Exhibit 59

Lambda Legal
making the case for equality

March 27, 2018

VIA ELECTRONIC SUBMISSION

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 Rule, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03

To Whom It May Concern:

Lambda Legal Defense and Education Fund, Inc. ("Lambda Legal") appreciates the opportunity provided by the Department of Health and Human Services ("HHS" or the "Department") to offer comments in response to the Proposed Rule, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03 ("Proposed Rule" or "Rule"), published in the Federal Register on January 26, 2018.[1] As described herein, the Proposed Rule both exceeds its statutory authority and contravenes this Department's mission, the legal rights of patients, the ethical obligations of health professionals, and the legal rights and responsibilities of institutional health care providers. It should be withdrawn.

Lambda Legal is the oldest and largest national legal organization dedicated to achieving full recognition of the civil rights of lesbian, gay, bisexual, and transgender ("LGBT") people and everyone living with HIV through impact litigation, policy advocacy, and public education. For decades, Lambda Legal has been a leader in the fight to ensure access to quality health care for our vulnerable communities. In recent years, Lambda Legal has submitted a series of comments to HHS regarding the importance of reducing discrimination against LGBT people in health care services, the fact that current law already protects health worker conscience rights appropriately, and the ways that conscience-based exemptions to health standards endanger LGBT people and others.[2] Recently, Lambda Legal also has opposed an HHS proposal to expand

[1] 83 Fed. Reg. 3880 *et seq*. (proposed Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88).

[2] *Lambda Legal Comments on Proposed Rule 1557 Re: Nondiscrimination in Health Programs and Activities, 1557 NPRM (RIN 0945-AA02)* (submitted Nov. 9, 2015) ("Lambda Legal 1557 Comments"), https://www.lambdalegal.org/in-court/legal-docs/hhs_dc_20151117_letter-re-1557; *Lambda Legal Comments on Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities (RIN 0945-AA02 & 0945-ZA01)* (submitted Sept. 30, 2013) ("Lambda Legal Nondiscrimination Comments"), https://www.lambdalegal.org/in-court/legal-docs/ltr_hhs_20130930_discrimination-in-health-services. *See also* Brief of Amici Curiae Lambda Legal et al., *Zubik v. Burwell*, 136 S. Ct. 1557

the ability of religiously-affiliated health care institutions and individuals to impose their religious beliefs on workers and on patients, cautioning in detail about the likely harmful consequences of any such expansions for LGBT people and people living with HIV.[3]

As to the Proposed Rule now under consideration, Lambda Legal emphatically recommends its withdrawal because:

(1) It improperly expands statutory religious exemptions in multiple ways, including by:

(a) permitting workers to refuse job duties that cannot reasonably be understood as "assisting" with an objected-to procedure, [4] and instead have merely an "articulable" connection to the procedure[5];

(b) expanding who may assert religious objections from employees performing or assisting in specified procedures to any member of the workforce[6];

(c) using an improperly expanded definition of "referral"[7] that includes providing any information or directions that could assist a patient in pursuing care; and

(d) defining "discrimination" to focus on protecting the interests of health care providers in continuing to receive favorable financial, licensing or other treatment, rather than on patients' interest in receiving medically appropriate care[8]; and

(e) defining health care entity to include health insurance plans, plan sponsors, and third-party administrators.[9]

(2016) (Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, 15-191), http://www.lambdalegal.org/in-court/legal-docs/zubik_us_20160217_amicus.

[3] *See, e.g., Lambda Legal Comments on Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (RIN 0938-AT46)* (submitted Dec. 5, 2017), https://www.lambdalegal.org/in-court/legal-docs/dc_20171205_aca-moral-exemptions-and-accommodations; *Lambda Legal Comments on Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (RIN 0938-AT20)* (submitted Dec. 5, 2017), https://www.lambdalegal.org/in-court/legal-docs/dc_20171205_aca-religious-exemptions-and-accommodations.

[4] 42 U.S.C.A. § 300a-7(b) and (d).

[5] Section 88.2, 83 Fed. Reg. at 3923.

[6] Section 88.2, 83 Fed. Reg. at 3924.

[7] *Id*.

[8] *Id*.

[9] *Id*.

(2) It encourages workers and institutions to refuse care and does not acknowledge the rights of patients, such as the right against sex discrimination provided by Section 1557 of the Affordable Care Act.[10]

(3) It encourages workers and institutions to refuse care and does not acknowledge the legal rights and duties of health care providers, such as those under Title VII of the Civil Rights Act of 1964,[11] or health professionals' ethical obligations to patients.

(4) Using broad, vague language, it addresses a purported "problem" of health workers being pressed to violate their conscience, suggesting that workers should have broad religious rights to decline care and refuse other work of any sort in any context, going far beyond the narrow contexts specified in the authorizing statutes.

(5) Its proposed enforcement mechanisms are draconian, threatening the loss of federal funding and even the potential of funding "claw backs," with limited if any due process protections, all of which would skew health systems improperly in favor of religious refusals and against patient care.

(6) The heavy-handed enforcement mechanisms inevitably would invite discrimination and aggravate existing health disparities and barriers to health care faced by LGBT people and others, contrary to the mission of HHS and, in particular, its Office for Civil Rights.

(7) It is the result of a rushed, truncated process inconsistent with procedural requirements including the Administrative Procedure Act.[12]

In sum, the role of the HHS Office for Civil Rights ("OCR") described in the Proposed Rule is not to promote access to health care and to safeguard patients against discrimination, but instead to impose vague, overbroad *restraints* on health care provision, as a practical matter elevating "conscience" objections of workers over the needs of patients. In so doing, the Proposed Rule turns the mission of HHS/OCR on its head. Freedom of religion is a core American value, which is why it is already protected by the First Amendment of the Constitution. But, that freedom does not and must not allow anyone to impose their beliefs on others or to discriminate. This basic principle is nowhere more important than in medical contexts where religion-based refusals can cost patients their health and even worse.

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[10] 42 U.S.C.A. § 18116.

[11] Civil Rights Act of 1964 § 7, 42 U.S.C.A. § 2000e *et seq.* (1964).

[12] 5 U.S.C.A. § 500 *et seq*.

I. The Proposed Rule Improperly Expands Statutory Religious Exemptions.

The Proposed Rule improperly expands statutory religious exemptions beyond their narrow, specific parameters in numerous ways. It includes definitions that would broaden the exemptions in the Church Amendments, which currently allow health workers to decline to assist in an abortion or sterilization procedure if doing so "would be contrary to [their] religious beliefs or moral convictions."[13] The Proposed Rule reinterprets what it means to "assist in the performance" of a procedure from participating in "any activity with a *reasonable* connection" to a procedure [14] to "any … activity with an *articulable* connection" to an objected-to procedure.[15] In other words, any connection that can be described, no matter how tenuous, potentially could suffice. Confirming the potentially indefinite expansion of *what* can be deemed "assistance" is a broad definition of *who* may object. From the prior common language understanding of who might be involved in a medical procedure, the new definition appears to authorize any member of the workforce to object to performing their job duties.[16]

The Proposed Rule also includes an aggressive expansion of the concept of "referral" from the common understanding of actively connecting a patient with an alternate source of a particular service to the provision of any information or directions that could possibly assist a patient who might be pursuing a form of care to which the employee objects.[17] This goes far beyond a reasonable understanding of what the underlying statute justifies.

Similarly, where the statute authorizes "health care entities" to assert religious objections, the Proposed Rule grossly expands the entities covered by that term to include health insurance plans, plan sponsors, and third-party administrators.[18] It also adds a definition of "discrimination" that focuses not on patients' interest in receiving equal, medically appropriate services, but rather on protecting health care providers' interests in continuing to receive favorable financial, licensing or other treatment while refusing on religious or moral objections to provide care despite medical standards, nondiscrimination rules, or other requirements.[19]

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[13] 42 U.S.C.A. § 300a-7.

[14] 45 C.F.R. § 88.2 (2008) (emphasis added).

[15] Proposed Rule, 83 Fed. Reg. at 3923 (emphasis added).

[16] Section 88.2, 83 Fed. Reg. at 3924.

[17] Section 88.2, 83 Fed. Reg. at 3924.

[18] Section 88.2, 83 Fed. Reg. at 3924.

[19] Section 88.2, 83 Fed. Reg. at 3924.

In numerous places, the Proposed Rule seems to indicate that HHS is adopting interpretations that would extend the Amendments' reach beyond current understanding that the exemptions only concern abortion and sterilization and follow the common medical understanding of those terms.[20] As one example, it seems likely that the "sterilization" references within the Proposed Rule could be applied to deny health care to transgender patients because the Rule itself, at footnote 36, cites *Minton v. Dignity Health* approvingly.[21] *Minton* addresses whether a Catholic hospital was legally justified when it blocked a surgeon from performing a hysterectomy for a transgender man as part of the prescribed treatment for gender dysphoria. The hospital defended on religious freedom grounds, arguing that it was bound "to follow well-known rules laid down by the United States Conference of Catholic Bishops," including rules prohibiting "direct sterilization."[22]

But, to equate hysterectomy to treat gender dysphoria with direct sterilization is medically inaccurate. Sterilization procedures undertaken for the *purpose* of sterilization are fundamentally different from procedures undertaken for other medical purposes that incidentally affect reproductive functions. Regardless of whether the United States Conference of Catholic Bishops considers gender transition-related care to be sterilization as a religious matter, were the federal government to approve a religious rationale as grounds for stretching a federal statute and permitting denial of medically necessary care would be problematic for both statutory interpretation and Establishment Clause reasons.

