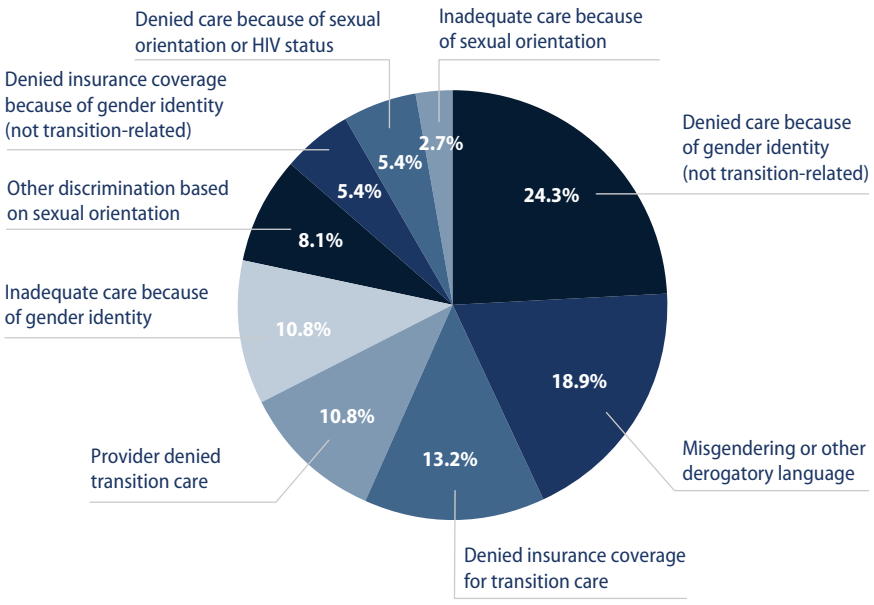
- A woman was separated from her wife during an emergency room visit and her wife was not permitted to enter her room for more than two hours.

- While recovering from an appendectomy, the doctor treating a transgender woman refused to call her by the correct pronouns and said the doctor does not deal with "these kinds" of patients.[19]

FIGURE 1

Forms of health care discrimination against LGBTQ people reported in closed complaints to HHS

Percentage of times each issue was asserted



Note: Figure based on 34 complaints that included a total of 37 issue claims. Several complaints included more than one issue claim.

Source: Data are from documents on file with the authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the Department of Health and Human Services for complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 2010 to January 20, 2017.

Many complaints were resolved through voluntary corrective action rather than costly litigation

The plaintiffs in *Franciscan Alliance* claimed that they feared facing costly litigation as a result of the rule. However, what the available complaints show is that HHS overwhelmingly worked with the subject of the complaint to amend policies and implement trainings to teach staff how to treat transgender patients without discrimination, rather than taking them to court. This was true for all cases involving the misgendering of patients—seven of the 37 closed issue claims CAP reviewed—and for nearly all cases involving coverage or provision of transition-related care—11. HHS investigations had uncovered evidence to substantiate two of the complaints CAP obtained. In one of two complaints, a receptionist told a transgender person the clinic would not perform surgery because the "Lord does not approve."[20] After the complaint was filed and HHS investigated, the clinic offered to proceed with the surgery, updated its nondiscrimination policy, formulated new policies on transgender health care, and trained its staff on the policy. While the *Franciscan Alliance* litigation relied heavily on hypothetical scenarios—and misstatements of accepted medical standards of care—regarding transgender children, none of the complaints CAP reviewed involved transition-related care for a minor.[21]

Finally, beyond the outright denial of care, there were five complaints involving patients who alleged receiving substandard care because of their sexual orientation or gender identity. These involved situations where someone's care was delayed or they were released from a hospital prematurely. In these instances, the subjects of the complaints took voluntary corrective action and trained their staff on nondiscrimination obligations under the law and LGBTQ cultural competency. There were also two complaints of people being treated differently because their spouse was the same sex. In these cases, the subjects of the complaints also voluntarily trained staff or changed their record-keeping policies to ensure all married couples were treated the same.

In the two instances CAP reviewed where the complaints were substantiated by HHS, the subjects of the complaints also took corrective actions. In addition to the case mentioned above, an individual was denied a flu shot because they were HIV-positive. In this case it was determined they were discriminated against on the basis of having a disability.

Finally, contrary to assertions made by the plaintiffs in *Franciscan Alliance*, in no case did HHS threaten to sue or withhold federal funding, nor did it order a health care professional to perform a service against their medical judgment.

Conclusion

Reviewing this subset of Section 1557 complaints resolved by HHS shows that the enforcement of the statute was working well to resolve very real issues of discrimination, and that the fears raised by the *Franciscan Alliance* lawsuit are not well-founded.

Research shows that discrimination affects whether transgender people are able to receive timely, quality care, as well as the willingness of transgender people to seek care in the future. A survey by CAP found 23.5 percent of transgender respondents avoided doctor's offices in the past year out of fear of facing discrimination.[22] Robust enforcement of the ACA's nondiscrimination protections reassures these Americans that they will not be refused for discriminatory reasons.

Contrary to the findings of the Texas court in *Franciscan Alliance*,[23] Section 1557's implementing rule simply creates a regulatory structure and administrative process for enforcing what the ACA already requires. A claim for anti-transgender discrimination already existed under the ACA. The implementing rule is important, because its administrative procedures enable victims to seek redress without the costs and time associated with litigation. The present analysis suggests that this process has often worked well for those who have availed themselves of it.

As *Franciscan Alliance v. Burwell* proceeds, the ACA's protections remain in effect and continue to be critical for addressing the well-documented health disparities facing LGBTQ people.[24] However, due to costs of litigation and the apparent success of the closed administrative claims, it is vital that the administrative process remain an avenue for addressing discrimination grievances. Unfortunately, HHS indicated in recent court filings that rather than preserving this critical mechanism for protecting LGBTQ people from discrimination, it is rewriting the rule and likely removing explicit protections for LGBTQ people.[25] HHS also recently announced that it will open a separate civil rights office that is solely focused on defending religious refusals to provide health care. HHS' recent actions do not signal a commitment to protecting all Americans' access to care. Rather, they further underline the Trump administration's commitment to undermining the basic rights, health, and well-being of LGBTQ people.[26]

Sharita Gruberg is the associate director of the LGBT Research and Communications Project at the Center for American Progress. Frank J. Bewkes is a policy analyst for the LGBT Research and Communications Project at the Center.

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Endnotes

1 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities," *Federal Register* 81 (96) (2016), available at https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities; Kellan Baker, "LGBT Protections In Affordable Care Act Section 1557," *Health Affairs*, June 6, 2016, available at http://www.healthaffairs.org/do/10.1377/hblog20160606.055155/full/.

2 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities." See, for example, *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004), available at https://scholar.google.com/scholar_case?case=9882340233444710 66&q=Smith+v.+City+of+Salem,+378+F.3d+566&hl=en&as_sdt=20006&as_vis=1.

3 See *Franciscan Alliance Inc. v. Burwell*, 227 F.Supp.3d 660 (N.D. Tex., 2016).

4 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756 (S.D. Cal., 2017), available at https://www.courthousenews.com/wp-content/uploads/2017/09/Trans-Rady-MTD-ORDER.pdf.

5 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756 (S.D. Cal., 2017).

6 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities."

7 Legal Information Institute, "42 U.S. Code § 18116 – Nondiscrimination," available at https://www.law.cornell.edu/uscode/text/42/18116 (last accessed February 2018).

8 See, for example, *Whitaker v. Kenosha Unified School District*, 858 F.3d 1034 (7th Cir. 2017), available at http://media.ca7.uscourts.gov/cgi-bin/rssExec.pl?Submit=Display&Path=Y2017/D05-30/C:16-3522:J:Williams:aut:T:fnOp:N:1971382:S:0 (Title IX and Equal Protection Clause); *Dodds v. U.S. Department of Education*, 845 F.3d 217 (6th Cir. 2016), available at http://www.opn.ca6.uscourts.gov/opinions.pdf/16a0291p-06.pdf (Title IX and Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act), available at http://caselaw.findlaw.com/us-6th-circuit/1413440.html; *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); A.H. ex rel. *Handling v. Minersville Area School District*, 3:17-CV-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and Equal Protection Clause); *Stone v. Trump*, F.Supp.3d, No. 17–2459 (D. Md. Nov. 21, 2017) (Equal Protection Clause); *Doe v. Trump*, F.Supp.3d, 2017 WL 4873042 (D.D.C. Oct. 30, 2017) (Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, F.Supp.3d, 2017 WL 4310756 (S.D. Cal. Sept. 27, 2017) (Section 1557); *E.E.O.C. v. Rent-a-Center East Inc*., F.Supp.3d , 2017 WL 4021130 (C.D. Ill. Sept. 8, 2017) (Title VII); *Brown v. Department of Health and Human Services*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017) (Equal Protection Clause); *Smith v. Avanti*, 249 F.Supp.3d 1194 (D. Colo. 2017) (Fair Housing Act); Students and Parents for Privacy v. U.S. Department of Education, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); *Mickens v. General Electric Co*. No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hospital of Central Connecticut*, 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *United States v. Southeast Oklahoma State University*, No. CIV–15–324–C, 2015 WL 4606079 (Title VII); *Finkle v. Howard County*, 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Lopez v. River Oaks Imaging and Diagnostic Group*, Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); *Mitchell v. Axcan Scandipharm, Inc*., No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); *Tronetti v. Healthnet Lakeshore Hospital*, No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII). But see *Etsitty v. Utah Transit Authority*, 502 F.3d 1215 (10th Cir. 2007) (relying on now-overturned U.S. Court of Appeals for the 7th Circuit precedent to hold that anti-transgender discrimination is not covered per se under Title VII but may be covered as sex stereotyping discrimination).

9 *Prescott v. Rady Children's Hospital-San Diego,* 2017 WL 4310756, at *4 (S.D. Cal., 2017).

10 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756 (S.D. Cal., 2017).

11 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities."

12 See, for example, *Hively v. Ivy Tech Community College of Indiana* 853 F.3d 339 (7th Cir. 2017), available at http://media.ca7.uscourts.gov/cgi-bin/rssExec.pl?Submit=Display&Path=Y2017/D04-04/C:15-1720:J:Wood:aut:T:fnOp:N:1942256:S:0; *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004), available at https://scholar.google.com/scholar_case?case=9882340233444710 66&hl=en&as_sdt=6&as_vis=1&oi=scholarr; *Koren v. Ohio Bell Telephone Co.*, 894 F. Supp. 2d 1032, 1038 (N.D. Ohio 2012), available at http://courtweb.pamd.uscourts.gov/courtwebsearch/ndoh/YdIx_0N8uG.pdf; *Heller v. Columbia Edgewater Country Club*, 195 F. Supp. 2d 1212, 1223 (D. Or. 2002), available at https://scholar.google.com/scholar_case?case=12565249645123009449&hl=en&as_sdt=6&as_vis=1&oi=scholarr.

13 Out2Enroll, "Summary of Findings: 2018 Marketplace Plan Compliance with Section 1557," available at https://out2enroll.org/out2enroll/wp-content/uploads/2017/11/Overview-of-Trans-Exclusions-in-2018-Marketplace-Plans-1.pdf (last accessed February 2018).

14 Sam P.K. Collins, "How Obamacare Is Helping Protect Trans People's Right To Health Care," ThinkProgress, July 15, 2015, available at https://thinkprogress.org/how-obamacare-is-helping-protect-trans-peoples-right-to-health-care-d79fa20034bf/.

15 U.S. Department of Health and Human Services, *Voluntary Resolution Agreement Between the U.S. Department of Health and Human Services Office for Civil Rights and the Brooklyn Hospital Center* (2015), available at https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBHC/vra.pdf.

16 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities."

17 One case in CAP's FOIA response was an employment discrimination case that was submitted to the wrong agency and was not included in the authors' totals. Data are from documents on file with authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the U.S. Department of Health and Human Services for copies of de-identified complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 23, 2010 to January 20, 2017.

18 Data are from documents on file with authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the U.S. Department of Health and Human Services for copies of de-identified complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 23, 2010 to January 20, 2017.

19 Data from documents are on file with authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the U.S. Department of Health and Human Services for copies of de-identified complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 23, 2010 to January 20, 2017.

20 Ibid.

21 But see *Cruz et al v. Zucker*, 218 F.Supp.3d 246, 247 (S.D.N.Y., 2016), available at https://cases.justia.com/federal/district-courts/new-york/nysdce/1:2014cv04456/428588/134/0.pdf?ts=1467894220, which finds that New York State's age exclusion for Medicaid coverage of transition-related care violated Section 1557 and Title XIX of the Social Security Act, based in part on published clinical standards and expert testimony supporting coverage.

22 Sejal Singh and Laura Durso, "Widespread Discrimination Continues to Shape LGBT People's Lives in Both Subtle and Significant Ways," Center for American Progress, May 2, 2017, available at https://www.americanprogress.org/issues/lgbt/news/2017/05/02/429529/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways/.

23 *Franciscan Alliance, Inc. et al v. Burwell*, 227 F.Supp.3d 660 (N.D. Tex., 2016), available at https://www.clearinghouse.net/chDocs/public/PB-TX-0012-0003.pdf.

24 Sandy E. James and others, "The Report of the 2015 U.S. Transgender Survey" (Washington: National Center for Transgender Equality, 2016), available at http://www.ustranssurvey.org; Kellan Baker and others, "The Senate Health Care Bill Would Be Devastating for LGBTQ People," Center for American Progress, July 6, 2017, available at https://www.americanprogress.org/issues/lgbt/news/2017/07/06/435452/senate-health-care-bill-devastating-lgbtq-people/; Lambda Legal, "When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV" (2010), available at https://www.lambdalegal.org/publications/when-health-care-isnt-caring; Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Washington: National Academies Press, 2011), available at https://www.ncbi.nlm.nih.gov/books/NBK64806/.

25 Equality Case Files, "7:16-cv-00108 #11," available at http://files.eqcf.org/cases/716-cv-00108-111/ (last accessed February 2018).

26 U.S. Government Publishing Office, "83 FR 2802 – Statement of Organization, Function, and Delegations of Authority," January 19, 2018, available at https://www.gpo.gov/fdsys/granule/FR-2018-01-19/2018-00820.

EXHIBIT 5

Morning Mix

Pediatrician refuses to treat baby with lesbian parents and there's nothing illegal about it

By Abby Phillip February 19, 2015

A Michigan pediatrician declined to treat the infant daughter of a lesbian couple in yet another example of the growing tensions between advocates for LGBT rights and those who want greater religious expression protections.

Krista and Jami Contreras were eager to bring their 6-day-old infant for her first doctor visit after her birth in October. The doctor that they had carefully chosen knew they were lesbians and after the first prenatal visit, they were under the impression that everything was fine. But the morning they arrived for the appointment after baby Bay's birth, another doctor in the practice greeted them instead.

"The first thing Dr. Karam said was, 'I'll be your doctor, I'll be seeing you today because Dr. Roi decided this morning that she prayed on it and she won't be able to care for Bay,' " Jami told WJBK. "Dr. Karam told us she didn't even come to the office that morning because she didn't want to see us."

['Relationship with Jesus' doesn't justify florist's refusal to serve gay couple, judge rules]

In a handwritten letter to the couple months later, their would-be doctor Vesna Roi explained what happened.

