

Exhibit 77



HEALTH CARE FOR ALL

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

To Whom It May Concern:

Health Care For All respectfully submits these comments regarding the proposed rule entitled Protecting Statutory Conscience Rights in Health Care, published January 26.¹ Health Care For All is a non-profit consumer health advocacy organization that promotes health justice by working to reduce disparities and ensure coverage and access for everyone in Massachusetts. We are deeply concerned that the proposed rule will create unnecessary barriers to care for consumers in Massachusetts and across the nation.

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.

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

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].

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 pregnancy⁵ 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 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

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://nwlrc.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 Fundamentalists Doctors*, Lambda Legal, September 29, 2009, accessed at https://www.lambdalegal.org/news/ca_20090929_settlement-reached.

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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 pregnancies⁷ -- 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.

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

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-Apr; 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).

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](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*

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.

6. 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 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

7. 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

expectations and preferences for family planning care, Contraception and Stulberg, D., et al, accessed here: [http://www.contraceptionjournal.org/article/S0010-7824\(14\)00358-8/fulltext](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](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).

¹⁷ Uttley, L, et al, *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.

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 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

8. 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

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](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.

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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.

9. 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 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, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons Health Care For All calls on the Department to withdraw the proposed rule in its entirety.

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.

Exhibit 78



Access • Quality • Equity

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Statutory Conscience Rights in Health Care RIN 0945-ZA03**

To Whom It May Concern:

I am writing on behalf of Consumer Health First in response to the request for public comment on the proposed rule entitled, “Protecting Statutory Conscience Rights in Health Care” published January 26.¹ Consumer Health First is a statewide, alliance of thousands of individuals and approximately one hundred organizations working to promote health equity through access to comprehensive, high quality and affordable health care for all Marylanders. As such, we represent the communities that would be impacted the most by this rule.

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.

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

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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

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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](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 al, accessed here: [http://www.contraceptionjournal.org/article/S0010-7824\(14\)00358-8/fulltext](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](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.*

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 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

¹⁶ See The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).

¹⁷ Uttley, L, et al, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), p. 16, <https://www.aclu.org/report/miscarriage-medicine>.

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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>.

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²¹ See Kira Shepherd, et al., *supra* note 19, at 29.

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 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

²² See *The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), <https://nwlcciw49tixgw5lbab.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](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. SHEPES 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>.

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

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, fosters confusion, and harms patients. In addition, the proposed rule, runs counter to the Department's stated mission 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."

For all of these reasons Consumer Health First strongly opposes the proposed rule and calls on the Department to withdraw it in its entirety.

Sincerely,



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.

Kathy Ruben, M.S., PhD. - kathyruben@consumerhealthfirst.org

Executive Director

Exhibit 79

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 LHI-Houston in response to the request for public comment on the proposed rule entitled, “Protecting Statutory Conscience Rights in Health Care” published January 26.¹ LHI-Houston serves thousands of Lesbian, Gay, Bisexual and Queer identifying women and anyone transgender and nonbinary, particularly people of color, all throughout the greater Houston area.

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.

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

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, e.g., *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT’L WOMEN’S L. CTR. (2017), <https://nwl.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>.

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 pregnancy⁵ 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 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

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/>

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 pregnancies⁷—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.

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

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-Apr; 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).

¹¹ The notice requirement is spelled out in section 88.5 of the proposed rule.

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.

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6. The proposed rule carries severe consequences for patients and will exacerbate existing inequities.

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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 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

¹⁸ See, e.g., *supra* note 2.

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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](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/>.

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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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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 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, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons LHI-Houston calls on the Department to withdraw the proposed rule in its entirety.

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.