The Proposed Rule's apparent embrace of the Bishops' view poses an overtly discriminatory and unacceptable threat to transgender patients. This concern is not speculative. The Proposed Rule's footnote referencing *Minton* supports the following statement: "Many religious health care personnel and faith-based medical entities have further alleged that health care personnel are being targeted for their religious beliefs."[23] For the Proposed Rule to equate a transgender patient expecting to receive medically necessary care from health care personnel with those personnel "being targeted for their religious beliefs" is a chilling indicator of the direction the Proposed Rule would take health care in this country. Not only would health providers be invited to turn away transgender patients, but those that abide by their obligation to

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[20] *Compare* cases describing statute's applicability to provision or refusal provide abortions or sterilization, *e.g.*, *Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695 (2d Cir. 2010), *and Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974), *with Geneva Coll. v. Sebelius*, 929 F. Supp. 2d 402 (W.D. Pa. 2013), *on reconsideration in part* (May 8, 2013) (statute does not apply to provision of emergency contraception, which is not abortion or sterilization).

[21] No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017).

[22] Defendant Dignity Health's Reply Brief in Support of Demurrer to Verified Complaint, *Minton v. Dignity Health*, No. 17-558259, at 2 (Calif. Super. Ct. Apr. 19, 2017) (filed Aug. 8, 2017), https://www.aclusocal.org/sites/default/files/brf.sup_.080817_defendant_dignity_healths_reply_in_support_of_demurrer_to_verified_complaint.pdf.

[23] Proposed Rule, 83 Fed. Reg. at 3888 n. 36.

provide nondiscriminatory care and require their employees to act accordingly could be stripped of federal funding if equal treatment of those patients offended any workers' personal beliefs.

The overbroad definitions and suggestive language all contribute to the alarming overall theme of the Proposed Rule—that it addresses a purported problem of health workers ostensibly being pressed wrongfully to act against their rights of conscience. The Proposed Rule's suggested cure appears to be that workers should have broad religious rights to decline care of any sort in any context. This theme starts with the broad language stating the Proposed Rule's purpose and runs throughout the rule.[24] It creates at least a serious concern that, for example, language long understood to be bounded by its statutory context only to concern abortion and sterilization could be misconstrued as authorizing health care providers to refuse to participate in *any* part of *any* health service program or research activity "contrary to [their] religious beliefs or moral convictions."[25] While such an interpretation obviously could be challenged legally, many patients have neither the knowledge nor the means to resist such improper care refusals and would simply suffer the delay or complete denial of medically needed treatments.

II. The Proposed Rule Invites Workers And Institutions To Refuse Care And Does Not Acknowledge The Rights Of Patients.

By issuing the Proposed Rule, HHS invites health workers and institutions to refuse to provide medical care for religious reasons, without acknowledging that patients often have countervailing rights. Yet, all federal agencies, including HHS, must comply with the federal statutes that protect LGBT people and others from discrimination, such as Section 1557 of the Affordable Care Act, which bars discrimination based on sex in federally funded health services and programs.[26] Properly understood, Section 1557 protects transgender patients from discriminatory denials of care based on their gender identity or transgender status.[27] It also protects lesbian, gay, and bisexual patients.[28] Even if it were not contrary to the mission of OCR

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[24] *See, e.g.*, Section 88.1 (Purpose); Appendix A (required notice to employees) to 45 C.F.R., 83 Fed. Reg. at 3931 (declaring broad right to accommodation for any religious or moral belief); 83 Fed. Reg. at 3881, 3887-89, 3903 (addressing "problem" of workers being required to meet patient needs despite their personal beliefs).

[25] 42 U.S.C.A. § 300a-7(d). See cases cited *supra* note 20.

[26] 42 U.S.C.A. § 18116.

[27] *Rumble v. Fairview Health Services*, 2015 WL 1197415 (D. Minn. March 16, 2015) (Affordable Care Act, Section 1557). *See also Whitaker v. Kenosha Unified School District No. 1 Board of Education, 858 F.3d 1034 (7th Cir. 2017*) (analogous protection against sex discrimination in Title IX protects transgender students); *EEOC v. R.G. v. G.R. Harris Funeral Homes, Inc.*, __ F.3d __, 2018 WL 1177669 (6th Cir. March 7, 2018) (analogous protection against sex discrimination in Title VII protects transgender workers).

[28] *Cf. Zarda v. Altitude Express, Inc.*, 883 F.3d 100 (2d Cir. 2018) (sexual orientation discrimination is sex discrimination under Title VII); *Hively v. Ivy Tech Comm'ty College*, 853 F.3d 339 (7th Cir. 2017) (same).

to undermine patient protections against discrimination, the agency lacks the authority to reduce the protections provided to patients by separate statutes.

The ACA also includes patient protections to ensure access to essential health services, including reproductive health services. Yet, the Proposed Rule's aggressive approach to advancing conscience rights offers nothing to explain how those refusal rights are to coexist with patients' rights under the ACA. As to these conflicts, Lambda Legal joins the comments submitted by the National Health Law Program.

Moreover, the Proposed Rule also is inconsistent with several core constitutional guarantees: (1) each of us is entitled to equal protection under law; (2) the Establishment Clause forbids our government from elevating the religious wishes of some above the needs of others to be protected from harm, including the harms of discrimination; and (3) congressional spending powers have limits. On the latter point, the Proposed Rule references the spending powers of Congress as grounds for the new enforcement powers created for HHS to condition federal funding upon health care providers' acquiescence in religious refusal demands of their workers.[29] However, as well-established by *South Dakota v. Dole*[30] and its progeny, Congress's spending powers are limited. Any exertion of power must be in pursuit of the general welfare; must not infringe upon states' abilities "to exercise their choice knowingly, cognizant of the consequences of their participation"; must be related "'to the federal interest in particular national projects or programs;'" and must be otherwise constitutionally permissible.[31]

Multiple Equal Protection and Establishment Clause concerns implicate the final prong of the *South Dakota v. Dole* test for unconstitutional conditions on federal funds. But the first prong deserves immediate focus because it obviously does not serve the general welfare to use severe de-funding threats to intimidate medical facilities into deviating from medical practice standards in favor of religious interests in secular settings, to the detriment of individual and public health.

In addition, with its explicit intention to enforce federal "conscience" rights despite contrary state and local protections for patients, the Proposed Rule further implicates federalism concerns. It states: "Congress has exercised the broad authority afforded to it under the Spending Clause to attach conditions on Federal funds for respect of conscience, and such conscience conditions supersede conflicting provisions of State law[.]"[32] It then asserts that it "does not impose substantial direct effects on States," "does not alter or have any substantial direct effects on the relationship between the Federal government and the States," and "does not implicate" federalism concerns under Executive Order 13132.[33] Yet, by inviting health professionals and

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[29] Proposed Rule, 83 Fed. Reg. at 3889.

[30] 483 U.S. 203 (1987).

[31] *Id*. at 207-08.

[32] Proposed Rule, 83 Fed. Reg. at 3889.

[33] *Id.* at 3918-19.

other workers to turn away patients and refuse job duties in such a sweeping way, the Proposed Rule directly conflicts with state and local nondiscrimination laws and other patient protections. Its assertions to the contrary are patently inaccurate.

III. The Proposed Rule Invites Workers To Refuse Care And Does Not Acknowledge The Legal Rights And Duties, And Ethical Obligations, Of Health Care Providers.

The Proposed Rule aims improperly to empower workers to object to job duties without addressing the impacts on employers and coworkers left somehow to try to ensure that patient needs are met by others, with whatever increased costs, workload, and other burdens it may entail. The proposed approach fails to acknowledge that the federal employment nondiscrimination law, Title VII of the Civil Rights Act of 1964, limits the extent to which employers are to be burdened by employee demands for religious accommodation.[34] Undue burdens on employers could include objections by coworkers to unfair additional job duties or to coworker proselytizing. Likewise, it certainly would impose unjustifiable burdens to require employers to hire duplicate staff simply to ensure patient needs are met by employees willing to perform basic job functions. Indeed, courts have confirmed that when denial of a requested accommodation is "reasonably necessary to the normal operation of the particular business or enterprise,"[35] employers, including health care employers,[36] need only show that they "offered a reasonable accommodation *or* that a reasonable accommodation would be an undue burden."[37]

Such limitations on employee religious rights are essential to ensure that health care employers can hire those who will perform the essential functions of their jobs, and will comply with all statutory obligations including prohibitions against discrimination. If instead, employees who claim "conscience" objections to providing the health care services to LGBT people or people living with HIV are empowered by the Proposed Rule to threaten their employees with loss of federal funding if they do not allow such discrimination, employers will face logistical

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[34] 42 U.S.C.A. § 2000e *et seq. See, e.g., See, e.g., Bruff v. North Miss. Health Servs., Inc.*, 244 F.3d 495, 497-98 (5th Cir. 2001) (Title VII duty to accommodate employees' religious concerns did not require employer to accommodate employee's requests to be excused from counseling patients about non-marital relationships, which meant "she would not perform some aspects of the position itself"); *Berry v. Dep't of Social Servs.*, 447 F.3d 642 (9th Cir. 2006) (employer entitled to prohibit employee from discussing religion with clients).

[35] 42 U.S.C.A. § 2000e-2(e).

[36] *See, e.g., Grant v. Fairview Hosp. & Healthcare Servs.*, No. Civ. 02-4232JNEJGL, 2004 WL 326694 (D. Minn. Feb. 18, 2004) (hospital wasn't required to accommodate employee's request to be able to proselytize or provide pastoral counseling to patients to try to persuade them not to have abortions); *Robinson v. Children's Hosp. Boston*, Civil Action No. 14-10263-DJC, 2016 WL 1337255 (D. Mass. Apr. 5, 2016) (granting hospital employee's request to forgo flu shot would have been an undue hardship for hospital).