> "After much prayer following your prenatal, I felt that i would not be able to develop the personal patient-doctor relationships that I normally do with my patients," Roi wrote in her letter on Feb. 9. "I felt that it was an exciting time for the two of you and I felt that if I came in and shared my decision it would take away much of the excitement. That was my mistake. I should not have made that assumption and I apologize for that."

The incident has raised valid questions about whether Roi's actions were justified, ethical or even legal.

"As far as we know, Bay doesn't have a sexual orientation yet so I'm not really sure what that matters," Jami added to WJBK. "We're not your patient — she's your patient. And the fact is that your job is to keep babies healthy and you can't keep a baby

healthy that has gay parents?

[This Colorado baker refused to put an anti-gay message on cakes. Now she is facing a civil rights complaint.]

The answer is: It depends.

Ethically speaking, the American Medical Association takes a strong stance against denying care to people because of their sexual orientation — and it is reasonable to assume, the sexual orientation of their parents.

But their ethical guidance is just that: Guidance. Doctors aren't bound by it.

"Respecting the diversity of patients is a fundamental value of the medical profession and reflected in long-standing AMA ethical policy opposing any refusal to care for patients based on race, gender, sexual orientation, gender identity or any other criteria that would constitute invidious discrimination," said Gregory Blaschke, chair of the AMA's LGBT Advisory Committee, in a statement to the Detroit Free Press.

But what about the legality of it all? Well, that depends, too.

There's no federal law prohibiting doctors or any other service providers or merchants from refusing service to gay people. And in Michigan, there's no state law prohibiting it either.

"There's no law that prohibits it," Wayne State University constitutional law Prof. Robert Sedler explained to the Free Press. "It's the same as a florist refusing to sell flowers for a same-sex wedding."

And while individual states have taken steps to ban the practice, Michigan is considering going in exactly the opposite direction.

[Some conservatives urging right not to serve gays on religious grounds]

A House bill that would allow adoption agencies to refuse placements based on moral or religious grounds is under consideration in the legislature. And last year, the Michigan House passed a controversial "religious freedom" bill, but it stalled in the Senate. The bill was introduced in the state Senate in this year's legislative session in January.

Backers of Michigan's "religious freedom" legislation, Michigan House Speaker James "Jase" Bolger, explained it to the The Post's Sandhya Somashekhar this way:

> He said he was compelled by the stories of business owners who have been punished for declining to participate in same-sex weddings, such as the couple in Upstate New York who provided their barn to gay couples for receptions but balked when asked to host a same-sex wedding ceremony. The couple was fined.

> "I have been stunned at the number of Americans arguing that the only place people can practice their religion is while they're hiding in their homes and hiding in their churches, and once they leave their home and their church they are not allowed to practice their religion," Bolger said.

The wave of same-sex marriage legalization across the country has only emboldened conservatives to turn to legislative alternatives that would codify "religious freedoms" or their right to refuse service to gay people based on moral or religious beliefs.

Roi didn't specify that Bay's lesbian parents were the reason felt she couldn't serve as her doctor. But the subtext was clear. And with no law prohibiting the practice, the couple has little choice but to accept it.

"When we started calling other pediatricians, my first thing on the phone was, we're lesbian moms — is this okay with you?" Krista told the Free Press.

82 Comments

Abby Phillip is a national political reporter covering the White House for The Washington Post.

EXHIBIT 6

STATUS OF LGBTQ HEALTH: SANTA CLARA COUNTY 2013

Santa Clara County PUBLIC HEALTH

LGBTQ Health Assessment

- Historically, very limited data available on LGBTQ health in Santa Clara County
- Board President Ken Yeager, State of the County 2013
- *First* health assessment of Lesbian, Gay, Bisexual, Transgender and Queer SCC residents
- Goal: understand health needs of LGBTQ residents to identify priorities, strategies, and resources to address disparities

Timeline

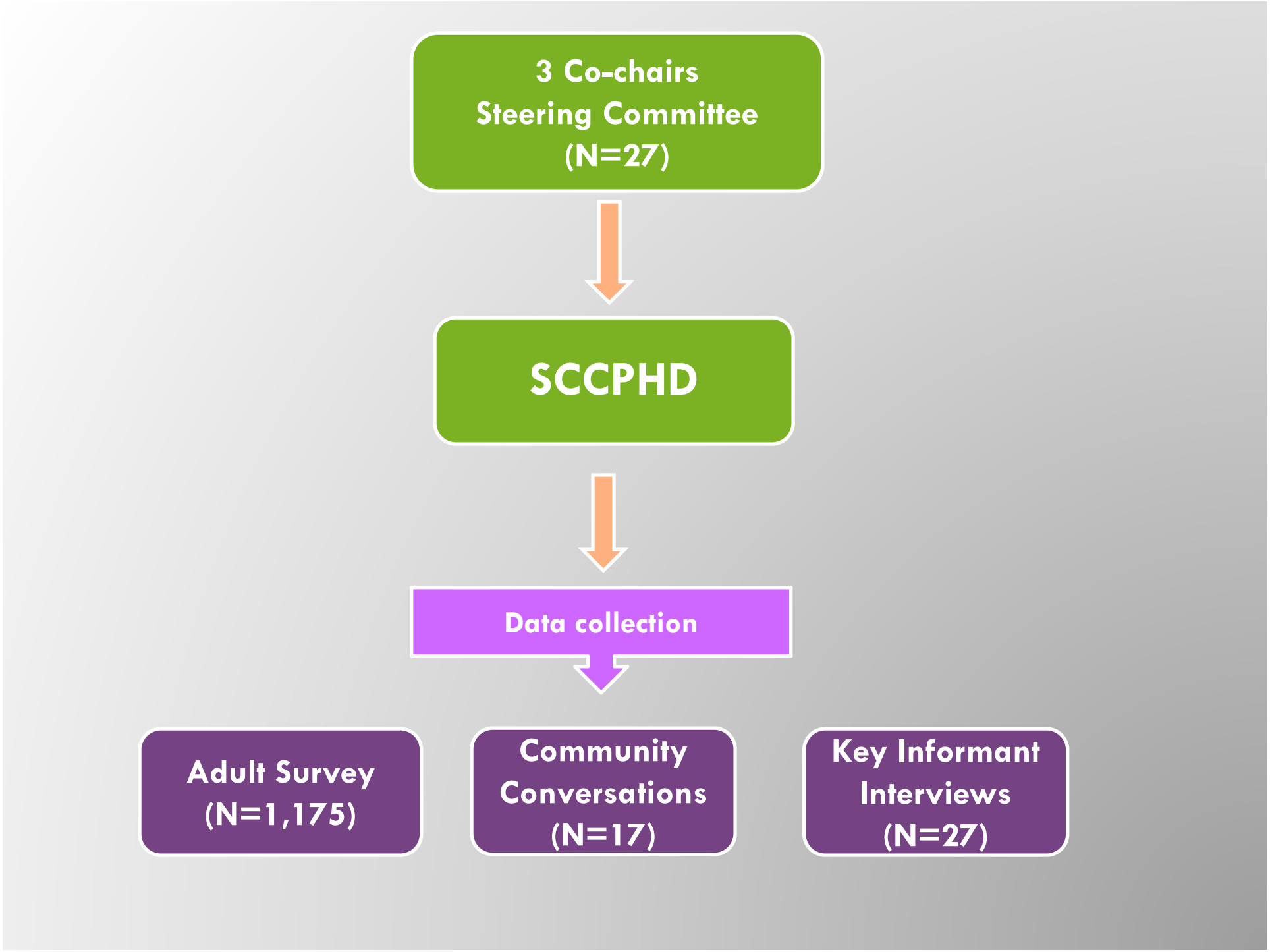
- **August 5**: First Steering Committee Meeting
- **August 17-18**: Adult paper survey administered at San Jose PRIDE
- **August 28**: Community stakeholder meeting and community conversations
- **September-October**: Online LGBTQ adult survey in English, Mandarin, Spanish & Vietnamese
- **September-November**: Key Informant Interviews and additional community conversations
- **November 14**: Community Forum (i.e. recommendations and strategy development)
- **December 20**: Final Report

Community engagement & participation

Co-chairs

PHD **RDA**

- Steering Committee Members
- Community conversations and key informant interviews
- Community forum


3 Co-chairs
Steering Committee
(N=27)
SCCPHD
Data collection
Adult Survey
(N=1,175)
Community
Conversations
(N=17)
Key Informant
Interviews
(N=27)

Community conversations

Health and social issues

- Community connectedness and social cohesion
- Discrimination and acceptance
- Health care access and discrimination
- Families
- Outness
- Substance use and abuse
- Resiliency
- Safety
- Youth
- Mental health

Additional population specific conversations identified:
Latino/a LGBTQ (in Spanish); Asian; Seniors; Lesbian; Transgender men/women; African Americans; Youth (<18)


#SanJosePride
PUBLIC HEALTH
SANJOSEPRIDE.COM
San José
I Spoke Out!


PUBLIC HEALTH
San José


Things Start with Good
HIV Testing Today


SANJOSEPRIDE.COM
#SanJosePride
I Spoke Out!
Santa Clara County
PUBLIC HEALTH

Key informant interviews

- 27 community leaders, experts, and service providers knowledge about particular issues or populations
- Similar topics as in community conversations

Community forum

SOCIODEMOGRAPHICS

Population size and SES

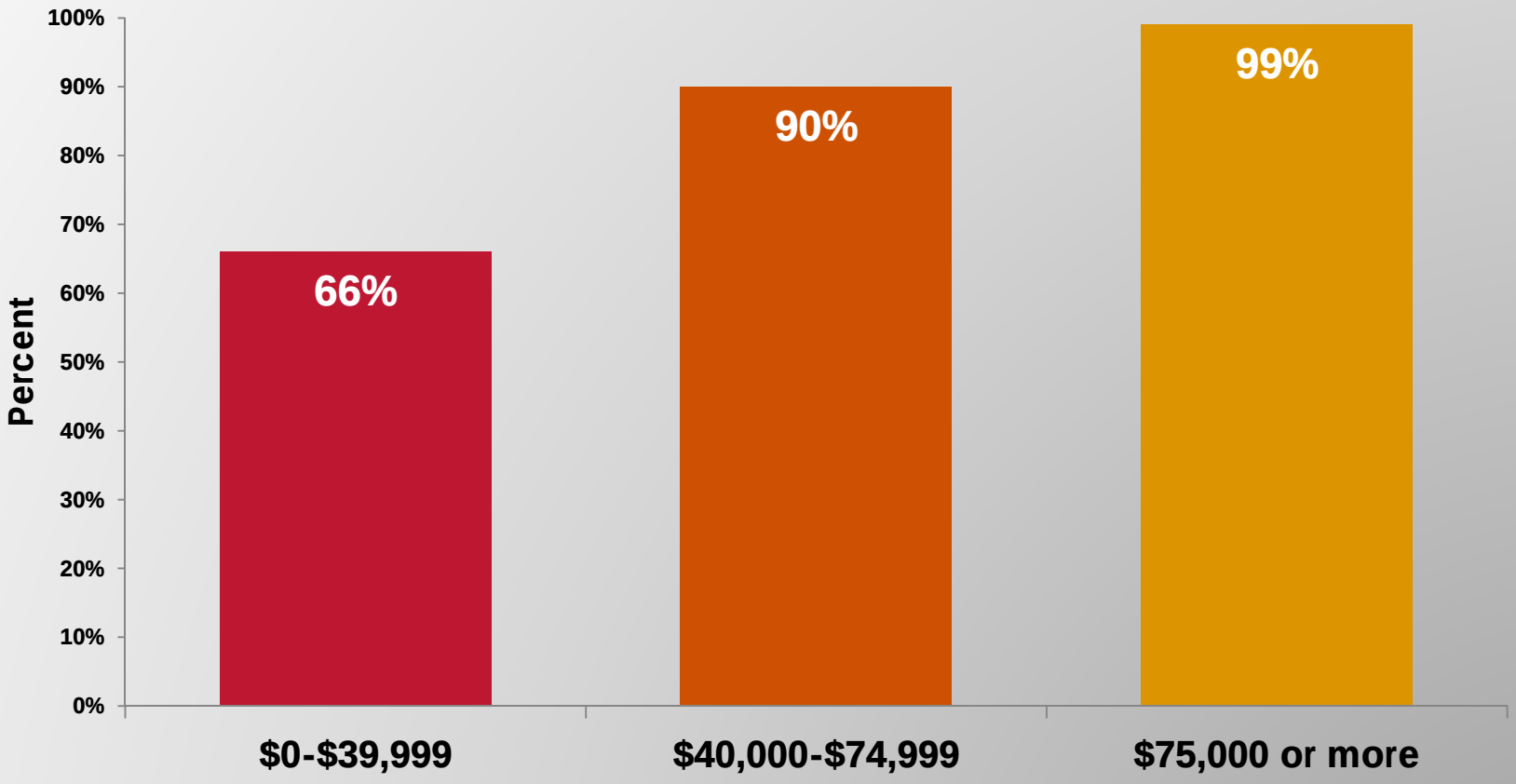
- Lesbian or gay: 31,000 adults (3% of SCC adults)
- Bisexual: 16,000 adults (1% of SCC adults)
- Transgender: 3,500 adults (based on national estimates)
- Higher education than heterosexual adults but more likely to live below 200% FPL

Source: California Health Interview Survey, 2011-12

HEALTHCARE

Percentage of LGBTQ survey respondents with health insurance by household income

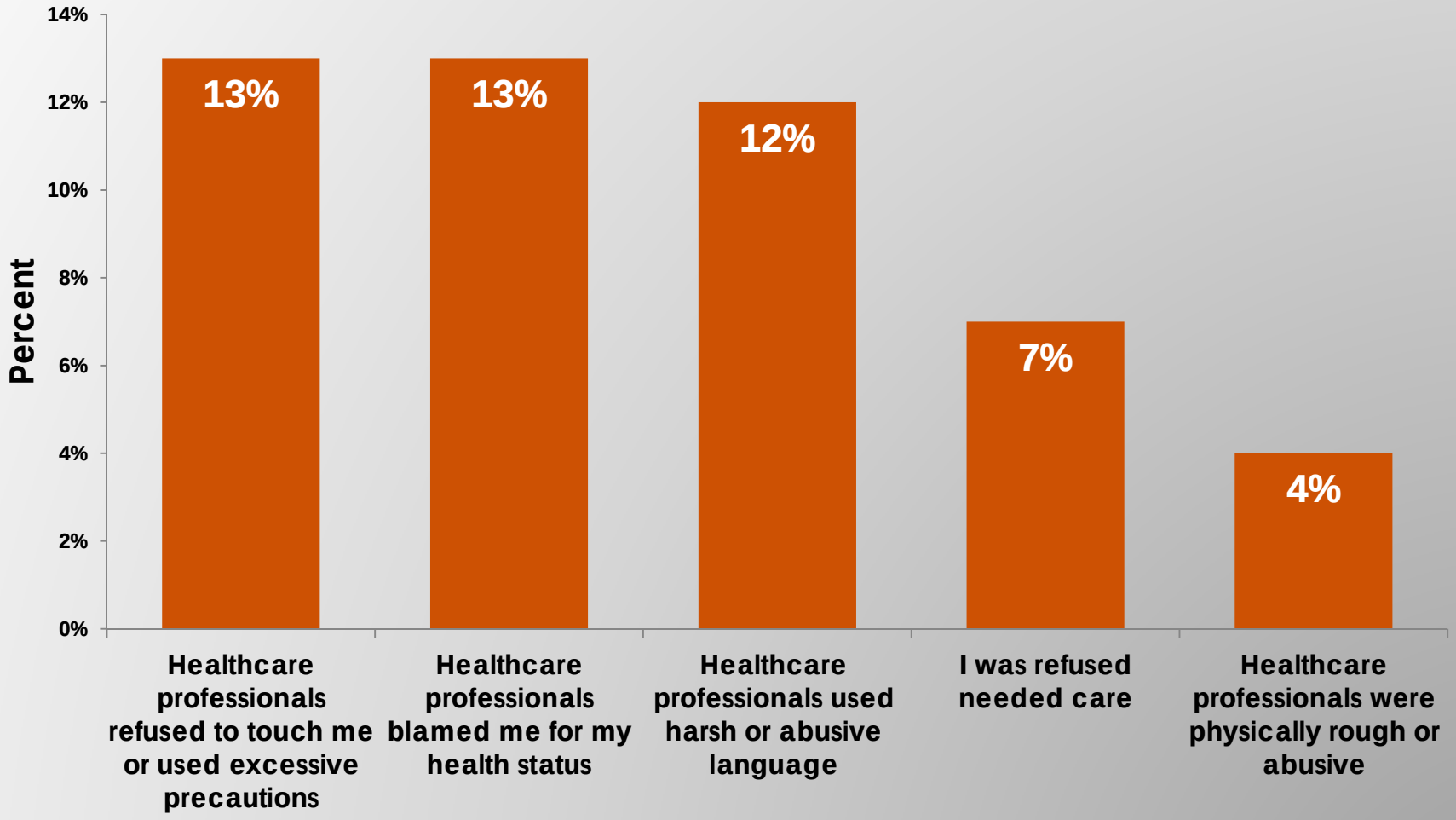
13



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Percentage of LGTBQ survey respondents who have experienced healthcare discrimination in the past 5 years