[37] *See, e.g., Sánchez-Rodríguez v. AT & T Mobility P. R., Inc.*, 673 F.3d 1, 8 (1st Cir. 2012).

nightmares and the employees without such beliefs will be unfairly subjected to increased workloads.

This seems like an inevitable repercussion particularly in light of the Proposed Rule's explanation in its definition of prohibited "discrimination" that "religious individuals or institutions [must] be allowed a level playing field, and that their beliefs not be held to disqualify them from participation in a program or benefit."[38] This definition lacks any qualifying language confirming that employers may condition employment on willingness to perform essential parts of a job. The likely effects would include increased burnout among those staff who have additional work delegated to them when religious exemptions are claimed. The Proposed Rule also would drain institutional resources as employers must respond (with management time and legal fees) to complaints filed by overburdened workers and by those who file implausible "conscience" objections upon receiving negative work evaluations. The waste of essential health care resources in service of improper denials of medical care cannot be justified.

Moreover, the Proposed Rule similarly ignores that health professionals are bound by ethical standards to do no harm and to put patient needs first. Concerning the application of this point to ensuring patients' reproductive health needs are not improperly subordinated to others' religious concerns, Lambda Legal endorses the comments submitted by the National Health Law Program. Concerning patients' needs to be treated equally regardless of gender identity, sexual orientation, and other irrelevant personal characteristics, the Joint Commission's accreditation standards and the ethical rules of the American Medical Association and other leading medical associations all impose a duty of nondiscrimination. For example, AMA Ethical Rule E-9.12 prohibits discrimination against patients and Ethical Rule E-10.05 provides that health professionals' rights of conscience must not be exercised in a discriminatory manner.[39] But that is precisely what results when, for example, a medically necessarily hysterectomy is denied to a patient because it is needed as treatment for gender dysphoria, and is provided to other patients as treatment for fibroids, endometriosis, or cancer.[40]

The Tennessee Counseling Association has expressed the bottom line cogently. Like many medical associations across the country, the TCA has codified the "do no harm" mandate and issued a formal statement opposing legislation proposing to allow denials of medical care through religious exemptions in that state: "When we choose health care as a profession, we

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[38] Proposed Rule, 83 Fed. Reg. at 3892.

[39] AMA ethical rule E-9.12, "Patient-Physician Relationship: Respect for Law and Human Rights," E-10.05, "Potential Patients."

[40] See discussion of Proposed Rule reference to *Minton v. Dignity Health*, No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017), at page 5, footnote 22. *See also Conforti v. St. Joseph's Healthcare Sys.* (D. N.J. filed Jan. 5, 2017), case documents at https://www.lambdalegal.org/in-court/cases/nj-conforti-v-st-josephs; Amy Littlefield, *Catholic Hospital Denies Transgender Man a Hysterectomy on Religious Grounds*, Rewire.News, Aug. 31, 2016, https://rewire.news/article/2016/08/31/catholic-hospital-denies-transgender-man-hysterectomy-on-religious-grounds/.

choose to treat all people who need help, not just the ones who have goals and values that mirror our own."[41]

IV. The Proposed Rule's Enforcement Mechanisms Are Draconian And Would Skew Health Systems In Favor Of Religious Refusals And Against Patient Care.

The Proposed Rule's enforcement mechanisms include aggressive investigation, require medical facilities to subject themselves to an extensive scheme of regulatory surveillance by HHS, and allocate authority to OCR "to handle complaints, perform compliance reviews, investigate, and seek appropriate action."[42] The Proposed Rule even "make[s] explicit the Department's authority to investigate and handle violations and conduct compliance reviews *whether or not a formal complaint has been filed*."[43] In addition to conditioning federal funding on prospective pledges to comply with broad, vague requirements, penalties can include not just the loss of future federal funding but even the potential of funding "claw backs,"[44] all with limited if any due process protections.

For many major medical providers, the threat of loss of federal funding is a threat to the facilities' very existence. It is nearly unfathomable that the government intends to force medical facilities either to forego their ethical obligations not to harm their patients or to close their doors. But, that easily could be the effect of the Proposed Rule in many instances. More often, the likely result would be simply to skew health systems dangerously in favor of religious refusals and against patient care. Doing so would both invite discrimination and aggravate existing health disparities and barriers to health care faced by LGBT people and others, contrary to the mission of HHS and, in particular, its Office for Civil Rights.

V. The Proposed Rule Inevitably Would Invite Discrimination And Worsen Health Disparities Affecting LGBT People And Others.

Discrimination and related health disparities already are widespread problems for LGBT people and people living with HIV.[45] In 2010, Lambda Legal conducted the first-ever national

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[41] *See* Emma Green, *When Doctors Refuse to Treat LGBT Patients*, The Atlantic, April 19, 2016, https://www.theatlantic.com/health/archive/2016/04/medical-religious-exemptions-doctors-therapists-mississippi-tennessee/478797/, citing Tenn. Counseling Assoc., *TCA Opposes HB 1840* (2016), http://www.tncounselors.org/wp-content/uploads/2016/03/TCA-Opposes-HB-1840-3.9.16.pdf.

[42] Proposed Rule, 83 Fed. Reg. at 3898.

[43] *Id*. (emphasis added).

[44] *Id*.

[45] *See, e.g.*, Inst. of Med., *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011) ("IOM Report") (undertaken at the request of the National Institutes of Health, and providing an overview of the public health research concerning health disparities for LGBT people and the adverse health consequences of anti-LGBT attitudes),

survey to examine the refusals of care and other barriers to health care confronting LGBT people and people living with HIV, *When Health Care Isn't Caring: Survey on Discrimination Against LGBT People and People Living with HIV*.[46] Of the nearly 5,000 respondents, more than half reported that they had experienced at least one of the following types of discrimination in care:

- Health care providers refusing to touch them or using excessive precautions;
- Health care providers using harsh or abusive language;
- Health care providers being physically rough or abusive;
- Health care providers blaming them for their health status.[47]

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.[48] Almost 8 percent of LGB respondents reported having been denied needed care because of their sexual orientation,[49] and 19 percent of respondents living with HIV reported being denied care because of their HIV status.[50] The picture was even more disturbing for transgender and gender-nonconforming respondents, who reported the highest rates of being refused care (nearly 27 percent), being subjected to harsh language (nearly 21 percent), and even being abused physically (nearly 8 percent).[51]

Respondents of color and low-income respondents reported much higher rates of hostile treatment and denials of care. Nearly half of low-income respondents living with HIV reported that medical personnel refused to touch them, while the overall rate among those with HIV was

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https://www.ncbi.nlm.nih.gov/books/NBK64806; Sandy E. James et al., Nat'l Ctr. For Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 93-129 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf; Lambda Legal, Health Care; Shabab Ahmed Mirza & Caitlin Rooney, Ctr. For Am. Progress, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

[46] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010) ("Lambda Legal, Health Care"), http://www.lambdalegal.org/publications/when-health-care-isnt-caring.

[47] *Id*. at 5, 9-10.

[48] *Id*.

[49] *Id*. at 5, 10.

[50] *Id*.

[51] *Id*. at 10-11.

nearly 36 percent.[52] And while transgender respondents as a whole reported a care-refusal rate of almost 27 percent, low-income transgender respondents reported a rate of nearly 33 percent.[53] People of color living with HIV and LGB people of color were at least twice as likely as whites to report experiencing physically rough or abusive treatment by medical professionals.[54]

Also detailed in the report are particular types of discrimination in health care based on gender identity, sex discrimination against LGB people, and discrimination against people living with HIV. Such discrimination can take many forms, from verbal abuse and humiliation to refusals of care;[55] to refusal to recognize same-sex family relationships in health care settings to the point of keeping LGBT people from going to the bedsides of their dying partners;[56] to lack of understanding and respect for LGBT people.[57] The resulting harms are manifold, from transgender patients denied care postponing, delaying, or being afraid to seek medical treatment, sometimes with severe health consequences, or resorting out of desperation to harmful self-treatment;[58] to the mental and physical harms of stigma;[59] to other immediate physical harms from being denied medical care.

As described, the discriminatory treatment of LGBT people too often occurs in the name of religion. When it does, that religious reinforcement of anti-LGBT bias often increases the mental health impacts of discrimination.[60]

Since the 2010 Lambda Legal survey, other studies have similarly documented the disparities faced by LGBT people seeking health care. For example, *The Report of the 2015 U.S. Transgender Survey*, a survey of nearly 28,000 transgender adults nationwide, found that 33 percent "of respondents who had seen a health care provider in the past year reported having at least one negative experience related to being transgender, such as verbal harassment, refusal of treatment, or having to teach the health care provider about transgender people to receive

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[52] *Id*. at 11.

[53] *Id*.

[54] *Id*. at 12.

[55] *Id*. at 5-6.

[56] *Id*. at 15-16.

[57] *Id*. at 12-13.

[58] *Id.* at 6, 8, 12-13.

[59] *Id*. at 2.

[60] Ilan H. Meyer et al., *The Role of Help-Seeking in Preventing Suicide Attempts among Lesbians, Gay Men, and Bisexuals*, Suicide & Life Threatening Behavior, 8 (2014), http://www.columbia.edu/~im15/papers/meyer-2014-suicide-and-life.pdf ("[A]lthough religion and spirituality can be helpful to LGB people, negative attitudes toward homosexuality in religious settings can lead to adverse health effects") (internal citations omitted).

appropriate care" and that "23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person[.]"[61]

The Center for American Progress in 2017 conducted another nationally representative survey with similar results about LGBT health disparities, including findings 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).[62]
>
> 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.

[61] James et al., *supra* n. 45, at 93.

[62] Mirza & Rooney, *supra* n. 45.

> 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).[63]

Independently of our own and others' research studies, Lambda Legal has become distressingly aware of the nature and scope of the discrimination problem from our legal work and requests for assistance received by our Legal Help Desks. We have repeatedly submitted information about the pattern of religion-based refusals of medical care to LGBT people in response to HHS requests. For example, in our 2013 response to the Request For Information for Section 1557 of the ACA, we documented numerous cases in which health professionals had denied medical care or otherwise discriminated against LGBT people and/or people living with HIV, based on the professionals' personal religious views, including:

> • Guadalupe "Lupita" Benitez was referred for infertility care to North Coast Women's Care Medical Group, a for-profit clinic that had an exclusive contract with Benitez's insurance plan. After eleven months of preparatory treatments, including medication and unwarranted surgery, Lupita's doctors finally admitted they would not perform donor insemination for her because she is a lesbian. The doctors claimed a right not to comply with California's public accommodations law due to their fundamentalist Christian views against treating lesbian patients as they treat others. In a unanimous decision, the California Supreme Court held that religious liberty protections do not authorize doctors to violate the civil rights of lesbian patients. *North Coast Women's Care Med. Grp., Inc. v. San Diego Cnty. Superior Court (Benitez)*, 189 P.3d 959 (Cal. 2008)
>
> • Counseling student's objections to providing relationship counseling to same-sex couples. *Keeton v. Anderson-Wiley*, 664 F.3d 865 (11th Cir. 2011) (finding student unlikely to prevail on free speech and religious liberty claims challenging her expulsion from counseling program due to her religiously based refusal to counsel same-sex couples, contrary to professional standards requiring nonjudgmental, nondiscriminatory treatment of all patients).
>
> • Physician's objection to working with an LGB person. *Hyman v. City of Louisville*, 132 F. Supp. 2d 528, 539-540 (W.D. Ky. 2001) (physician's religious beliefs did not exempt him from law prohibiting employment discrimination based on sexual orientation or gender identity), *vacated on other grounds by* 53 Fed. Appx. 740 (6th Cir. 2002).

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[63] *Id.*

> • Proselytizing to patients concerning religious condemnation of homosexuality. *Knight v. Connecticut Dep't of Pub. Health*, 275 F.3d 156 (2d Cir. 2001) (rejecting free exercise wrongful termination claim of visiting nurse fired for antigay proselytizing to home-bound AIDS patient).
>
> • Refusal to process lab specimens from persons with HIV. *Stepp v. Review Bd. of Indiana Emp. Sec. Div.*, 521 N.E.2d 350, 352 (Ind. 1988) (rejecting religious discrimination claim of lab technician fired for refusing to do tests on specimens labeled with HIV warning because he believed "AIDS is God's plague on man and performing the tests would go against God's will").[64]

In addition, testimonies received in Lambda Legal's health survey describe similar encounters with health professionals who felt free to express their religiously grounded bias toward LGBT patients:

> • Kara in Philadelphia, PA: "Since coming out, I have avoided seeing my primary physician because when she asked me my sexual history, I responded that I slept with women and that I was a lesbian. Her response was, 'Do you know that's against the Bible, against God?'"[65]
>
> • Joe in Minneapolis, MN: "I was 36 years old at the time of this story, an out gay man, and was depressed after the breakup of an eight-year relationship. The doctor I went to see told me that it was not medicine I needed but to leave my 'dirty lifestyle.' He recalled having put other patients in touch with ministers who could help gay men repent and heal from sin, and he even suggested that I simply needed to 'date the right woman' to get over my depression. The doctor even went so far as to suggest that his daughter might be a good fit for me."[66]

Lambda Legal documented additional recent examples of health care denials or discriminatory treatment in its amicus brief to the Supreme Court in *Masterpiece Cakeshop v. Colorado Civil Rights Commission*,[67] including the following two Lambda Legal cases:

- Lambda Legal client Naya Taylor, a transgender woman in Mattoon, Illinois, who sought hormone replacement therapy (HRT), a treatment for gender dysphoria, from the health clinic where she had received care for more than a decade. When her primary care physician refused her this standard treatment, clinic staff told her that, because of

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[64] Lambda Legal Nondiscrimination Comments (citations partially omitted).

[65] *Id.*

[66] *Id.*

[67] *See* Brief of Amici Curiae Lambda Legal et al., *Masterpiece Cakeshop Ltd. v. Colorado Civil Rights Comm'n*, No. 16-111, at 11-14, 17-18, 26, 30 (filed Oct. 30, 2017), https://www.lambdalegal.org/in-court/cases/masterpiece-cakes-v-co-civil-rights-commission.

the religious beliefs of the clinic's doctors, they do not have to treat "people like you."[68]

- Lambda Legal client Jionni Conforti, who was refused a medically necessary hysterectomy despite his treating physician's desire to perform the surgery. The hospital where the surgeon had admitting privileges was religiously affiliated and withholds permission for all gender transition-related care.[69]

These examples are just a tip of the iceberg, a few of many incidents across the country in which religion has been used to justify denial of health care or other discrimination against LGBT people and people living with HIV. Although courts consistently have rejected such reliance on religion to excuse discrimination, examples of religion-based discrimination in health care continue to occur with regularity.[70] This mistreatment contributes to persistent health disparities, including elevated rates of stress-related conditions.[71]

Given this landscape, Lambda Legal is deeply concerned that this Proposed Rule, designed to protect and even encourage religious refusals of health care, inevitably will facilitate further discrimination by health professionals in contexts involving sexual orientation, gender identity, or HIV status. As a result, the health of patients across the country, as well as others, would be at risk, and "conscience" claims could too easily become a way for providers to turn away LGBT patients. The past examples of religiously-based discrimination indicate there is significant likelihood that too-many individual and institutional care providers will demand exemptions from rules and standards designed to ensure that patients receive proper treatment regarding the following needs:

- Treatment of patients who need counseling, hormone replacement therapy, gender confirmation surgeries, or other treatments for gender dysphoria.
- For patients with a same-sex spouse or who are in a same-sex relationship, bereavement counseling after the loss of a same-sex partner or other mental health care that requires

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[68] In April 2014, Lambda Legal filed a claim of sex discrimination on Ms. Taylor's behalf under Section 1557 of the ACA; however, Ms. Taylor subsequently passed away and her case was voluntarily dismissed. *See* Complaint, *Taylor v. Lystila*, 2:14-cv-02072-CSB-DGB (C.D. Ill., Apr. 15, 2014), *available at* https://www.lambdalegal.org/in-court/legal-docs/taylor_il_20140416_complaint.

[69] *See Conforti v. St. Joseph's Healthcare Sys.* (D. N.J. filed Jan. 5, 2017) case documents at https://www.lambdalegal.org/in-court/cases/nj-conforti-v-st-josephs. *See also* Amy Littlefield, *Catholic Hospital Denies Transgender Man a Hysterectomy on Religious Grounds*, Rewire.News, Aug. 31, 2016, https://rewire.news/article/2016/08/31/catholic-hospital-denies-transgender-man-hysterectomy-on-religious-grounds/.

[70] *See* Lambda Legal 1557 Comments; Brief of Amici Curiae Lambda Legal et al., *Zubik v. Burwell*, 136 S. Ct. 1557 (2016).

[71] *See* Mark Hatzenbuehler, *Structural Stigma: Research Evidence and Implications for Psychological Science*, 71 AM. PSYCHOLOGIST, 742, 742–51 (2016), http://dx.doi.org/10.1037/amp0000068; IOM Report, *supra* n. 45.

respectful acknowledgment of a person's sexual orientation or gender identity.

- Care for patients living with HIV, including the option of pre-exposure prophylaxis (PrEP), a highly effective medication that dramatically reduces the risk of HIV infection among those who are otherwise at high risk, including people who are in a sexual relationship with a partner who is living with HIV.
- Treatment of patients who are unmarried or in a same-sex relationship and require infertility treatment or other medical services related to pregnancy, childbirth or pediatric needs.

In addition, the Proposed Rule threatens to undermine the community's trust in health care providers. Although there may be health care facilities that remain safer places for patients who face increased risk of discrimination in health care facilities, those facilities that are more welcoming of LGBT patients and patients seeking HIV care and willing to provide them with full health care access will become overburdened and increasingly unable to meet the needs of all who come through their doors.

If the number of health care facilities that LGBT people can feel comfortable going to, knowing they won't be turned away is reduced as the inevitable result of this Proposed Rule, access to health care will become harder, and nearly impossible for some, who, for example, are low income[72] or who live in remote areas and cannot travel long distances for medical care. Patients seeking more specialized care such as infertility treatments or HIV treatment or prevention are already often hours away from the closest facility. The Proposed Rule threatens to build even greater barriers between those who are most vulnerable and the health care they need.

For the Proposed Rule to transform the role of HHS from an agency focused on ensuring nondiscriminatory provision of health care to one that facilitates refusals of care is a disturbing about-face contrary to the Department's mission and authorizing statutes. Its failure to explain how the enhanced powers of health care providers to refuse patient care in the name of "conscience" should be reconciled with the protections for patients under the ACA and other statutes, and for employers under Title VII, make clear that this proposal is legally untenable as well as unjustifiably dangerous as a matter of federal health policy.

VI. The Proposed Rule Is The Result Of A Rushed, Truncated Process Contrary To The Department's Mission And Inconsistent With Procedural Requirements.