14



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Out to healthcare provider

- By race/ethnicity:
  - African American: 29%
  - Asian/PI: 67%
  - Latino: 66%
  - White: 78%
- By age:
  - Ages 18-24: 56%
  - Ages 25-54: 69%
  - Ages 55+: 96%

Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their own words: Medical provider competence

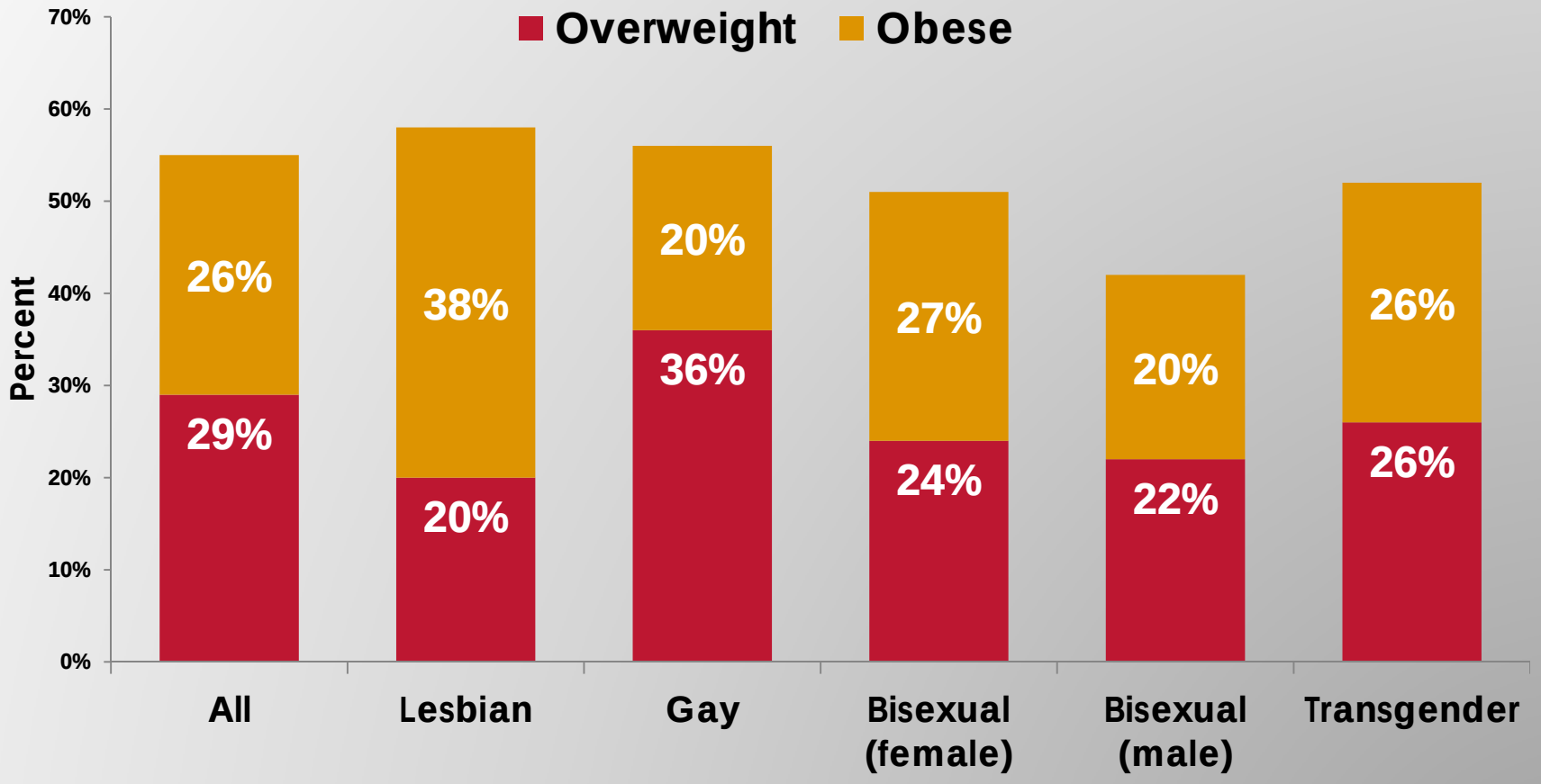
- *Being "LGBTQ friendly" is not enough; providers need to be "LGBTQ knowledgeable".*
- *"It's nice to educate our doctors [about trans issues], but I want to know that <u>they</u> know what they're doing, and not just fudging a little bit and figuring it out on us."*

Recommendations: Healthcare

- **Develop LGBTQ competency trainings** for all providers and staff in healthcare settings.
- **Educate LGBTQ healthcare consumers and providers about LGBTQ rights** and enforce existing nondiscrimination statutes.
- **Standardize medical forms** to include optional gender identity and sexual orientation questions to prevent unintentional discrimination.
- **Create an inventory** of LGBTQ-competent healthcare providers and conduct outreach around available services.

GENERAL HEALTH

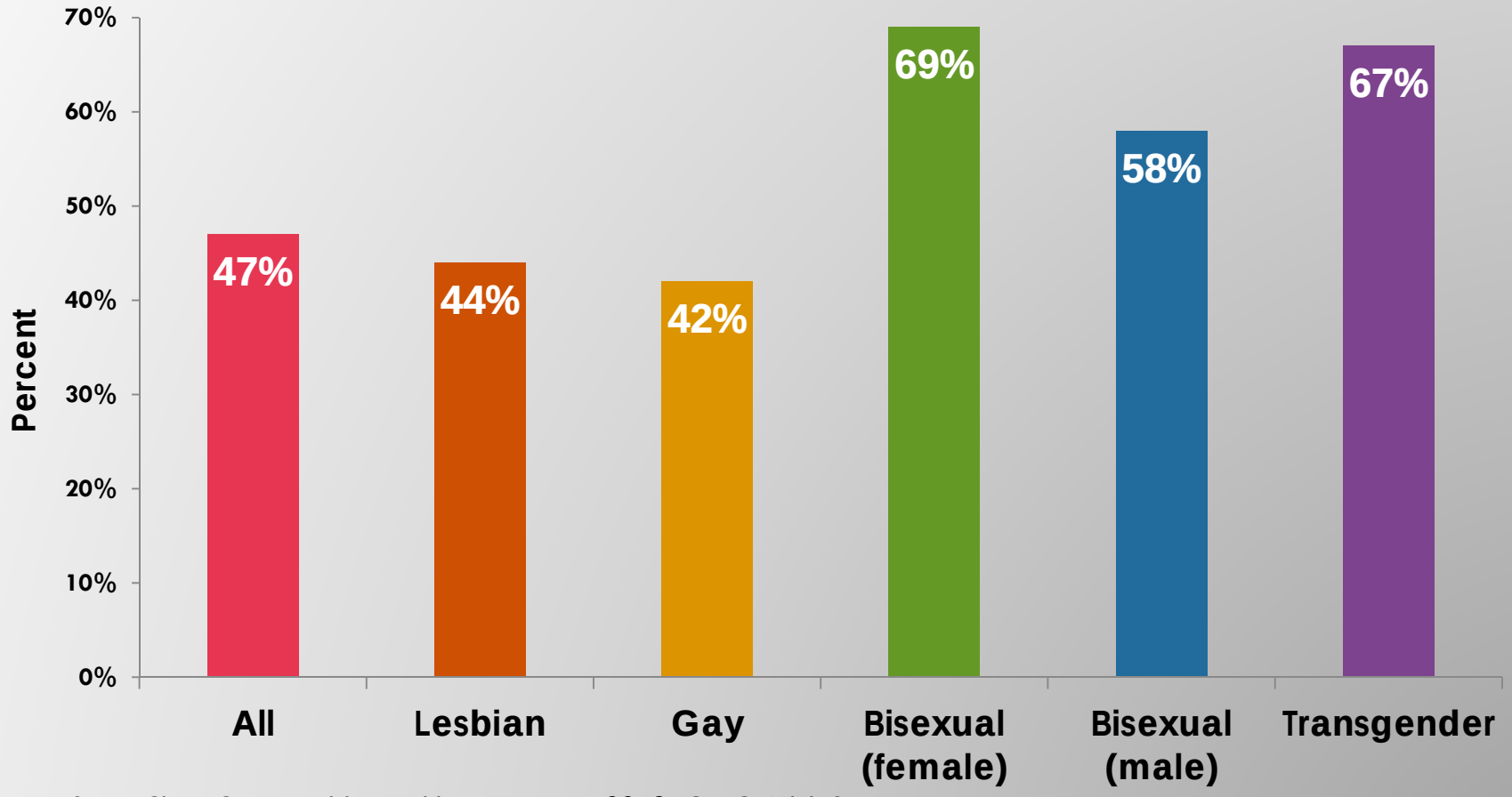
Percentage of LGBTQ survey respondents who are overweight or obese



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

MENTAL HEALTH AND SUBSTANCE USE

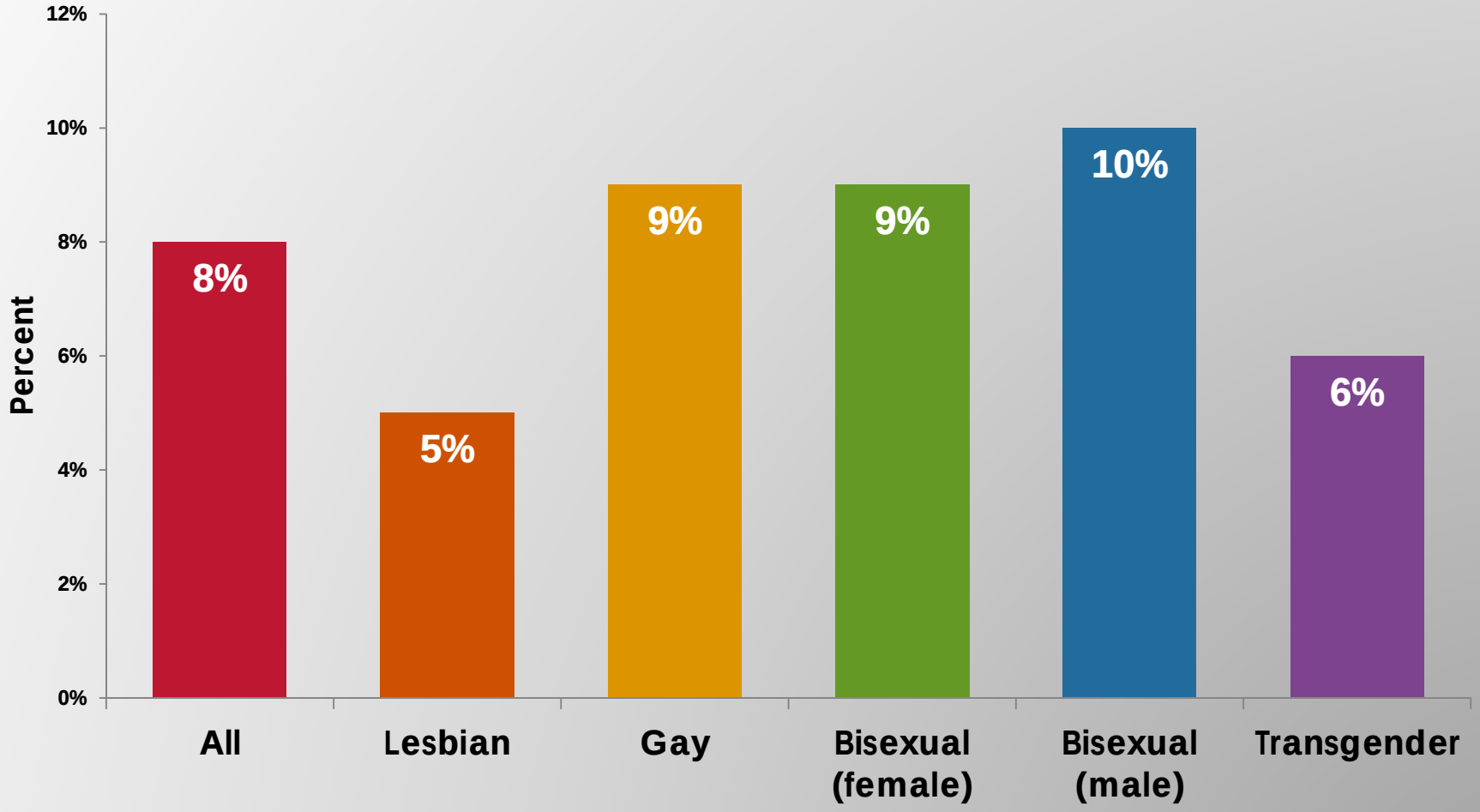
Percentage of LGBTQ survey respondents who felt that they might need to see a professional in the past 12 months because of concerns with their mental health, emotions, nerves, or use of alcohol or drugs



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Percentage of LGBTQ survey respondents who had ever shot up or injected any drugs other than those prescribed

22



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their voices: Mental health and substance use

- *Mental health and substance use among LGBTQ people are often connected to rejection, isolation from families, discrimination, and harassment.*
- *"Mental health issues are dramatically different from the straight community. Not only do you have internal struggles; there is a lot of internalized oppression and stigma."*
- *"I had two episodes where I was near suicidal - one before transition because of the stress of that, and one after because it broke up my family."*

Homelessness and LGBTQ in SCC

- LGBTQ: 29% of the homeless < age 25
- LGBTQ: 10% of the homeless ages 25+
- Transgender: 4% of homeless < age 25
- Transgender or "other": 2% of homeless ages 25+

Source: Santa Clara County Homeless Census and Survey, 2013

Affordable housing and homelessness

- *"Everybody I know who has come out [as trans] has had some family relationship that's been disrupted. For young people it impacts their ability to survive."*

- *"[As a senior] there are two choices: Maintaining my identity and being isolated or going back to the closet after being out for so many years."*