Considering the well-recognized health disparities and difficulty obtaining nondiscriminatory care that already confront the LGBT community, the Proposed Rule's apparent goal of inviting more discrimination and care denials to LGBT people and is peculiar

[72] Contrary to some misperceptions, LGBT people and people living with HIV are disproportionately economically disadvantaged. *See, e.g.*, M.V. Lee Badgett et al., *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community*, WILLIAMS INST. (June 2013), https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-poverty-update-june-2013.

and alarming. Indeed, the lack of concern for the Proposed Rule's inevitable impacts is especially shocking because this Department itself has conducted studies revealing disparities in LGBT health outcomes. As reported in the 2014 National Health Statistics Reports:

> [R]ecent studies have examined the health and health care of lesbian, gay, and bisexual (LGB) populations and have found clear disparities among sexual minority groups (i.e., gay or lesbian and bisexual) and between sexual minorities and straight populations. These disparities appear to be broad-ranging, with differences identified for various health conditions (e.g., asthma, diabetes, cardiovascular disease, or disability) … health behaviors such as smoking and heavy drinking … and health care access and service utilization …. Across most of these outcomes, sexual minorities tend to fare worse than their nonminority counterparts.[73]

Thus, in addition to the legal and ethical conflicts it would generate, the Proposed Rule also would undermine HHS's national and local efforts to reduce LGBT health disparities. For example, this Department's "Healthy People 2020 initiative" and the Institute of Medicine have called for steps to be taken to address LGBT health disparities"[74]; medical associations including the American Medical Association, the Association of American Medical Colleges, the American College of Physicians, the American Psychiatric Association, and others are committed to improving medical care for LGBT people through education and cultural competency training; and legislation is increasingly being considered and passed to improve LGBT health access and reduce health disparities.[75] The Proposed Rule endangers the important progress made on this front.

With this Department's past focus on addressing LGBT health disparities, it would be a bizarre and disturbing reversal of course for HHS now to become an active participant in the very denials of health care and discriminatory treatment that cause these disparities. Years of careful study and deliberation went into framing the protections against discrimination implemented pursuant to Section 1557 of the ACA, including the explicit protections against gender identity discrimination and other forms of sex discrimination and the accompanying

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[73] Brian W. Ward et al., *Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013*, Nat'l Health Statistics Report No. 77, 1, (July 15, 2014), https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf.

[74] Dep't of Health & Human Servs., *Healthy People 2020: LGBT Health Topic Area* (2015), http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health; IOM Report.

[75] *See* Timothy Wang et al., The Fenway Inst., *The Current Wave of Anti-LGBT Legislation: Historic Context and Implications for LGBT Health* at 6, 8-9 (June 2016), http://fenwayhealth.org/wp-content/uploads/The-Fenway-Institute-Religious-Exemption-Brief-June-2016.pdf.

value statement that "HHS supports prohibiting sexual orientation discrimination as a matter of policy[.]"[76]

In addition, the Proposed Rule has been issued without adequate time spent considering the thousands of comments submitted on related proposals. It lacks acknowledgment of countervailing interests of patients and many health provider institutions, let alone any explanation of how those interests are to be reconciled with the proposed aggressive enforcement of inconsistent religious interests. All in all, the Department's process has been arbitrary, capricious, and dangerous.[77] Consequently, along with its numerous other legal infirmities, it also violates the Administrative Procedure Act.[78]

VII. Conclusion

The Proposed Rule would have a chilling effect on the full and unbiased provision of health care, including to members of the LGBT community and everyone living with HIV, in a manner that conflicts with ethical, legal, and constitutional standards. While freedom of religion is a fundamental right protected by our Constitution and federal laws, it does not give anyone the right to use religious or moral beliefs as grounds for violating the rights of others. Instead, the Constitution commands that any religious or moral accommodation must be "measured so that it does not override other significant interests" or "impose unjustified burdens on other[s]."[79] Indeed, when the Supreme Court addressed the related question in *Burwell v. Hobby Lobby Stores, Inc.*, it explained that a religious accommodation should be provided in that case because the impact on third parties would be "precisely zero."[80]

Here, the Proposed Rule conflicts with statutory rights of health care providers to operate with reasonable efficiency and cost, and within their ethical obligations to care for patients according to professional standards. Most importantly, it also conflicts with legal and ethical protections for patients, potentially putting their health and even lives at risk. It is ill conceived and has no place in federal health policy.

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[76] Press Release, U.S. Dep't of Health & Human Servs., HHS Finalizes Rule to Improve Health Equity Under the Affordable Care Act (May 13, 2016), https://wayback.archive-it.org/3926/20170127191750/https://www.hhs.gov/about/news/2016/05/13/hhs-finalizes-rule-to-improve-health-equity-under-affordable-care-act.html.

[77] 5 U.S.C.A. § 706(2)(a).

[78] 5 U.S.C.A. § 500 *et seq*.

[79] *Cutter v. Wilkinson*, 544 U.S. 709, 722, 726 (2005).

[80] 134 S. Ct. 2751, 2760 (2014). Indeed, every member of the Court, whether in the majority or in dissent, reaffirmed that the burdens on third parties must be considered. *See id* at 2781 n. 37; *id.* at 2786–87 (Kennedy, J., concurring); *id.* at 2790, 2790 n. 8 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ., dissenting).

For the foregoing reasons, we emphatically recommend that the Department set aside this Proposed Rule.

Most respectfully,

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Exhibit 60

Office of the Attorney General

Washington, D.C. 20530

October 6, 2017

MEMORANDUM FOR ALL EXECUTIVE DEPARTMENTS AND AGENCIES

FROM: THE ATTORNEY GENERAL

SUBJECT: Federal Law Protections for Religious Liberty

The President has instructed me to issue guidance interpreting religious liberty protections in federal law, as appropriate. Exec. Order No. 13798 § 4, 82 Fed. Reg. 21675 (May 4, 2017). Consistent with that instruction, I am issuing this memorandum and appendix to guide all administrative agencies and executive departments in the execution of federal law.

Principles of Religious Liberty

Religious liberty is a foundational principle of enduring importance in America, enshrined in our Constitution and other sources of federal law. As James Madison explained in his Memorial and Remonstrance Against Religious Assessments, the free exercise of religion "is in its nature an unalienable right" because the duty owed to one's Creator "is precedent, both in order of time and in degree of obligation, to the claims of Civil Society."[1] Religious liberty is not merely a right to personal religious beliefs or even to worship in a sacred place. It also encompasses religious observance and practice. Except in the narrowest circumstances, no one should be forced to choose between living out his or her faith and complying with the law. Therefore, to the greatest extent practicable and permitted by law, religious observance and practice should be reasonably accommodated in all government activity, including employment, contracting, and programming. The following twenty principles should guide administrative agencies and executive departments in carrying out this task. These principles should be understood and interpreted in light of the legal analysis set forth in the appendix to this memorandum.

1. **The freedom of religion is a fundamental right of paramount importance, expressly protected by federal law.**

Religious liberty is enshrined in the text of our Constitution and in numerous federal statutes. It encompasses the right of all Americans to exercise their religion freely, without being coerced to join an established church or to satisfy a religious test as a qualification for public office. It also encompasses the right of all Americans to express their religious beliefs, subject to the same narrow limits that apply to all forms of speech. In the United States, the free exercise of religion is not a mere policy preference to be traded against other policy preferences. It is a fundamental right.

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[1] James Madison, Memorial and Remonstrance Against Religious Assessments (June 20, 1785), *in* 5 THE FOUNDERS' CONSTITUTION 82 (Philip B. Kurland & Ralph Lerner eds., 1987).

2. The free exercise of religion includes the right to *act* or *abstain from action* in accordance with one's religious beliefs.

The Free Exercise Clause protects not just the right to believe or the right to worship; it protects the right to perform or abstain from performing certain physical acts in accordance with one's beliefs. Federal statutes, including the Religious Freedom Restoration Act of 1993 ("RFRA"), support that protection, broadly defining the exercise of religion to encompass all aspects of observance and practice, whether or not central to, or required by, a particular religious faith.

3. The freedom of religion extends to persons *and* organizations.

The Free Exercise Clause protects not just persons, but persons collectively exercising their religion through churches or other religious denominations, religious organizations, schools, private associations, and even businesses.

4. Americans do not give up their freedom of religion by participating in the marketplace, partaking of the public square, or interacting with government.

Constitutional protections for religious liberty are not conditioned upon the willingness of a religious person or organization to remain separate from civil society. Although the application of the relevant protections may differ in different contexts, individuals and organizations do not give up their religious-liberty protections by providing or receiving social services, education, or healthcare; by seeking to earn or earning a living; by employing others to do the same; by receiving government grants or contracts; or by otherwise interacting with federal, state, or local governments.

5. Government may not restrict acts or abstentions because of the beliefs they display.

To avoid the very sort of religious persecution and intolerance that led to the founding of the United States, the Free Exercise Clause of the Constitution protects against government actions that target religious conduct. Except in rare circumstances, government may not treat the same conduct as lawful when undertaken for secular reasons but unlawful when undertaken for religious reasons. For example, government may not attempt to target religious persons or conduct by allowing the distribution of political leaflets in a park but forbidding the distribution of religious leaflets in the same park.

6. Government may not target religious individuals or entities for special disabilities based on their religion.

Much as government may not restrict actions only because of religious belief, government may not target persons or individuals because of their religion. Government may not exclude religious organizations as such from secular aid programs, at least when the aid is not being used for explicitly religious activities such as worship or proselytization. For example, the Supreme Court has held that if government provides reimbursement for scrap tires to replace child playground surfaces, it may not deny participation in that program to religious schools. Nor may

government deny religious schools—including schools whose curricula and activities include religious elements—the right to participate in a voucher program, so long as the aid reaches the schools through independent decisions of parents.