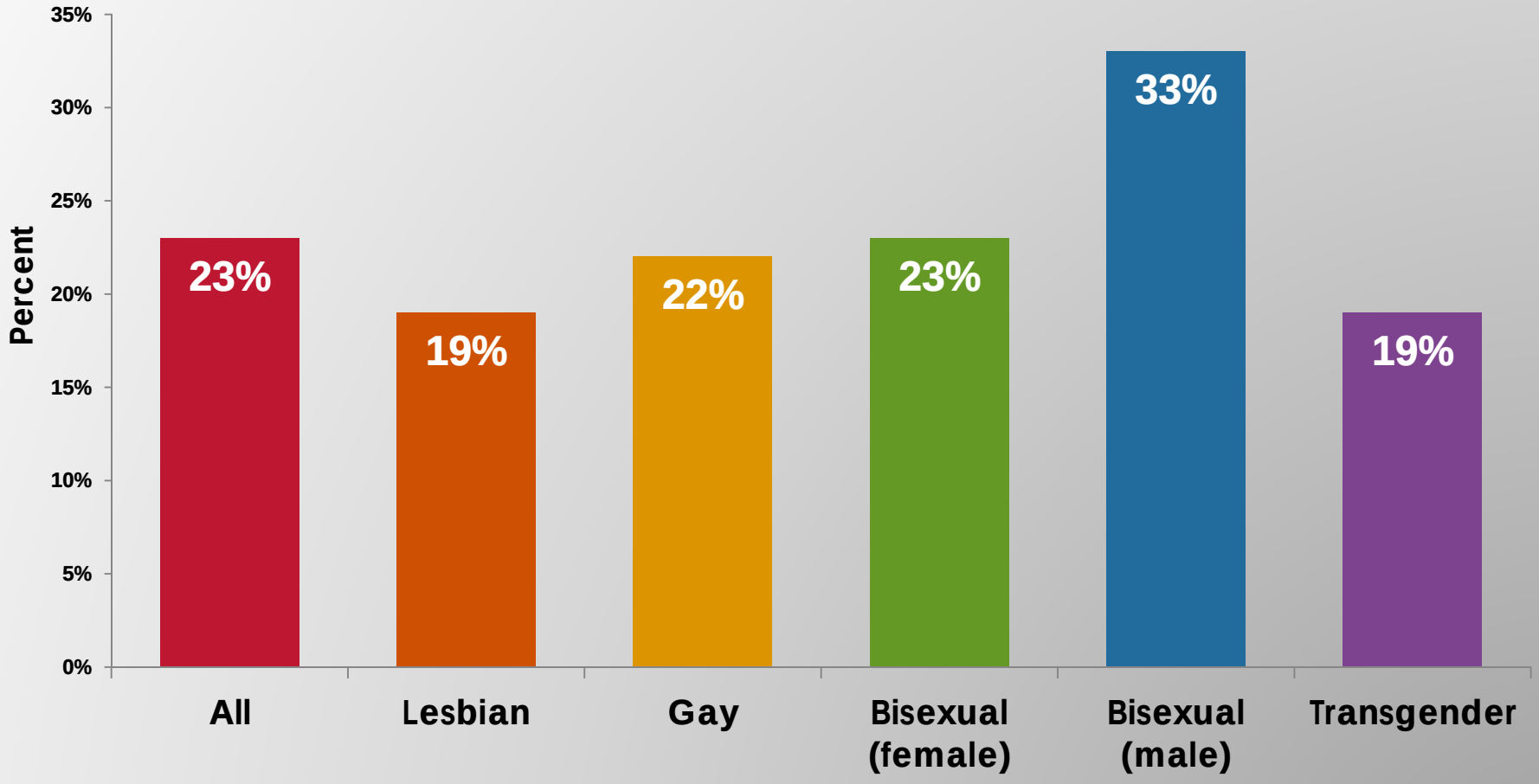
Recommendations: Mental health and substance use

- **Designate the LGBTQ population as high-risk for mental health issues** in order to prioritize services and funding.
- **Develop LGBTQ-specific mental health and substance use services** to reduce barriers and mitigate fears of discrimination.
- **Provide training to ensure an LGBTQ-competent workforce** in mental health and substance use.
- **Continue targeted outreach and education** related to mental health and substance use as well as information on available services.
- **Conduct regular tobacco cessation campaigns** that target LGBTQ populations.

TOBACCO USE

Percentage of LGBTQ survey respondents who smoked 1 or more cigarettes in the past 7 days

28



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their voices: Tobacco use

- *Some participants expressed that tobacco use in the LGBTQ community, specifically smoking, is an issues of concern that should not be overlooked.*
- *Community members cited sporadic LGBTQ public health-related tobacco education campaigns, acknowledging a need for more frequent outreach and education.*

SEXUALLY TRANSMITTED INFECTIONS AND SAFER SEX

Testing for sexually transmitted infections

Among MSM survey respondents:

- 21% have **never been tested** for HIV
- 43% have **never been tested** for syphilis
- 38% have **never been tested** for gonorrhea

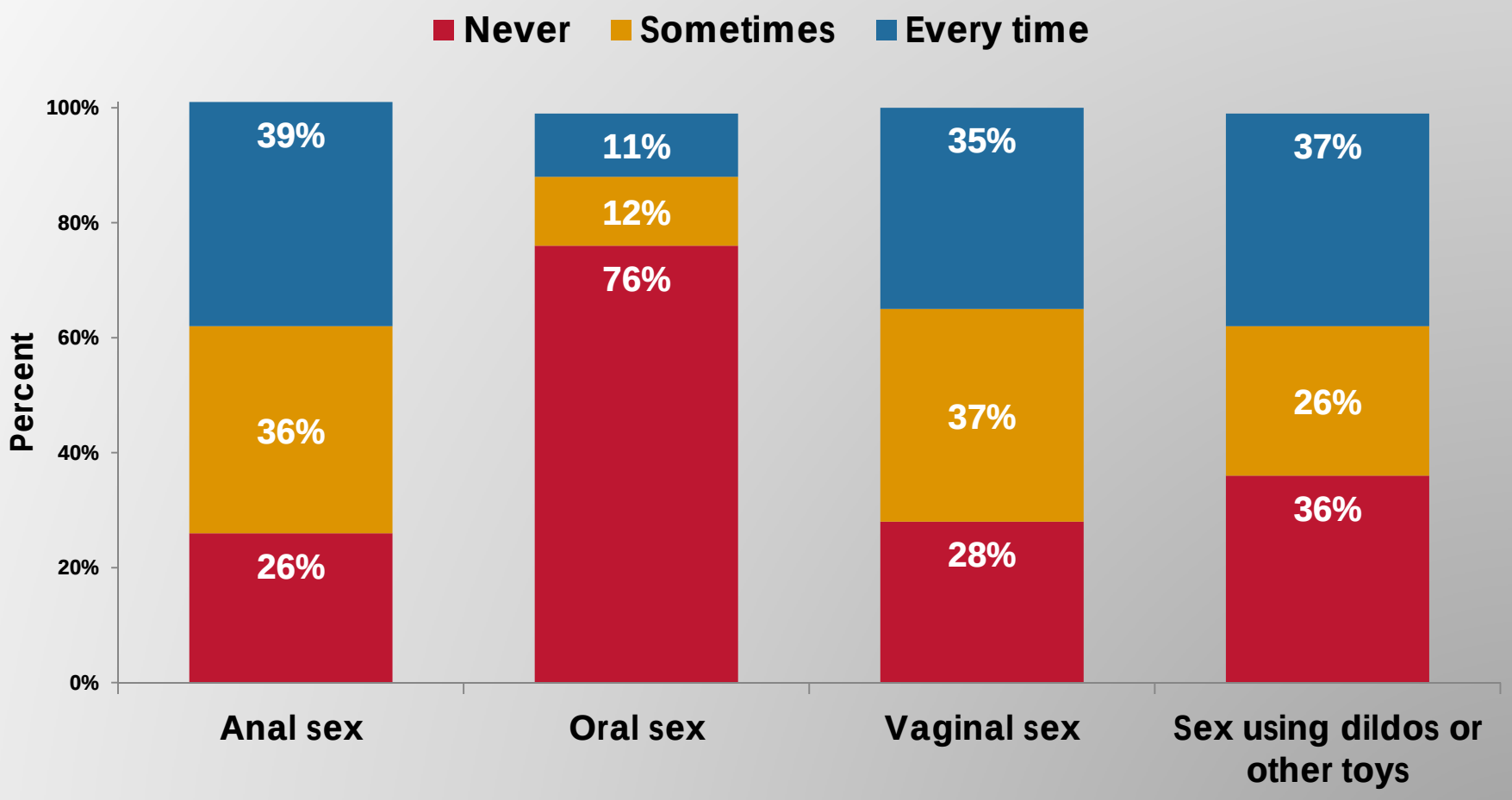
Among lesbian, bisexual women, and transgender survey respondents:

- Between 34% and 40% have **never been tested** for HIV
- Between 45% and 65% have **never been tested** for chlamydia, gonorrhea, or syphilis (transgender)

Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Percentage of MSM survey respondents who used condoms when having sex in the past 6 months

32



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their voices: STIs

- *Community members identified a shortage of HIV and other STI outreach and testing.*
- *Participants highlighted stereotypes about who is at risk for HIV and other STIs as a barrier to increasing access to HIV and other STI testing.*
- *"Normally, gay men go out of the county to San Francisco to get a one-stop shop service."*

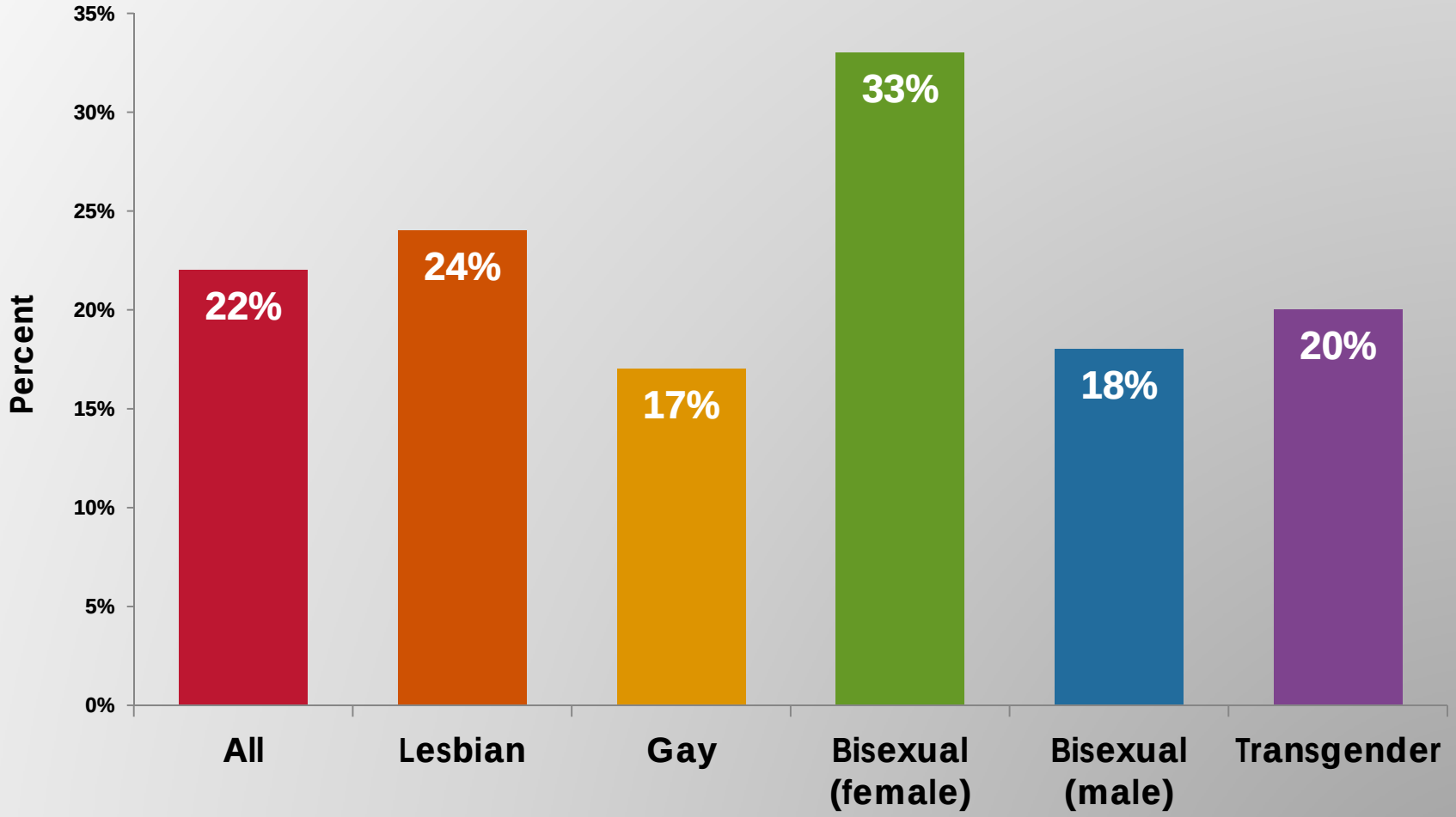
Recommendations: STIs

- **Offer free, comprehensive HIV and other STI testing.**
- **Integrate testing in community venues.**
- **Reduce barriers to testing** by offering low-cost and anonymous testing.
- **Promote and subsidize in-home HIV testing kits.**
- **Train medical providers** on how to talk to patients about STI risk, testing, and care.
- **Improve outreach for hard-to-reach groups.**
- **Raise public awareness to reduce stigma** about HIV and other STIs.
- **Mandate school-based sex education** inclusive of LGBTQ identities.

DOMESTIC VIOLENCE

Percentage of LGBTQ survey respondents ever hit, slapped, pushed, kicked, or physically hurt in any way by an intimate partner

36



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their own words: Domestic violence

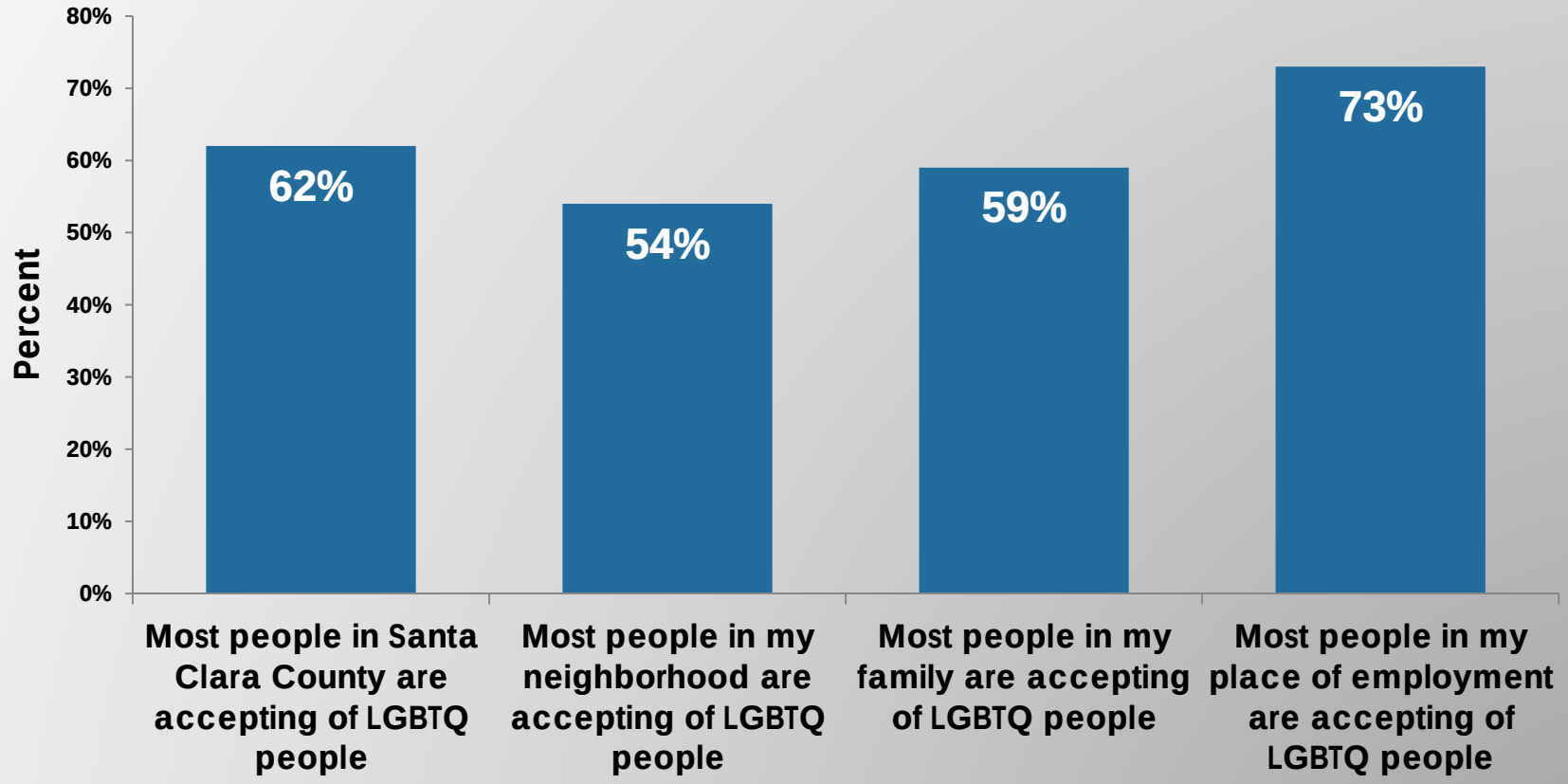
- Community members emphasized that intimate partner violence is a hidden issue in the LGBTQ community.
- Participants also cited instances of parents abusing their children for coming out.
- *"LGBT people in family violence situations often don't come forward. Domestic violence is a dirty little secret in our community."*

Recommendations: Domestic violence

- **Increase education and outreach within the LGBTQ community** to lessen stigma around intimate partner violence.
- **Develop LGBTQ-specific** intimate partner violence services, shelters, and youth crisis services.
- **Facilitate reporting** by training law enforcement agencies and courts about responding to LGBTQ intimate partner violence. Instate victims advocates trained in LGBTQ issues at local police stations.

SOCIAL ACCEPTANCE AND DISCRIMINATION

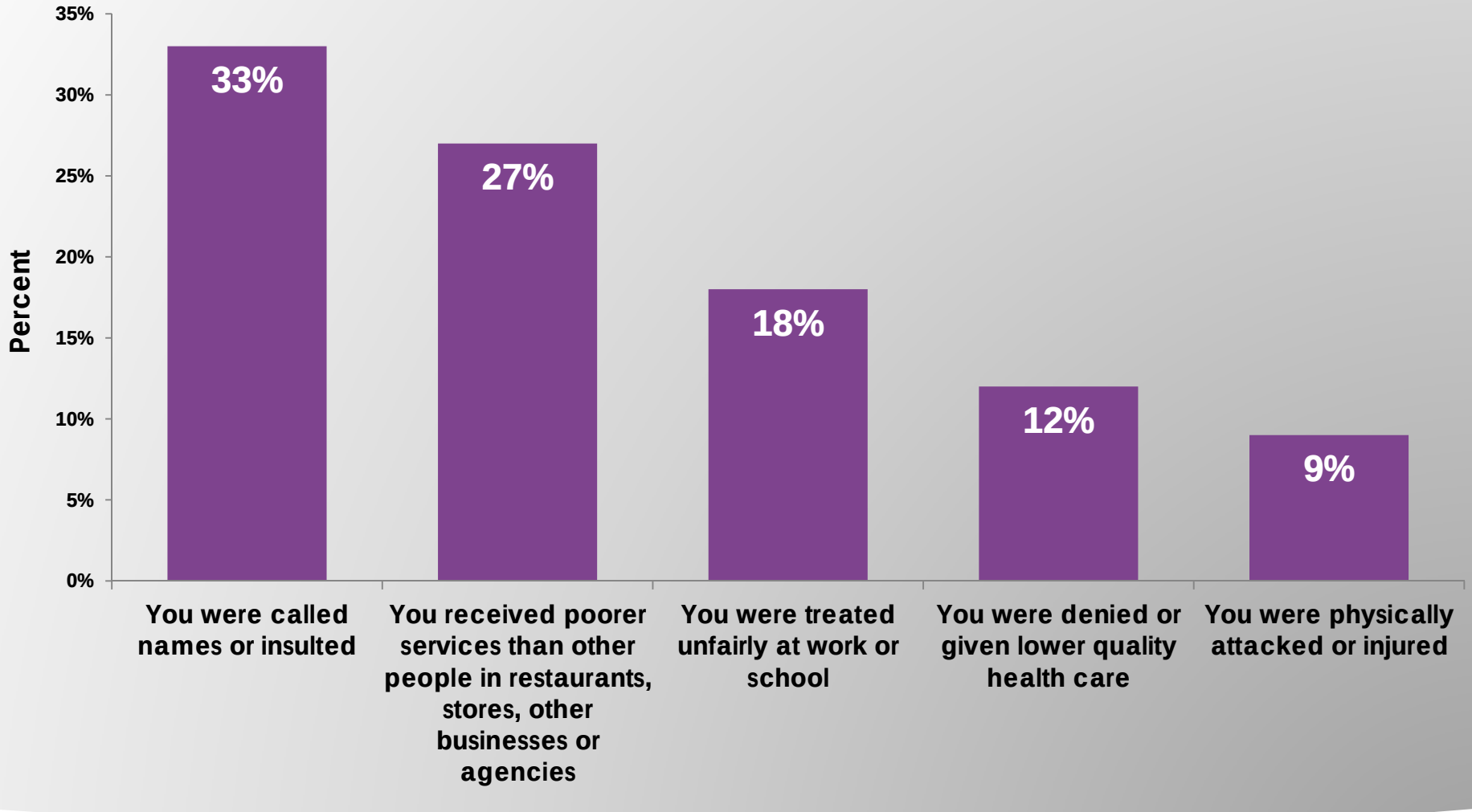
Percentage of LGBTQ survey respondents who agreed or strongly agreed with statements regarding social acceptance of LGBTQ people in Santa Clara County



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

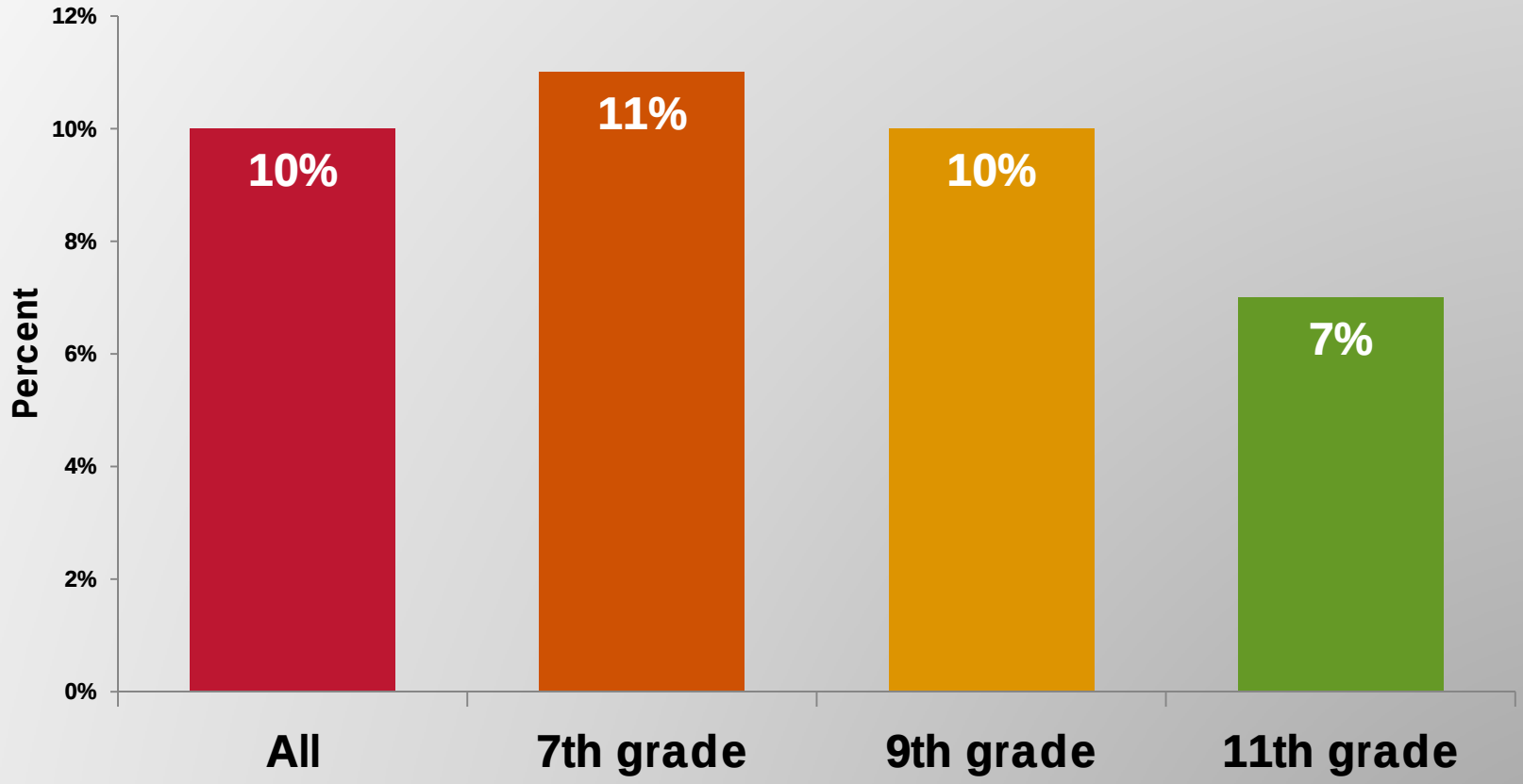
Percentage of LGBTQ survey respondents who experienced discrimination due to sexual orientation and/or gender identity in the past 12 months

41



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Percentage of 7th, 9th, and 11th graders who were harassed or bullied on school property in the past 12 months because they were gay or lesbian or someone thought they were



Source: California Healthy Kids Survey, 2009-10

In their voices: Social acceptance and discrimination

- *"[The trans] community as a whole recognize that walking out the door, sitting at the bus stop, going to the store, realistically can cost us our lives."*

Next steps

- Disseminate widely: report available online & print
- Data from report and recommendations from forum will help inform: community organizations, county agencies, and elected officials
- Goal: generate equitable action-oriented solutions to improve the lives of the LGBTQ community

Acknowledgements

- Supervisor Ken Yeager, Dr. Marty Fenstersheib, and Mr. Fred Ferrer
- Public Health Department staff
  - CDIP: Kris Vantornhout and staff
  - HIV/AIDS: Maharlika Aguirre and Raj Gill
  - Communications: Danica Cho, Amy Cornell and Johanna Silverthorne
- Steering Committee and community organizations
- Special thanks to the LGBTQ community of Santa Clara County


Reports - Public Health Department - County of Santa Clara - Windows Internet Explorer
http://www.sccgov.org/sites/sccphd/en-us/Partners/Data/Pages/Reports-and-Fact-Sheets.aspx
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Reports - Public Health Department - County of Santa...
COUNTY OF SANTA CLARA
SCCgov
Search Public Health Department...
Contacts | Agencies & Departments | Services
Santa Clara County
PUBLIC HEALTH
Great Things Start with Good Health
En Español | Tiếng Việt
About SCCPHD
For Residents
For Partners
For Providers
For Media
Disease Search
Home > For Partners > Data and Statistics
PRINT
Reports
This section contains health status reports and fact sheets created by the Public Health Department.
Status of LGBTQ Health in Santa Clara County, 2013
Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey
HIV/AIDS Report, 2012
Pertussis Report, through September 28, 2013
Previous Pertussis Reports in 2013
Child Poverty in Santa Clara County Report, 2013
Obesity, Physical Activity and Nutrition Report, 2013
Secondhand Smoke and Multi-Unit Housing in Gilroy: A Desktop HIA, 2013
Influenza Reports
Influenza Report, January 12-18, 2014
Influenza Report, January 5-11, 2014
Previous Influenza Reports
Status of Latino/Hispanic Health Santa Clara County 2012
Executive Summary (English)
Executive Summary (Spanish)
Volume 1: Latino/Hispanic Health Matters
Volume 2: Neighborhood Conditions that Affect Latino/Hispanic Health
Appendix: Methods and Tools
Additional Tables and Graphs
Presentations
Neighborhood Profiles
Leading Causes of Death for Latinos/Hispanics versus Other Racial/Ethnic Groups
External Links
Centers for Disease Control and Prevention
California Department of Public Health
American FactFinder
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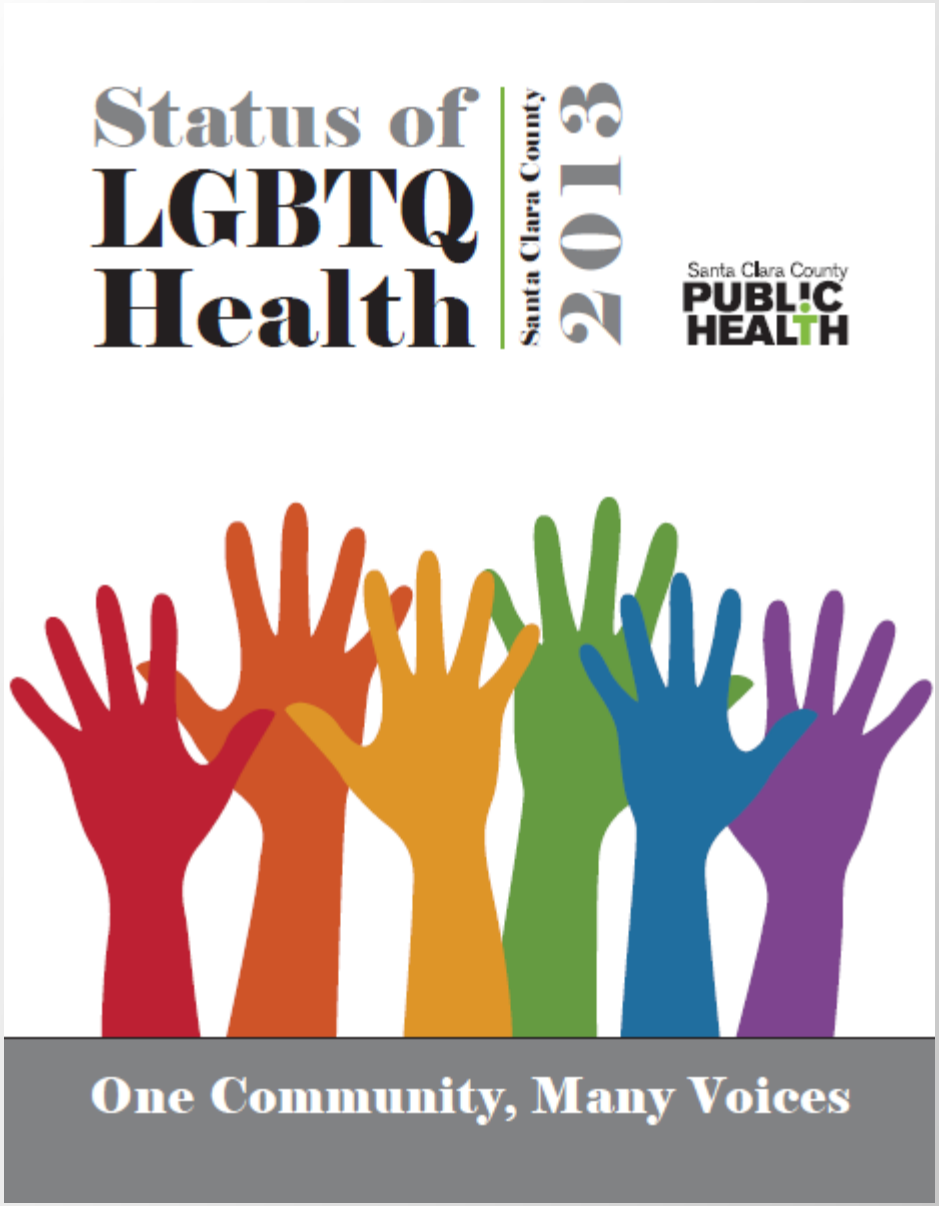