7. Government may not target religious individuals or entities through discriminatory enforcement of neutral, generally applicable laws.

Although government generally may subject religious persons and organizations to neutral, generally applicable laws—e.g., across-the-board criminal prohibitions or certain time, place, and manner restrictions on speech—government may not apply such laws in a discriminatory way. For instance, the Internal Revenue Service may not enforce the Johnson Amendment—which prohibits 501(c)(3) non-profit organizations from intervening in a political campaign on behalf of a candidate—against a religious non-profit organization under circumstances in which it would not enforce the amendment against a secular non-profit organization. Likewise, the National Park Service may not require religious groups to obtain permits to hand out fliers in a park if it does not require similarly situated secular groups to do so, and no federal agency tasked with issuing permits for land use may deny a permit to an Islamic Center seeking to build a mosque when the agency has granted, or would grant, a permit to similarly situated secular organizations or religious groups.

8. Government may not officially favor or disfavor particular religious groups.

Together, the Free Exercise Clause and the Establishment Clause prohibit government from officially preferring one religious group to another. This principle of denominational neutrality means, for example, that government cannot selectively impose regulatory burdens on some denominations but not others. It likewise cannot favor some religious groups for participation in the Combined Federal Campaign over others based on the groups' religious beliefs.

9. Government may not interfere with the autonomy of a religious organization.

Together, the Free Exercise Clause and the Establishment Clause also restrict governmental interference in intra-denominational disputes about doctrine, discipline, or qualifications for ministry or membership. For example, government may not impose its nondiscrimination rules to require Catholic seminaries or Orthodox Jewish yeshivas to accept female priests or rabbis.

10. The Religious Freedom Restoration Act of 1993 prohibits the federal government from substantially burdening any aspect of religious observance or practice, unless imposition of that burden on a particular religious adherent satisfies strict scrutiny.

RFRA prohibits the federal government from substantially burdening a person's exercise of religion, unless the federal government demonstrates that application of such burden to the religious adherent is the least restrictive means of achieving a compelling governmental interest. RFRA applies to all actions by federal administrative agencies, including rulemaking, adjudication or other enforcement actions, and grant or contract distribution and administration.

11. RFRA's protection extends not just to individuals, but also to organizations, associations, and at least some for-profit corporations.

RFRA protects the exercise of religion by individuals and by corporations, companies, associations, firms, partnerships, societies, and joint stock companies. For example, the Supreme Court has held that Hobby Lobby, a closely held, for-profit corporation with more than 500 stores and 13,000 employees, is protected by RFRA.

12. RFRA does not permit the federal government to second-guess the reasonableness of a religious belief.

RFRA applies to all sincerely held religious beliefs, whether or not central to, or mandated by, a particular religious organization or tradition. Religious adherents will often be required to draw lines in the application of their religious beliefs, and government is not competent to assess the reasonableness of such lines drawn, nor would it be appropriate for government to do so. Thus, for example, a government agency may not second-guess the determination of a factory worker that, consistent with his religious precepts, he can work on a line producing steel that might someday make its way into armaments but cannot work on a line producing the armaments themselves. Nor may the Department of Health and Human Services second-guess the determination of a religious employer that providing contraceptive coverage to its employees would make the employer complicit in wrongdoing in violation of the organization's religious precepts.

13. A governmental action substantially burdens an exercise of religion under RFRA if it bans an aspect of an adherent's religious observance or practice, compels an act inconsistent with that observance or practice, or substantially pressures the adherent to modify such observance or practice.

Because the government cannot second-guess the reasonableness of a religious belief or the adherent's assessment of the religious connection between the government mandate and the underlying religious belief, the substantial burden test focuses on the extent of governmental compulsion involved. In general, a government action that bans an aspect of an adherent's religious observance or practice, compels an act inconsistent with that observance or practice, or substantially pressures the adherent to modify such observance or practice, will qualify as a substantial burden on the exercise of religion. For example, a Bureau of Prisons regulation that bans a devout Muslim from growing even a half-inch beard in accordance with his religious beliefs substantially burdens his religious practice. Likewise, a Department of Health and Human Services regulation requiring employers to provide insurance coverage for contraceptive drugs in violation of their religious beliefs or face significant fines substantially burdens their religious practice, and a law that conditions receipt of significant government benefits on willingness to work on Saturday substantially burdens the religious practice of those who, as a matter of religious observance or practice, do not work on that day. But a law that infringes, even severely, an aspect of an adherent's religious observance or practice that the adherent himself regards as unimportant or inconsequential imposes no substantial burden on that adherent. And a law that regulates only the government's internal affairs and does not involve any governmental compulsion on the religious adherent likewise imposes no substantial burden.

14. The strict scrutiny standard applicable to RFRA is exceptionally demanding.

Once a religious adherent has identified a substantial burden on his or her religious belief, the federal government can impose that burden on the adherent only if it is the least restrictive means of achieving a compelling governmental interest. Only those interests of the highest order can outweigh legitimate claims to the free exercise of religion, and such interests must be evaluated not in broad generalities but as applied to the particular adherent. Even if the federal government could show the necessary interest, it would also have to show that its chosen restriction on free exercise is the least restrictive means of achieving that interest. That analysis requires the government to show that it cannot accommodate the religious adherent while achieving its interest through a viable alternative, which may include, in certain circumstances, expenditure of additional funds, modification of existing exemptions, or creation of a new program.

15. RFRA applies even where a religious adherent seeks an exemption from a legal obligation requiring the adherent to confer benefits on third parties.

Although burdens imposed on third parties are relevant to RFRA analysis, the fact that an exemption would deprive a third party of a benefit does not categorically render an exemption unavailable. Once an adherent identifies a substantial burden on his or her religious exercise, RFRA requires the federal government to establish that denial of an accommodation or exemption to that adherent is the least restrictive means of achieving a compelling governmental interest.

16. Title VII of the Civil Rights Act of 1964, as amended, prohibits covered employers from discriminating against individuals on the basis of their religion.

Employers covered by Title VII may not fail or refuse to hire, discharge, or discriminate against any individual with respect to compensation, terms, conditions, or privileges of employment because of that individual's religion. Such employers also may not classify their employees or applicants in a way that would deprive or tend to deprive any individual of employment opportunities because of the individual's religion. This protection applies regardless of whether the individual is a member of a religious majority or minority. But the protection does not apply in the same way to religious employers, who have certain constitutional and statutory protections for religious hiring decisions.

17. Title VII's protection extends to discrimination on the basis of religious observance or practice as well as belief, unless the employer cannot reasonably accommodate such observance or practice without undue hardship on the business.

Title VII defines "religion" broadly to include all aspects of religious observance or practice, except when an employer can establish that a particular aspect of such observance or practice cannot reasonably be accommodated without undue hardship to the business. For example, covered employers are required to adjust employee work schedules for Sabbath observance, religious holidays, and other religious observances, unless doing so would create an undue hardship, such as materially compromising operations or violating a collective bargaining agreement. Title VII might also require an employer to modify a no-head-coverings policy to allow a Jewish employee to wear a yarmulke or a Muslim employee to wear a headscarf. An

employer who contends that it cannot reasonably accommodate a religious observance or practice must establish undue hardship on its business with specificity; it cannot rely on assumptions about hardships that might result from an accommodation.

18. The Clinton Guidelines on Religious Exercise and Religious Expression in the Federal Workplace provide useful examples for private employers of reasonable accommodations for religious observance and practice in the workplace.

President Clinton issued Guidelines on Religious Exercise and Religious Expression in the Federal Workplace ("Clinton Guidelines") explaining that federal employees may keep religious materials on their private desks and read them during breaks; discuss their religious views with other employees, subject to the same limitations as other forms of employee expression; display religious messages on clothing or wear religious medallions; and invite others to attend worship services at their churches, except to the extent that such speech becomes excessive or harassing. The Clinton Guidelines have the force of an Executive Order, and they also provide useful guidance to private employers about ways in which religious observance and practice can reasonably be accommodated in the workplace.

19. Religious employers are entitled to employ only persons whose beliefs and conduct are consistent with the employers' religious precepts.

Constitutional and statutory protections apply to certain religious hiring decisions. Religious corporations, associations, educational institutions, and societies—that is, entities that are organized for religious purposes and engage in activity consistent with, and in furtherance of, such purposes—have an express statutory exemption from Title VII's prohibition on religious discrimination in employment. Under that exemption, religious organizations may choose to employ only persons whose beliefs and conduct are consistent with the organizations' religious precepts. For example, a Lutheran secondary school may choose to employ only practicing Lutherans, only practicing Christians, or only those willing to adhere to a code of conduct consistent with the precepts of the Lutheran community sponsoring the school. Indeed, even in the absence of the Title VII exemption, religious employers might be able to claim a similar right under RFRA or the Religion Clauses of the Constitution.

20. As a general matter, the federal government may not condition receipt of a federal grant or contract on the effective relinquishment of a religious organization's hiring exemptions or attributes of its religious character.

Religious organizations are entitled to compete on equal footing for federal financial assistance used to support government programs. Such organizations generally may not be required to alter their religious character to participate in a government program, nor to cease engaging in explicitly religious activities outside the program, nor effectively to relinquish their federal statutory protections for religious hiring decisions.

Guidance for Implementing Religious Liberty Principles

Agencies must pay keen attention, in everything they do, to the foregoing principles of religious liberty.