Status of
LGBTQ
Health
Santa Clara County
2013
Santa Clara County
PUBLIC
HEALTH
One Community, Many Voices

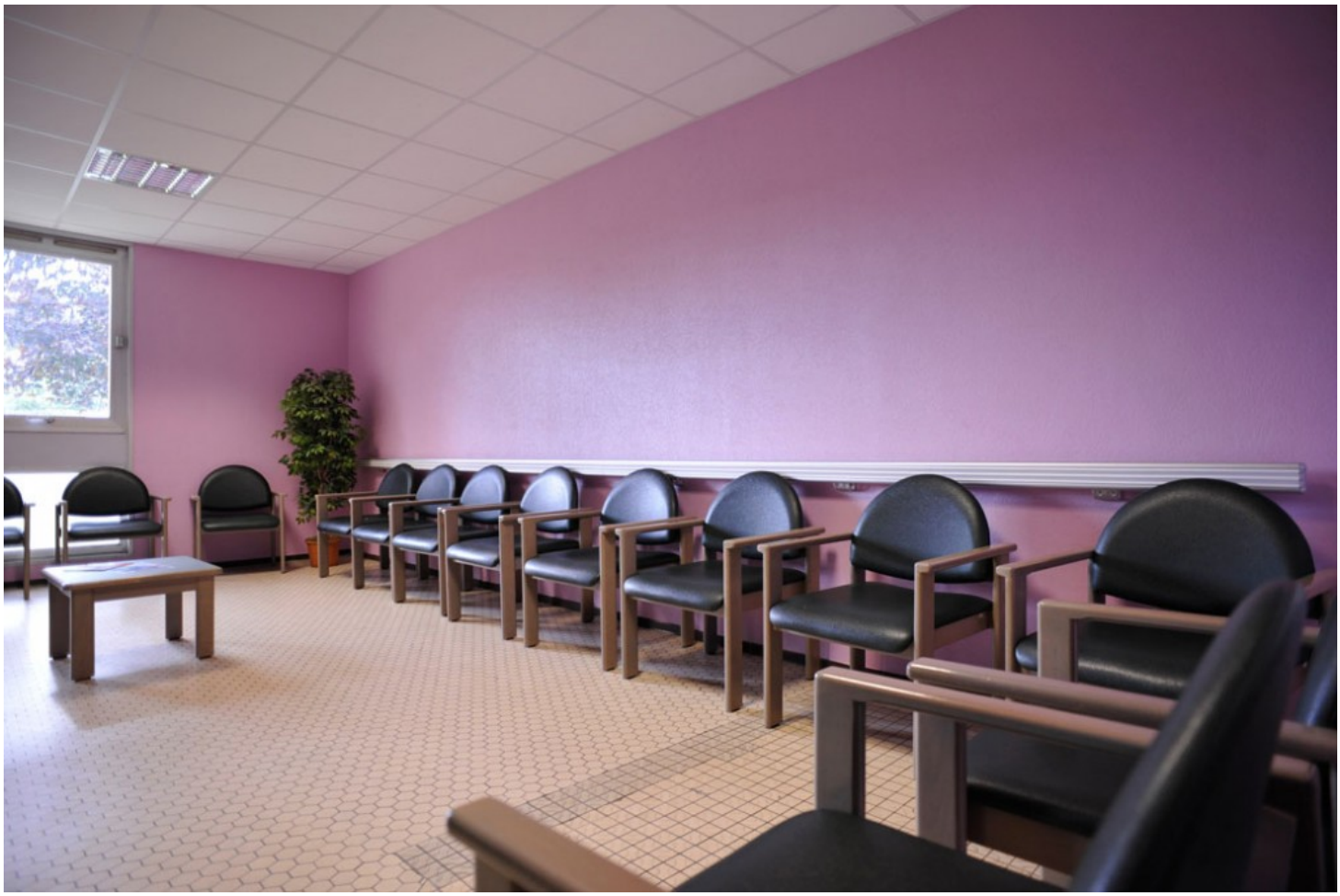
Questions?

EXHIBIT 7

LGBT

Discrimination Prevents LGBTQ People from Accessing Health Care

By Shabab Ahmed Mirza and Caitlin Rooney | Posted on January 18, 2018, 9:00 am



Getty/BSIP, UIG

A waiting room, March 2015.

All people who need medical care should be able to see their doctor without worrying about being mistreated, harassed, or denied service outright. The Affordable Care Act (ACA) helped address this

issue by prohibiting health care providers and insurance companies from engaging in discrimination. As a result of several court rulings and an Obama administration rule, LGBTQ people are explicitly protected against discrimination in health care on the basis of gender identity and sex stereotypes. However, conservative forces and the Trump-Pence administration are seeking to make it easier for health care providers to discriminate against LGBTQ people and women.

Discrimination in health care settings endangers LGBTQ people's lives through delays or denials of medically necessary care. For example, after one patient with HIV disclosed to a hospital that he had sex with other men, the hospital staff refused to provide his HIV medication. In another case, a transgender teenager who was admitted to a hospital for suicidal ideation and self-inflicted injuries was repeatedly misgendered and then discharged early by hospital staff. He later committed suicide. Discrimination affects LGBTQ parents as well: In Michigan, an infant was turned away from a pediatrician's office because she had same-sex parents. Even though many states, such as Michigan, lack explicit statewide laws against LGBTQ discrimination in health care, Section 1557 of the ACA provides federal protections.

New data from a nationally representative CAP survey conducted in 2017 show that LGBTQ people experience discrimination in health care settings; that discrimination discourages them from seeking care; and that LGBTQ people may have trouble finding alternative services if they are turned away. These data underscore the importance of protecting LGBTQ people from discrimination in health care.

LGBTQ people face discrimination and mistreatment at doctors' offices

Despite existing protections, LGBTQ people face disturbing rates of health care discrimination—from harassment and humiliation by providers to being turned away by hospitals, pharmacists, and doctors. The CAP survey data show the types of discrimination that many LGBTQ people face when seeking health care.

Among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:

- 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation.

- 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation.
- 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner.
- 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them.
- 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).

Among transgender people who had visited a doctor or health care providers' office in the past year:

- 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity.
- 12 percent said a doctor or other health care provider refused to give them health care related to gender transition.
- 23 percent said a doctor or other health care provider intentionally misgendered them or used the wrong name.
- 21 percent said a doctor or other health care provider used harsh or abusive language when treating them.
- 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).

Discrimination discourages LGBTQ people from seeking health care

Discrimination—and even the potential for discrimination—can deter LGBTQ people from seeking care in the first place. CAP survey data show that discrimination played a role in preventing a significant number of LGBTQ people from seeking health care. In the year prior to the survey, 8 percent of all LGBTQ people—and 14 percent of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year—avoided or postponed needed medical care because of disrespect or discrimination from health care staff. Among transgender people, 22 percent reported such avoidance. With regard to preventative screenings, 7 percent of

LGBTQ respondents reported avoiding or postponing care in the year prior to the survey, while 17 percent of LGBTQ respondents who had experienced discrimination that year and 19 percent of transgender people reporting avoidance during that period.

An earlier CAP analysis reported other findings from this survey that also indicated the effect of discrimination on LGBTQ people's willingness to seek out health care. In that analysis, 6.7 percent of LGBTQ people reported that they avoided doctor's offices in the past year out of fear of discrimination. This avoidance behavior is even more common among LGBTQ people who reported having experienced discrimination in the past year: 18.4 percent reported avoiding doctor's offices to avoid discrimination, nearly seven times the rate of LGBTQ people who had not experienced discrimination in the past year, at 2.7 percent. These CAP data are consistent with other research. The 2015 U.S. Transgender Survey found that nearly 1 in 4 transgender people (23 percent) had avoided seeking needed health care in the past year due to fear of discrimination or mistreatment due to their gender identity.

Finding another doctor is not an answer for all LGBTQ patients

The expansion of legislation, lawsuits, and administrative rule-making allowing for broad religious exemptions from providing services puts another impediment in the way of LGBTQ people receiving medical care. For those patients that do seek medical care and are turned away by providers, alternatives may not be easily accessible. This concern is exacerbated by a shortage of medical providers in key areas of treatment (such as mental health care) and geographic areas (such as rural communities).

CAP survey data show that many LGBTQ people would face significant difficulty finding an alternative provider if they were turned away by a health care provider, such as a hospital, clinic, or pharmacy.

- 18 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 17 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 8 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.

LGBTQ people living outside of a metropolitan area report a high rate of difficulty accessing alternative services, which may be because such services could be further away and transportation costs have the potential to be higher.

- 41 percent of nonmetro LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 31 percent of nonmetro LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 17 percent of nonmetro LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.

Transgender people also report difficulty accessing alternatives at a high rate:

- 31 percent of transgender people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 30 percent of transgender people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 16 percent of transgender people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.

Some people may go to LGBTQ community health centers to avoid such discrimination, but they are not widely available across the United States, and many do not provide comprehensive services. A total of 13 states—mainly those in the central United States—do not have any LGBTQ community health centers. On the U.S. Transgender Survey, 29 percent of respondents seeking transition-related care reported having to travel 25 miles or more to access such care.

Conclusion

Despite the importance of protecting people from discrimination in health care settings, current regulations are under attack. On August 23, 2016, a group of conservative religious organizations and eight states filed a lawsuit against the U.S. Department of Health and Human Services (HHS), challenging the 1557 rule. They made dubious claims that the nondiscrimination protections would require doctors to provide treatment that violated their religious beliefs, such as transition-related surgeries for transgender patients. Even though numerous courts have ruled that laws such as 1557

protect LGBTQ people, in December 2016, a single federal judge issued a nationwide injunction prohibiting HHS from enforcing the 1557 rule's prohibition on discrimination on the basis of gender identity. On May 2, 2017, the Trump-Pence administration filed a motion indicating that the 1557 rule was under review, and in August, it announced that HHS had already written a draft proposal to roll back the rule. Given the Trump-Pence administration's record on LGBTQ issues, new regulations will likely deny the existence of protections to LGBTQ people and make equal health care access and treatment more difficult to obtain for this historically marginalized community. While the administration cannot change the protections for LGBTQ people that exist under the law, a regulatory rollback would cause fear and confusion for patients and promote discrimination by providers and insurers.

Shabab Ahmed Mirza is a research assistant for the LGBT Research and Communications Project at the Center for American Progress. Caitlin Rooney is a Research Assistant for the LGBT Research and Communications Project at the Center.

Methodology

To conduct this study, CAP commissioned and designed a survey, fielded by GfK SE, which surveyed 1,864 individuals about their experiences with health insurance and health care. Among the respondents, 857 identified as lesbian, gay, bisexual, and/or transgender, queer, or asexual, while 1,007 identified as heterosexual and cisgender/nontransgender. Respondents came from all income ranges and are diverse across factors such as race, ethnicity, education, geography, disability status, and age. The survey was fielded online in English in January 2017 to coincide with the fourth open enrollment period through the health insurance marketplaces and the beginning of the first full year of federal rules that specifically protect LGBTQ people from discrimination in health insurance coverage and health care. The data are nationally representative and weighted according to U.S. population characteristics. Metro is defined as a metropolitan core-based statistical area and nonmetro is defined as anything else, including micropolitan core-based statistical areas and locations outside of a core-based statistical area.

Additional information about study methods and materials are available in prior analyses and from the authors. Results reported in this column may differ slightly (two-tenths of 1 percent) but not substantively from other analyses of these data due to the statistical program employed.

The authors would like to thank Sharita Gruberg, Frank Bewkes, and Laura E. Durso from the Center for American Progress as well as Harper Jean Tobin, Katie Keith, and Kellan Baker for their contributions to this column.

Center for American Progress

EXHIBIT 8

Lesbian, Gay, Bisexual, and Transgender Health *New*

Goal

Improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals.

Overview

LGBT individuals encompass all races and ethnicities, religions, and social classes. Sexual orientation and gender identity questions are not asked on most national or State surveys, making it difficult to estimate the number of LGBT individuals and their health needs.

Research suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBT persons has been associated with high rates of psychiatric disorders,[1] substance abuse,[2, 3] and suicide.[4] Experiences of violence and victimization are frequent for LGBT individuals, and have long-lasting effects on the individual and the community.[5] Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals.[6]

The LGBT companion document to Healthy People 2010[7] highlighted the need for more research to document, understand, and address the environmental factors that contribute to health disparities in the LGBT community. As part of this work, we need to increase the number of nationally-representative health-related surveys that collect information on sexual orientation and gender identity (SOGI).

View HP2020 Data for:
▶ Lesbian Gay Bisexual and Transgender Health

Midcourse Review Data Are In!

Check out our interactive infographic to see progress toward the Lesbian Gay Bisexual and Transgender Health objectives and other Healthy People topic areas.

Why Is LGBT Health Important?

Eliminating LGBT health disparities and enhancing efforts to improve LGBT health are necessary to ensure that LGBT individuals can lead long, healthy lives. The many benefits of addressing health concerns and reducing disparities include:

- Reductions in disease transmission and progression
- Increased mental and physical well-being
- Reduced health care costs
- Increased longevity

Efforts to improve LGBT health include:

- Collecting SOGI data in health-related surveys and health records in order to identify LGBT health disparities [8]
- Appropriately inquiring about and being supportive of a patient's sexual orientation and gender identity to enhance the patient-provider interaction and regular use of care[9]
- Providing medical students with training to increase provision of culturally competent care[10]
- Implementing antibullying policies in schools[11]
- Providing supportive social services to reduce suicide and homelessness among youth[11]

- Curbing human immunodeficiency virus (HIV)/sexually transmitted infections (STIs) with interventions that work[12]

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Understanding LGBT Health

In order to effectively address LGBT health issues, we need to securely and consistently collect SOGI information in national surveys and health records. This will allow researchers and policy makers to accurately characterize LGBT health and disparities.