Agencies As Employers

Administrative agencies should review their current policies and practices to ensure that they comply with all applicable federal laws and policies regarding accommodation for religious observance and practice in the federal workplace, and all agencies must observe such laws going forward. In particular, all agencies should review the Guidelines on Religious Exercise and Religious Expression in the Federal Workplace, which President Clinton issued on August 14, 1997, to ensure that they are following those Guidelines. All agencies should also consider practical steps to improve safeguards for religious liberty in the federal workplace, including through subject-matter experts who can answer questions about religious nondiscrimination rules, information websites that employees may access to learn more about their religious accommodation rights, and training for all employees about federal protections for religious observance and practice in the workplace.

Agencies Engaged in Rulemaking

In formulating rules, regulations, and policies, administrative agencies should also proactively consider potential burdens on the exercise of religion and possible accommodations of those burdens. Agencies should consider designating an officer to review proposed rules with religious accommodation in mind or developing some other process to do so. In developing that process, agencies should consider drawing upon the expertise of the White House Office of Faith-Based and Neighborhood Partnerships to identify concerns about the effect of potential agency action on religious exercise. Regardless of the process chosen, agencies should ensure that they review all proposed rules, regulations, and policies that have the potential to have an effect on religious liberty for compliance with the principles of religious liberty outlined in this memorandum and appendix before finalizing those rules, regulations, or policies. The Office of Legal Policy will also review any proposed agency or executive action upon which the Department's comments, opinion, or concurrence are sought, *see, e.g.*, Exec. Order 12250 § 1-2, 45 Fed. Reg. 72995 (Nov. 2, 1980), to ensure that such action complies with the principles of religious liberty outlined in this memorandum and appendix. The Department will not concur in any proposed action that does not comply with federal law protections for religious liberty as interpreted in this memorandum and appendix, and it will transmit any concerns it has about the proposed action to the agency or the Office of Management and Budget as appropriate. If, despite these internal reviews, a member of the public identifies a significant concern about a prospective rule's compliance with federal protections governing religious liberty during a period for public comment on the rule, the agency should carefully consider and respond to that request in its decision. *See Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199, 1203 (2015). In appropriate circumstances, an agency might explain that it will consider requests for accommodations on a case-by-case basis rather than in the rule itself, but the agency should provide a reasoned basis for that approach.

Agencies Engaged in Enforcement Actions

Much like administrative agencies engaged in rulemaking, agencies considering potential enforcement actions should consider whether such actions are consistent with federal protections for religious liberty. In particular, agencies should remember that RFRA applies to agency enforcement just as it applies to every other governmental action. An agency should consider RFRA when setting agency-wide enforcement rules and priorities, as well as when making decisions to pursue or continue any particular enforcement action, and when formulating any generally applicable rules announced in an agency adjudication.

Agencies should remember that discriminatory enforcement of an otherwise nondiscriminatory law can also violate the Constitution. Thus, agencies may not target or single out religious organizations or religious conduct for disadvantageous treatment in enforcement priorities or actions. The President identified one area where this could be a problem in Executive Order 13798, when he directed the Secretary of the Treasury, to the extent permitted by law, not to take any "adverse action against any individual, house of worship, or other religious organization on the basis that such individual or organization speaks or has spoken about moral or political issues from a religious perspective, where speech of *similar character*" from a non-religious perspective has not been treated as participation or intervention in a political campaign. Exec. Order No. 13798, § 2, 82 Fed. Reg. at 21675. But the requirement of nondiscrimination toward religious organizations and conduct applies across the enforcement activities of the Executive Branch, including within the enforcement components of the Department of Justice.

Agencies Engaged in Contracting and Distribution of Grants

Agencies also must not discriminate against religious organizations in their contracting or grant-making activities. Religious organizations should be given the opportunity to compete for government grants or contracts and participate in government programs on an equal basis with nonreligious organizations. Absent unusual circumstances, agencies should not condition receipt of a government contract or grant on the effective relinquishment of a religious organization's Section 702 exemption for religious hiring practices, or any other constitutional or statutory protection for religious organizations. In particular, agencies should not attempt through conditions on grants or contracts to meddle in the internal governance affairs of religious organizations or to limit those organizations' otherwise protected activities.

* * *

Any questions about this memorandum or the appendix should be addressed to the Office of Legal Policy, U.S. Department of Justice, 950 Pennsylvania Avenue N.W., Washington, D.C. 20530, phone (202) 514-4601.

APPENDIX

Although not an exhaustive treatment of all federal protections for religious liberty, this appendix summarizes the key constitutional and federal statutory protections for religious liberty and sets forth the legal basis for the religious liberty principles described in the foregoing memorandum.

Constitutional Protections

The people, acting through their Constitution, have singled out religious liberty as deserving of unique protection. In the original version of the Constitution, the people agreed that "no religious Test shall ever be required as a Qualification to any Office or public Trust under the United States." U.S. Const., art. VI, cl. 3. The people then amended the Constitution during the First Congress to clarify that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof." U.S. Const. amend. I, cl. 1. Those protections have been incorporated against the States. *Everson v. Bd. of Educ. of Ewing*, 330 U.S. 1, 15 (1947) (Establishment Clause); *Cantwell v. Connecticut*, 310 U.S. 296, 303 (1940) (Free Exercise Clause).

A. Free Exercise Clause

The Free Exercise Clause recognizes and guarantees Americans the "right to believe and profess whatever religious doctrine [they] desire[]." *Empl't Div. v. Smith*, 494 U.S. 872, 877 (1990). Government may not attempt to *regulate* religious beliefs, *compel* religious beliefs, or *punish* religious beliefs. *See id.*; *see also Sherbert v. Verner*, 374 U.S. 398, 402 (1963); *Torcaso v. Watkins*, 367 U.S. 488, 492–93, 495 (1961); *United States v. Ballard*, 322 U.S. 78, 86 (1944). It may not lend its power to one side in intra-denominational disputes about dogma, authority, discipline, or qualifications for ministry or membership. *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. EEOC*, 565 U.S. 171, 185 (2012); *Smith*, 494 U.S. at 877; *Serbian Eastern Orthodox Diocese v. Milivojevich*, 426 U.S. 696, 724–25 (1976); *Presbyterian Church v. Mary Elizabeth Blue Hull Mem'l Presbyterian Church*, 393 U.S. 440, 451 (1969); *Kedroff v. St. Nicholas Cathedral of the Russian Orthodox Church*, 344 U.S. 94, 116, 120–21 (1952). It may not discriminate against or impose special burdens upon individuals because of their religious beliefs or status. *Smith*, 494 U.S. at 877; *McDaniel v. Paty*, 435 U.S. 618, 627 (1978). And with the exception of certain historical limits on the freedom of speech, government may not punish or otherwise harass churches, church officials, or religious adherents for speaking on religious topics or sharing their religious beliefs. *See Widmar v. Vincent*, 454 U.S. 263, 269 (1981); *see also* U.S. Const., amend. I, cl. 3. The Constitution's protection against government regulation of religious belief is absolute; it is not subject to limitation or balancing against the interests of the government. *Smith*, 494 U.S. at 877; *Sherbert*, 374 U.S. at 402; *see also West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943) ("If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein.").

The Free Exercise Clause protects beliefs rooted in religion, even if such beliefs are not mandated by a particular religious organization or shared among adherents of a particular religious

tradition. *Frazee v. Illinois Dept. of Emp't Sec.*, 489 U.S. 829, 833–34 (1989). As the Supreme Court has repeatedly counseled, "religious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection." *Church of the Lukumi Babalu Aye v. Hialeah*, 508 U.S. 520, 531 (1993) (internal quotation marks omitted). They must merely be "sincerely held." *Frazee*, 489 U.S. at 834.

Importantly, the protection of the Free Exercise Clause also extends to acts undertaken in accordance with such sincerely-held beliefs. That conclusion flows from the plain text of the First Amendment, which guarantees the freedom to "*exercise*" religion, not just the freedom to "believe" in religion. *See Smith*, 494 U.S. at 877; *see also Thomas*, 450 U.S. at 716; *Paty*, 435 U.S. at 627; *Sherbert*, 374 U.S. at 403–04; *Wisconsin v. Yoder*, 406 U.S. 205, 219–20 (1972). Moreover, no other interpretation would actually guarantee the freedom of belief that Americans have so long regarded as central to individual liberty. Many, if not most, religious beliefs require external observance and practice through physical acts or abstention from acts. The tie between physical acts and religious beliefs may be readily apparent (e.g., attendance at a worship service) or not (e.g., service to one's community at a soup kitchen or a decision to close one's business on a particular day of the week). The "exercise of religion" encompasses all aspects of religious observance and practice. And because individuals may act collectively through associations and organizations, it encompasses the exercise of religion by such entities as well. *See, e.g.*, *Hosanna-Tabor*, 565 U.S. at 199; *Church of the Lukumi Babalu Aye*, 508 U.S. at 525–26, 547; *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2770, 2772–73 (2014) (even a closely held for-profit corporation may exercise religion if operated in accordance with asserted religious principles).

As with most constitutional protections, however, the protection afforded to Americans by the Free Exercise Clause for physical acts is not absolute, *Smith*, 491 U.S. at 878–79, and the Supreme Court has identified certain principles to guide the analysis of the scope of that protection. First, government may not restrict "acts or abstentions only when they are engaged in for religious reasons, or only because of the religious belief that they display," *id.* at 877, nor "target the religious for special disabilities based on their religious status," *Trinity Lutheran Church of Columbia, Inc. v. Comer*, 582 U.S. ___, ___ (2017) (slip op. at 6) (internal quotation marks omitted), for it was precisely such "historical instances of religious persecution and intolerance that gave concern to those who drafted the Free Exercise Clause." *Church of the Lukumi Babalu Aye*, 508 U.S. at 532 (internal quotation marks omitted). The Free Exercise Clause protects against "indirect coercion or penalties on the free exercise of religion" just as surely as it protects against "outright prohibitions" on religious exercise. *Trinity Lutheran*, 582 U.S. at ___ (slip op. at 11) (internal quotation marks omitted). "It is too late in the day to doubt that the liberties of religion and expression may be infringed by the denial of or placing of conditions upon a benefit or privilege." *Id.* (quoting *Sherbert*, 374 U.S. at 404).