Understanding LGBT health starts with understanding the history of oppression and discrimination that these communities have faced. For example, in part because bars and clubs were often the only safe places where LGBT individuals could gather, alcohol abuse has been an ongoing problem.[14]

Related Topic Areas

- Access to Health Services
- Adolescent Health
- Cancer
- Early and Middle Childhood
- Educational and Community-Based Programs

More

Social determinants affecting the health of LGBT individuals largely relate to oppression and discrimination. Examples include:

- Legal discrimination in access to health insurance, employment, housing, marriage, adoption, and retirement benefits
- Lack of laws protecting against bullying in schools
- Lack of social programs targeted to and/or appropriate for LGBT youth, adults, and elders
- Shortage of health care providers who are knowledgeable and culturally competent in LGBT health

The physical environment that contributes to healthy LGBT individuals includes:

- Safe schools, neighborhoods, and housing
- Access to recreational facilities and activities
- Availability of safe meeting places
- Access to health services

LGBT health requires specific attention from health care and public health professionals to address a number of disparities, including:

- LGBT youth are 2 to 3 times more likely to attempt suicide.[15]
- LGBT youth are more likely to be homeless.[16, 17, 18]
- Lesbians are less likely to get preventive services for cancer.[19, 20]
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.[21]
- Lesbians and bisexual females are more likely to be overweight or obese.[22]
- Transgender individuals have a high prevalence of HIV/STDs,[23] victimization,[24] mental health issues,[25] and suicide[26] and are less likely to have health insurance than heterosexual or LGB individuals.[27]
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.[28]
- LGBT populations have the highest rates of tobacco,[29, 30] alcohol,[30, 31] and other drug use.[30, 32, 33]

Continuing Issues in LGBT Health

A number of issues will need to continue to be evaluated and addressed over the coming decade, including:

- Nationally representative data on LGBT Americans
- Prevention of violence and homicide toward the LGB community, and especially the transgender population
- Resiliency in LGBT communities
- LGBT parenting issues throughout the life course
- Elder health and well-being
- Exploration of sexual/gender identity among youth
- Need for a LGBT wellness model
- Recognition of transgender health needs as medically necessary

References

[1]McLaughlin KA, Hatzenbuehler ML, Keyes KM. Responses to discrimination and psychiatric disorders among black, Hispanic, female, and lesbian, gay, and bisexual individuals. Am J Public Health. 2010;100(8):1477-84.

[2]Ibanez GE, Purcell DW, Stall R, et al. Sexual risk, substance use, and psychological distress in HIV-positive gay and bisexual men who also inject drugs. AIDS. 2005;19(suppl 1):49-55.

[3]Herek GM, Garnets LD. Sexual orientation and mental health. Annu Rev Clin Psychol. 2007;3:353-75.

[4]Remafedi G, French S, Story M, et al. The relationship between suicide risk and sexual orientation: Results of a population-based study. Am J Public Health. 1998;88(1):57-60.

[5]Roberts AL, Austin SB, Corliss HL, et al. Pervasive trauma exposure among US sexual orientation minority adults and risk of posttraumatic stress disorder. Am J Public Health. 2010 Apr 15.

[6]US Department of Health and Human Services. Healthy People 2010. [Internet]. Available from: http://www.hhs.gov

[7]Gay and Lesbian Medical Association (GMLA). Healthy People 2010: A companion document for LGBT health [Internet]. San Francisco: GMLA; 2001 Apr. Available from: http://www.glma.org/_data/n_0001/resources/live/HealthyCompanionDoc3.pdf [PDF =- 2.3 MB]

[8]Cahill SR, Baker K, Deutsch MB, etal. Inclusion of Sexual Orientation and Gender Identity in Stage 3 Meaningful Use Guidelines: A Huge Step Forward for LGBT Health. LGBT Health. 2015; 0(0):1-3.

[9]Steele LS, Tinmouth JM, Lu A. Regular health care use by lesbians: A path analysis of predictive factors. Fam Pract. 2006;23:631-6.

[10]Sanchez NF, Rabatin J, Sanchez JP, et al. Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. Med Stud Edu. 2006;38(1):21-7.

[11]Suicide Prevention Resource Center. Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth. Newton, MA: Education Development Center, Inc.; 2009. Available from: http://www.sprc.org/sites/default/files/migrate/library/SPRC_LGBT_Youth.pdf [PDF - 428 KB]

[12]Centers for Disease Control and Prevention (CDC). Compendium of HIV prevention interventions with evidence of effectiveness [Internet]. Atlanta: CDC; 2017. Available from: https://www.cdc.gov/hiv/research/interventionresearch/compendium/

[13]Ponce NA, Cochran SD, Pizer JC, et al. The effects of unequal access to health insurance for same-sex couples in California. Health Affairs. 2010;29(8):1-10.

[14]Bux DA. The epidemiology of problem drinking in gay men and lesbians: A critical review. Clin Psych Rev. 1996;16:277-98.

[15]Garofalo R, Wolf RC, Wissow LS, et al. Sexual orientation and risk of suicide attempts among a representative sample of youth. Arch Pediatr Adolesc Med. 1999;153(5):487-93.

[16]Conron KJ, Mimiaga MJ, Landers SJ. A population-based study of sexual orientation identity and gender differences in adult health. Am J Public Health. 2010 Oct;100(10):1953-60.

[17]Kruks, G. Gay and lesbian homeless/street youth: Special issues and concerns. J Adolesc Health. 2010;12(7):515-8.

[18]Van Leeuwen JM, Boyle S, Salomonsen-Sautel S, et al. Lesbian, gay, and bisexual homeless youth: An eight-city public health perspective. Child Welfare. 2006 Mar–Apr;85(2):151-70.

Learn More

- Centers for Medicare & Medicaid Services: Final Rule on Changes to Hospital Conditions of Participation to Ensure Visitation Rights for All Patients
- HealthCare.gov: Health Care Coverage Options for Same Sex Couples
- www.stopbullying.gov
- U.S. Department of Health and Human Services: Health and Well-Being for Lesbian, Gay, Bisexual and Transgender Americans
- National Clearinghouse on Family and Youth: Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

More ▶

[19]Buchmueller T, Carpenter CS. Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000–2007. Am J Public Health. 2010;100(3):489-95.

[20]Dilley JA, Simmons KW, Boysun MJ, et al. Demonstrating the importance and feasibility of including sexual orientation in public health surveys: Health disparities in the Pacific Northwest. Am J Public Health. 2010;100(3):460-7.

[21]Centers for Disease Control and Prevention (CDC). HIV among Gay and Bisexual Men [Internet]. Atlanta: CDC; 2017 Feb [cited 2017 Aug 23].https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf

[22]Struble CB, Lindley LL, Montgomery K, et al. Overweight and obesity in lesbian and bisexual college women. J Am College Health. 2010;59(1):51-6.

[23]Herbst JH, Jacobs ED, Finlayson TJ, et al. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. AIDS Behav. 2008;(12):1-17.

[24]Whitbeck LB, Chen X, Hoyt DR, et al. Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. J Sex Research. 2004;41(4):329-42.

[25]Diaz RM, Ayala G, Bein E, et al. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from three US cities. Am J Public Health. 2001;91(6):141-6.

[26]Kenagy GP. Transgender health: Findings from two needs assessment studies in Philadelphia. Health Soc Work. 2005;30(1):19-26.

[27]National Gay and Lesbian Taskforce. National transgender discrimination survey: Preliminary findings. Washington, DC: National Gay and Lesbian Taskforce; 2009 Nov. Available from:
http://www.thetaskforce.org/downloads/reports/fact_sheets/transsurvey_prelim_findings.pdf [PDF - 1.17 MB]

[28]Cahill S, South K, Spade J. Outing age: Public policy issues affecting gay, lesbian, bisexual and transgender elders. Washington: National Gay and Lesbian Task Force; 2009 Nov.

[29]Lee GL, Griffin GK, Melvin CL. Tobacco use among sexual minorities in the USA: 1987 to May 2007: A systematic review. Tob Control. 2009;18:275-82.

[30]Xavier J, Honnold J, Bradford J. The health, health-related needs, and lifecourse experiences of transgender Virginians. Virginia HIV Community Planning Committee and Virginia Department of Health. Richmond, VA: Virginia Department of Health; 2007. Available from:
http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/documents/pdf/THISFINALREPORTVol1.pdf [PDF - 646 KB]

[31]Hughes TL. Chapter 9: Alcohol use and alcohol-related problems among lesbians and gay men. Ann Rev of Nurs Res. 2005;23:283-325.

[32]Lyons T, Chandra G, Goldstein J. Stimulant use and HIV risk behavior: The influence of peer support. AIDS Ed and Prev. 2006;18(5):461-73.

[33]Mansergh G, Colfax GN, Marks G, et al. The circuit party men's health survey: Findings and implications for gay and bisexual men. Am J Public Health. 2001;91(6):953-8.

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Site last updated 03/22/18

EXHIBIT Y

City and County of San Francisco
Mark Farrell
Mayor

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

Secretary Alex Azar
The U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Department of Health and Human Services Proposed Rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," Docket ID No. HHS-OCR-2018-0002 (RIN 0945-ZA03)

Dear Secretary Azar,

Thank you for the opportunity to submit comments on "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," Department of Health and Human Services (HHS) proposed rule RIN0945-ZA03, Docket ID No. HHS-OCR-2018-0002. **The San Francisco Department of Public Health (SFDPH) strongly opposes this proposed rule and requests that it be withdrawn.** In support of our position, we offer the information below based on our experience as a safety net provider of direct health services to thousands of insured and uninsured residents of San Francisco, including those most socially and medically vulnerable.

SFDPH, through the San Francisco Health Network (SFHN), provides San Francisco's only complete care system and includes primary care, dental care, emergency and trauma treatment, medical and surgical specialties, diagnostic testing, skilled nursing and rehabilitation, behavioral health services and jail health services. The mission of SFDPH is to protect and promote the health of all San Franciscans. SFDPH is dedicated to reducing health disparities and providing inclusive care to all patients. SFDPH provides this care though its top-rated programs, fifteen primary care community clinics, and hospitals, including Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG). For example, Zuckerberg San Francisco General alone delivers over one thousand babies a year, has been at the forefront of HIV/AIDS care from the beginning of the AIDS crisis, and provides gender-confirmation surgeries to transgender patients.

Zuckerberg San Francisco General cares for approximately one in eight San Franciscans a year, regardless of their ability to pay. As the City's safety net hospital, Zuckerberg San Francisco General provides the highest-quality services, including to many patients covered through Medi-Cal (California's Medicare program). It provides life-saving emergency care as the only level one trauma center in San Francisco, serving a region of more than 1.5 million people. With the busiest emergency room in San Francisco, Zuckerberg San Francisco General receives one-third of all ambulances in the City, and treats nearly four

thousand patients with traumatic injuries, annually. Many of Zuckerberg San Francisco General's programs focus on providing life-saving care in emergency situations.

As a safety net provider, SFDPH is extremely concerned by the proposed rule. HHS recently created the Division of Conscience and Religious Freedom with the purpose of protecting health care workers who refuse to treat patients on the basis of religious and moral objections. This new division and the proposed rule threaten the health of our patients, and are likely to have a particular negative impact on low-income people, women, and the LGBTQ community.

The proposed rule compromises patient care, undermines the oaths sworn to by medical and healthcare professionals, is unnecessary, and is practically unworkable.

First, the proposed rule provides no benefits and imposes only burdens on patients. It fails to take into account the very real costs it imposes on patients' rights to access care, and to do so without being subjected to discrimination. Prioritizing religious freedom over the provision of care allows discrimination and threatens the lives of patients, including women and the LGBTQ community. The proposed rule would undermine San Francisco's long-standing efforts to advance women's health and reproductive rights, prevent domestic violence, address sexual assault and human trafficking, and promote the health and well-being of women and the LGBTQ community through access to health promotion and health care services. The proposed rule threatens patients' constitutional right to access reproductive healthcare services, including abortions. This proposed rule would also exacerbate already enormous deficiencies in health care access among transgender and gender non-conforming individuals. Nearly a quarter of transgender people already report avoiding seeking medical care for fear of being mistreated.[1] This rule could further dissuade transgender people from seeking even the most routine services. The breadth of the rule is such that it is impossible to fully predict how the rule could impact patients—even access to basic care that on its face has no discernable connection to religious observance, such as dental care, could be threatened. Further, it would disproportionately place low-income San Franciscans at risk and threaten San Francisco's ability to provide necessary healthcare services to its residents most in need. The proposed rule completely fails to take into account the very real costs it imposes on patients' rights to access care, and to do so without being subjected to discrimination.

Second, the proposed rule elevates a right of conscience above all other ethical considerations. The proposed rule is in direct violation of the Hippocratic Oath, in which doctors swear to do no harm and to treat the ill to the best of their ability. Its definition of "refer" is so broad that it could potentially prevent SFDPH from ensuring that if one health care provider were unwilling to give certain care, another provider would be able to provide it without delay. When a patient seeks care from one of SFHN's clinics or hospitals, both the patient and SFDPH need to know that the patient is receiving all medically-necessary care.

Third, existing laws and regulations ensure that patients receive the essential health services they need, while adequately protecting the rights of conscience of healthcare workers. Patients have the right to access high-quality, inclusive and comprehensive care without encountering discrimination, and current

[1] Sandy E. James et al., The Report of the U.S. Transgender Survey 98 (2016), www.ustranssurvey.org/report.

law ensures that access while also allowing accommodations for healthcare workers' religious beliefs. SFDPH is not aware of any employee request for a religious accommodation that it has been unable to provide under existing laws and regulations. Current law is perfectly adequate, and there is no need for the proposed rule.

Lastly, the proposed rule is unworkable in many other respects. In addition to ignoring the needs of patients, the proposed rule fails to account for how a health care organization could legally administer it. The proposed rule ignores competing obligations imposed on SFHN by other statutes such as the Emergency Medical Treatment and Active Labor Act and California's Unruh Civil Rights Act. It also ignores SFDPH's contractual obligations to its employees; the proposed rule could create problems with the fair administration of labor contracts between employees asserting conscience rights and those who do not.

The rule also appears to create administrative obstacles to providing employees with religious accommodations. The current draft lacks a requirement that workers seeking to assert a right of conscience inform their organization of their request, and therefore could deny the organization an opportunity to provide the worker with an accommodation. Moreover, the proposed definition of "discrimination" is so broad that even if a worker did request an accommodation, the very act of providing one could be considered discriminatory. If an employee failed to request an accommodation in advance of being presented with a patient who has an immediate need for care, the proposed rule creates a very real risk that the patient could be denied legally required or medically necessary care. Patient care is SFDPH's first and primary priority, but it is worth noting that in addition to harming a patient, such a situation could also potentially expose SFDPH to liability for violations of other laws and for malpractice.

For these reasons, we respectfully request HHS withdraw the Proposed Rule from consideration.

Sincerely,

Barbara A. Garcia

Director of Health
San Francisco Department of Public Health

EXHIBIT Z

FAMILY VOICES®
. . . keeping families at the center of children's health care

March 27, 2018

Roger Severino, Director
Office of Civil Rights
Room 509F, HHH Building
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority
RIN 0945-ZA03 Docket ID No. HHS-OCR-2018-0002

Dear Director Severino:

Family Voices is a national, nonprofit, family-led organization promoting quality health care for all children and youth, particularly those with special health care needs. Working with family leaders and professional partners at the local, state, regional, and national levels since 1992, Family Voices has brought a respected family perspective to improving health care programs and policies and ensuring that health care systems include, listen to, and honor the voices of families.

Throughout the US, there are over 14 million children and youth with special health care needs (CYSHCN), constituting over 19 percent of the child population. More than one in five households with children has at least one child with special health care needs.

We are very concerned that the proposed rule would restrict access to medically necessary care for CYSHCN. It is already difficult to find the appropriate pediatric subspecialists and health care facilities for many children with special health care needs, particularly those with rare conditions, and particularly in rural areas. Many families have to travel long distances to obtain the specialized care their children need. If regulations are implemented to make it more acceptable to withhold health care, we fear that it will be even more difficult for CYSHCN to obtain medically necessary services.

There is already discrimination against some children with disabilities or other special health care needs. For example, some providers do not believe it is appropriate to extend certain services to children with intellectual disabilities (e.g., cochlear implants to improve hearing, or an organ transplant to save the life of a child with Down syndrome).

A more dramatic example of such discrimination might be found in a neonatal intensive care unit. Suppose a nurse has a moral conviction that society should not expend resources on children with severe physical or intellectual disabilities. Should he be protected, on the basis of his moral conviction, if he decides not to respond to an alarm signaling a heart problem for an infant born without legs?

Conversely, suppose a nurse held a religious belief that all measures must be taken to preserve life, and therefore resuscitated a terminally ill patient who had a "Do not resuscitate" order in place. Would the nurse's employer be prohibited from taking any disciplinary action against her in such a situation?

Religious beliefs can harm patients in more subtle but harmful ways as well. In a rural community, there may be a single physician. If a teen questioning his or her sexual orientation were to bring up the topic with the physician, and the physician indicated a belief that homosexuality was sinful, the teen ultimately may become depressed, despondent, and even suicidal. If an unmarried teen contracts a sexually transmitted infection, he or she may feel uncomfortable going to a physician who is known to disapprove of premarital sex, thus risking serious complications and the chance of passing the infection to others.

In addition to harming patients' health directly, we are concerned that this proposed rule would hurt families of CYSHCN financially, since it applies to insurers and employers as well as health care professionals and institutions. These entities have a vested interest in denying care in order to save money. This rule could provide them with an excuse to refuse coverage for expensive treatments.

Finally, we think the proposed rule contradicts current antidiscrimination laws and regulations. Will it provide a defense for health care providers or insurers who discriminate against people with disabilities?

The OCR has specifically requested comment on whether this rule would result in unjustified limitation on access to health care or treatments. We submit that it would.

We understand that there are health care professionals and institutions with strong religious or moral convictions that are inconsistent with rendering certain types of care. It is reasonable to accommodate their views, *provided that others are not harmed* in doing so.

At the same time, it is critical to protect patients from discrimination so they can obtain the care they need, particularly in an emergency. If an individual or institution chooses not to provide certain care on the basis of religious beliefs or moral convictions, then that provider should be required to inform prospective or current patients of those limitations in advance or as soon as possible. In addition, the provider should be required to provide information about alternative sources of care in a timely manner, and should be required to provide any treatment needed to stabilize a patient in an emergency situation.

Thank you for your attention to our comments.

Sincerely,

/s/

Nora Wells
Executive Director

EXHIBIT AA

regulations.gov
Your Voice in Federal Decision-Making

Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment

I live in a sparsely populate rural area. Health care providers are few and far between. I am very worried about the proposed legislation that would allow health care providers to deny legal, doctor prescribed, medical care due to their personal religious beliefs.

A medical provider, be they a primary care physician, a pharmacist, a nurse, etc. cannot impose their beliefs on the medical needs of a poorly served area. This will discriminate against the poor, women, minorities, and LGBTQ communities, the very people that are most in need of health care, and are also less able to travel great distances (the nearest hospital is 30 miles away - and if that facility won't treat them, they'd have to drive 50 miles) just to obtain basic medical care, such as filling prescriptions for birth control, etc.

Religious freedom means that the government can't impose a religion on the citizens, it doesn't permit a licensed health care provider to impose their religious beliefs on patients. This rule is draconian, and must be eliminated.

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-10190
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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment

I have faced discrimination in health services three different times in the past 10 years. I live in a rural community with one hospital owned by Seventh Day Adventists. I have been denied care based on religious prejudices. There has to be a compromise somewhere. A guarantee that health care practitioners can refuse to help (which no health care worker should be able to based on sex, religion, orientation, ethnicity, etc.), but that there are appropriate referral sources available and that those discrimination are made clear beforehand so as to not waste time or resources.

Basically, if a doctor doesn't want to treat a transgender person, they let people know upfront and have a list of referral sources available. That way the doctor can discriminate based on moral objections but patients (1) know beforehand and (2) are provided a list of service providers in their area who would gladly help them.

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-10240
Tracking Number: 1k2-925x-4rwe

Document Information

Date Posted:
Mar 28, 2018

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0945-ZA03

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Submitter Information

Submitter Name:
Beth Anonymous

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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-34784
Tracking Number: 1k2-924i-gx0i

Comment

I write to oppose the proposed rule entitled Protecting Statutory Conscience Rights in Health Care. This rule could encourage discrimination against LGBT people and those seeking reproductive health care, and it inappropriately puts the personal beliefs of health care providers over the health care needs of patients.

Myself and many of my community members struggle to afford healthcare as it is, even with full time jobs. I live in a rural area and even if you do have health insurance, access to healthcare is very difficult. I do not see how my sexual orientation, religion, or other parts of me that one might disagree with at a personal level has anything to do with my right to receive healthcare. This regulation, whatever it's intentions, will give those who are discriminatory the ability to act on this in a way that can harm the community and disproportionately provide support based on personal differences. I fear this will only further drive people apart.

Access to health care is a critical problem for many people, and HHS should not be making the problem worse by inviting health care institutions and providers to turn people away based on religious or moral reasons. Our nations largest health care agency should not be promoting discrimination. I oppose this proposed rule and urge HHS to withdraw it.

Document Information

Date Posted:
Mar 29, 2018

RIN:
0945-ZA03

Show More Details

Submitter Information

Submitter Name:
Alexandria Koontz

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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment

As a transgender individual, I have been refused important treatment at local doctors. I have to drive for 2 hours in order to receive basic medical care, because I cannot find a doctor who will help me in my town. Someday this very well might kill me if I need immediate, life-saving care. The ability for someone's "conscience" to decide whether I live or die is unfair, and horrifying. This rule is going to make my life worse. It is actively discriminating against me. I am strongly against it.

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-34687
Tracking Number: 1k2-924e-tb7e

Document Information

Date Posted:
Mar 29, 2018

RIN:
0945-ZA03

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Submitter Information

Submitter Name:
Alexis Long

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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment

Because I am gay and live in a rural area, my son (who is not gay) and I have been refused healthcare by our local clinic. As a result, we have been forced to seek a physician in another town rather than receive treatment from our local provider. This is simply wrong.

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-54505
Tracking Number: 1k2-925w-7k8n

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Submitter Information

Submitter Name:
Carl Knorr

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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment

The effort to provide exemptions for patient protections is dangerously misguided.

Please consider what if any medical provider complaints there are feeling "forced" to treat people that they don't wish to treat compared to those patients who deserve to be treated but who can't be.

I live in a more rural area of the country and worrying about disclosing my sexual preference shouldn't be a concern in trying to obtain health care. I can't imagine what it must be like for a transgender person. Can you?

Faith is personal and thus, one should not take on the study and practice of medical care if one is compelled only by faith that eschews exclusivity and judgment.

A mature society fashions protections for those who are marginalized, not for those who have a choice in what they wish to practice.

Access to healthcare should not be at the cost of a practitioners faith, but rather on need.

Thank you,

Noah Coleman
State College, PA

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-56146
Tracking Number: 1k2-926h-eh6q

Document Information

Date Posted:
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Submitter Information

Submitter Name:
Noah Coleman

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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment

Almost all the clinics in our small rural area have very swlf-proclaimed christian employees. Years ago when I was pregnant at a late age, I wanted to discuss all my options with them. They put me off, beat around the bush, mostly on the abortion option, kept not calling me back, et, etc. When, after a while, I had a miscarriage and they finally took my panicked call, they said, "oh, we thought you might have a miscarriage" REALLY! And why did you refuse to tell me that! Rotten bastids!

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-64757
Tracking Number: 1k2-928e-g37m

Document Information

Date Posted:
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RIN:
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Submitter Information

Submitter Name:
Elisa Greco

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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment

Living in a rural area is hard enough for ANYONE to gain access to care without the government letting healthcare providers claim religious exemption for any reason they want.

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-65403
Tracking Number: 1k2-928g-q09e

Document Information

Date Posted:
Mar 29, 2018

RIN:
0945-ZA03

Show More Details

Submitter Information

Submitter Name:
Carrie-Meghan Quick-Blanco

Health and Human Services Office of Civil Rights

In health care, patients must always come first. This new proposal from HHS encourages health care providers to abandon the principle of “first, do no harm” in favor of their personal beliefs. This puts transgender patients, people who need reproductive health care, and many others at risk of being denied necessary and even life-saving care. Transgender people already face high levels of discrimination by health care providers: for example, just in the past year, out of respondents to the 2015 U.S. Transgender Survey who saw a health care provider, one-third were denied treatment, turned away, or mistreated.

As a transgender woman in a somewhat rural Texas county, this is a significant restriction on availability of health care. Ethical standards for healthcare demand protection of the patient as the first priority. An example is treatment of battlefield injuries. Those that need the most help are treated first regardless of uniform. If we use that standard for wartime care, surely we can use a patient first standard for marginalized individuals.

Along with medical experts and many people of faith, I oppose the proposed regulation. Promoting discrimination is wrong, it is unnecessary, and can harm millions of people who need access to basic care.

Re: Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03

Katherine Murray

Lake Jackson , TX 77566

Health and Human Services Office of Civil Rights

In health care, patients must always come first. This new proposal from HHS encourages health care providers to abandon the principle of “first, do no harm” in favor of their personal beliefs. This puts transgender patients, people who need reproductive health care, and many others at risk of being denied necessary and even life-saving care. Transgender people already face high levels of discrimination by health care providers: for example, just in the past year, out of respondents to the 2015 U.S. Transgender Survey who saw a health care provider, one-third were denied treatment, turned away, or mistreated.

As a mother of a teenage transgender son. I was looking for help with anxiety, depression and attempted suicide. We live in the Midwest, so somewhat rural area. We located a psychiatrist only 10 miles away ~ Great! Finally I can get him out of his room and someone will help him, I thought! After completing tons of paperwork and waiting 3 months, for what I thought was going to be an appointment for help, I get a phone call that tells me; "I'm sorry, I don't think Dr. O... would be a very good fit for Alex" Ummm, now what ~ Okay, well try a little further away, 40 miles from home ~ No, sorry we don't accept anyone under 18 Years Old. So as a result, I have to take my child to the University of Iowa, over 100 miles from home, for both psychology and primary healthcare.
While we are fortunate to have an excellent facility in th UofI, others are not as fortunate!

Along with medical experts and many people of faith, I oppose the proposed regulation. Promoting discrimination is wrong, it is unnecessary, and can harm millions of people who need access to basic care.

Re: Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03

Cynthia Emdia
2238 190th ave
Donnellson , IA 52625

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Your Voice in Federal Decision-Making

Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment

As a Transgender Woman I have found Health Care access to be limited in my small rural Oregon Community. Allowing individuals to deny me emergency, routine or any health care is discrimination based on sex. I deserve access to health care. The slippery slope of discrimination in dichotomy 28th sex discrimination can result in horrible outcomes and does as is examples is Nation States where even attending school is denied women. My Nation doesn't year people down and leave them at risk through thoughtless discrimination. I urge you to deny discrimination based on sex by allowing the individual to harm another based on religious freedom.

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-71815
Tracking Number: 1k2-929d-99ts

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Mar 29, 2018

RIN:
0945-ZA03

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Submitter Information

Submitter Name:
Christina Ketcham

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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule:
Protecting Statutory Conscience Rights in Health Care; Delegations of Authority

For related information, **Open Docket Folder**

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-71880
Tracking Number: 1k2-929d-ssd3

Document Information

Date Posted:
Mar 29, 2018

RIN:
0945-ZA03

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Submitter Information

Submitter Name:
Darlene Fike

Comment

I was denied care by over 50 doctors because I am transgender and then I had to drive 4 hours to get the needed care. Do not allow this type of hate to continue.

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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-71960
Tracking Number: 1k2-929e-gkew

Comment

I have a chronic disease that requires quarterly monitoring including blood lab work. I live in an area where I have few health insurance options (currently two). If healthcare providers are allowed to opt out of providing care to me because I am a gay American, My chronic disease could become a much more expensive life threatening disease that would ultimately cost me, other tax payers and/or the government more money for treatment. Seriously, after all of the progress this country has made on ending discrimination (which research clearly illustrates is bad for our economy) would be a major step backward. If this Admonistration wants to make America great again, then keep no discrimination as a primary value that sets our country apart from much of the rest of the globe. If we don't, we could find ourselves living in a country where male, white, heavy set, old people could find themselves without anyone willing to provide them with healthcare. Is they really what this president and his administration envisions when he said he wants to "make America great again"? Discrimination is about exclusion. Discrimination may not feel like a threat until it starts excluding you. Allow discrimination in healthcare today, and watch what classifications of Americans get added next. This country deserves better than this. I demand better than this for myself, for my family, for all of my loved ones, and for those I don't know who won't take the time time write today.

Document Information

Date Posted:
Mar 29, 2018

RIN:
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Submitter Information

Submitter Name:
Jody Huckaby

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Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services** (HHS) Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, **Open Docket Folder**

Comment Period Closed
Mar 27 2018, at 11:59 PM ET

ID: HHS-OCR-2018-0002-71973
Tracking Number: 1k2-929e-guzz

Comment

I am a 100% disabled veteran who lives in a rural area with no doctors. I have to use non-VA doctors in Astoria Oregon for care using community care. So this legislation would leave me health care what so ever!! Is this how I am thanked for serving?? This legislation is an atrocity filled with hate. This is not what I fought for as a soldier in the US Army. I fought for everyone of you so your rights would be preserved on my watch. NOW where are you when mine are threatened... Who Will STAND for me???? I pray it's you.

Document Information

Date Posted:
Mar 29, 2018

RIN:
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Submitter Information

Submitter Name:
Monica Sicard

Ms. Jacqueline Klein
1328 N Blomberg Rd
Exeland, WI 54835-4119
(715) 415-5485

Feb 1, 2018

Planned Parenthood

Subject: Stop discrimination against patients

Dear Planned Parenthood,

I'm writing about the proposed rule that allows providers and other health care workers to deny access to basic health care services, including -- though certainly not limited to -- transgender health services, abortion, and even birth control. This rule, coupled with the newly created "Conscience and Religious Freedom" division within the Office of Civil Rights, would turn the office charged with protecting people throughout the country from discrimination into an office that gives health care workers a license to discriminate against people, simply because of who they are or the services they seek.

If this rule is adopted, it would result in people not getting the care they need -- from people living with HIV seeking treatment to women seeking safe, legal abortions to LGBTQ patients getting basic care for themselves or their families.

I live in a rural community in northern Wisconsin where there is already difficulty in accessing healthcare. This is an egregious attempt to promote discrimination and restrict access to health care, particularly for vulnerable communities like mine that already have trouble accessing it. I urge you to withdraw this dangerous and shameful proposed rule and instead focus your office on protecting access to care.

Sincerely,
Ms. Jacqueline Klein