Because a law cannot have as its official "object or purpose . . . the suppression of religion or religious conduct," courts must "survey meticulously" the text and operation of a law to ensure that it is actually neutral and of general applicability. *Church of the Lukumi Babalu Aye*, 508 U.S. at 533–34 (internal quotation marks omitted). A law is not neutral if it singles out particular religious conduct for adverse treatment; treats the same conduct as lawful when undertaken for secular reasons but unlawful when undertaken for religious reasons; visits "gratuitous restrictions

on religious conduct"; or "accomplishes . . . a 'religious gerrymander,' an impermissible attempt to target [certain individuals] and their religious practices." *Id.* at 533–35, 538 (internal quotation marks omitted). A law is not generally applicable if "in a selective manner [it] impose[s] burdens only on conduct motivated by religious belief," *id.* at 543, including by "fail[ing] to prohibit nonreligious conduct that endangers [its] interests in a similar or greater degree than . . . does" the prohibited conduct, *id.*, or enables, expressly or de facto, "a system of individualized exemptions," as discussed in *Smith*, 494 U.S. at 884; *see also Church of the Lukumi Babalu Aye*, 508 U.S. at 537.

"Neutrality and general applicability are interrelated, . . . [and] failure to satisfy one requirement is a likely indication that the other has not been satisfied." *Id.* at 531. For example, a law that disqualifies a religious person or organization from a right to compete for a public benefit—including a grant or contract—because of the person's religious character is neither neutral nor generally applicable. *See Trinity Lutheran*, 582 U.S. at ___–___ (slip op. at 9–11). Likewise, a law that selectively prohibits the killing of animals for religious reasons and fails to prohibit the killing of animals for many nonreligious reasons, or that selectively prohibits a business from refusing to stock a product for religious reasons but fails to prohibit such refusal for myriad commercial reasons, is neither neutral, nor generally applicable. *See Church of the Lukumi Babalu Aye*, 508 U.S. at 533–36, 542–45. Nonetheless, the requirements of neutral and general applicability are separate, and any law burdening religious practice that fails one or both must be subjected to strict scrutiny, *id.* at 546.

Second, even a neutral, generally applicable law is subject to strict scrutiny under this Clause if it restricts the free exercise of religion and another constitutionally protected liberty, such as the freedom of speech or association, or the right to control the upbringing of one's children. *See Smith*, 494 U.S. at 881–82; *Axson-Flynn v. Johnson*, 356 F.3d 1277, 1295–97 (10th Cir. 2004). Many Free Exercise cases fall in this category. For example, a law that seeks to compel a private person's speech or expression contrary to his or her religious beliefs implicates both the freedoms of speech and free exercise. *See, e.g.*, *Wooley v. Maynard*, 430 U.S. 705, 707–08 (1977) (challenge by Jehovah's Witnesses to requirement that state license plates display the motto "Live Free or Die"); *Axson-Flynn*, 356 F.3d at 1280 (challenge by Mormon student to University requirement that student actors use profanity and take God's name in vain during classroom acting exercises). A law taxing or prohibiting door-to-door solicitation, at least as applied to individuals distributing religious literature and seeking contributions, likewise implicates the freedoms of speech and free exercise. *Murdock v. Pennsylvania*, 319 U.S. 105, 108–09 (1943) (challenge by Jehovah's Witnesses to tax on canvassing or soliciting); *Cantwell*, 310 U.S. at 307 (same). A law requiring children to receive certain education, contrary to the religious beliefs of their parents, implicates both the parents' right to the care, custody, and control of their children and to free exercise. *Yoder*, 406 U.S. at 227–29 (challenge by Amish parents to law requiring high school attendance).

Strict scrutiny is the "most rigorous" form of scrutiny identified by the Supreme Court. *Church of the Lukumi Babalu Aye*, 508 U.S. at 546; *see also City of Boerne v. Flores*, 521 U.S. 507, 534 (1997) ("Requiring a State to demonstrate a compelling interest and show that it has adopted the least restrictive means of achieving that interest is the most demanding test known to constitutional law."). It is the same standard applied to governmental classifications based on race, *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 720 (2007), and

restrictions on the freedom of speech, *Reed v. Town of Gilbert, Ariz.*, 135 S. Ct. 2218, 2228 (2015). *See Church of the Lukumi Babalu Aye*, 508 U.S. at 546–47. Under this level of scrutiny, government must establish that a challenged law "advance[s] interests of the highest order" and is "narrowly tailored in pursuit of those interests." *Id.* at 546 (internal quotation marks omitted). "[O]nly in rare cases" will a law survive this level of scrutiny. *Id.*

Of course, even when a law is neutral and generally applicable, government may run afoul of the Free Exercise Clause if it interprets or applies the law in a manner that discriminates against religious observance and practice. *See, e.g.*, *Church of the Lukumi Babalu Aye*, 508 U.S. at 537 (government discriminatorily interpreted an ordinance prohibiting the unnecessary killing of animals as prohibiting only killing of animals for religious reasons); *Fowler v. Rhode Island*, 345 U.S. 67, 69–70 (1953) (government discriminatorily enforced ordinance prohibiting meetings in public parks against only certain religious groups). The Free Exercise Clause, much like the Free Speech Clause, requires equal treatment of religious adherents. *See Trinity Lutheran*, 582 U.S. at __ (slip op. at 6); *cf. Good News Club v. Milford Central Sch.*, 533 U.S. 98, 114 (2001) (recognizing that Establishment Clause does not justify discrimination against religious clubs seeking use of public meeting spaces); *Rosenberger v. Rector & Visitors of Univ. of Va.*, 515 U.S. 819, 837, 841 (1995) (recognizing that Establishment Clause does not justify discrimination against religious student newspaper's participation in neutral reimbursement program). That is true regardless of whether the discriminatory application is initiated by the government itself or by private requests or complaints. *See, e.g.*, *Fowler*, 345 U.S. at 69; *Niemotko v. Maryland*, 340 U.S. 268, 272 (1951).

B. Establishment Clause

The Establishment Clause, too, protects religious liberty. It prohibits government from establishing a religion and coercing Americans to follow it. *See Town of Greece, N.Y. v. Galloway*, 134 S. Ct. 1811, 1819–20 (2014); *Good News Club*, 533 U.S. at 115. It restricts government from interfering in the internal governance or ecclesiastical decisions of a religious organization. *Hosanna-Tabor*, 565 U.S. at 188–89. And it prohibits government from officially favoring or disfavoring particular religious groups as such or officially advocating particular religious points of view. *See Galloway*, 134 S. Ct. at 1824; *Larson v. Valente*, 456 U.S. 228, 244–46 (1982). Indeed, "a significant factor in upholding governmental programs in the face of Establishment Clause attack is their *neutrality* towards religion." *Rosenberger*, 515 U.S. at 839 (emphasis added). That "guarantee of neutrality is respected, not offended, when the government, following neutral criteria and evenhanded policies, extends benefits to recipients whose ideologies and viewpoints, including religious ones, are broad and diverse." *Id.* Thus, religious adherents and organizations may, like nonreligious adherents and organizations, receive indirect financial aid through independent choice, or, in certain circumstances, direct financial aid through a secular-aid program. *See, e.g.*, *Trinity Lutheran*, 582 U.S. at ___ (slip. op. at 6) (scrap tire program); *Zelman v. Simmons-Harris*, 536 U.S. 639, 652 (2002) (voucher program).

C. Religious Test Clause

Finally, the Religious Test Clause, though rarely invoked, provides a critical guarantee to religious adherents that they may serve in American public life. The Clause reflects the judgment

of the Framers that a diversity of religious viewpoints in government would enhance the liberty of all Americans. And after the Religion Clauses were incorporated against the States, the Supreme Court shared this view, rejecting a Tennessee law that "establishe[d] as a condition of office the willingness to eschew certain protected religious practices." *Paty*, 435 U.S. at 632 (Brennan, J., and Marshall, J., concurring in judgment); *see also id.* at 629 (plurality op.) ("[T]he American experience provides no persuasive support for the fear that clergymen in public office will be less careful of anti-establishment interests or less faithful to their oaths of civil office than their unordained counterparts.").

Statutory Protections

Recognizing the centrality of religious liberty to our nation, Congress has buttressed these constitutional rights with statutory protections for religious observance and practice. These protections can be found in, among other statutes, the Religious Freedom Restoration Act of 1993, 42 U.S.C. §§ 2000bb *et seq.*; the Religious Land Use and Institutionalized Persons Act, 42 U.S.C. §§ 2000cc *et seq.*; Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e *et seq.*; and the American Indian Religious Freedom Act, 42 U.S.C. § 1996. Such protections ensure not only that government tolerates religious observance and practice, but that it embraces religious adherents as full members of society, able to contribute through employment, use of public accommodations, and participation in government programs. The considered judgment of the United States is that we are stronger through accommodation of religion than segregation or isolation of it.

A. Religious Freedom Restoration Act of 1993 (RFRA)

The Religious Freedom Restoration Act of 1993 (RFRA), 42 U.S.C. § 2000bb *et seq.*, prohibits the federal government from "substantially burden[ing] a person's exercise of religion" unless "it demonstrates that application of the burden to the person (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." *Id.* § 2000bb-1(a), (b). The Act applies even where the burden arises out of a "rule of general applicability" passed without animus or discriminatory intent. *See id.* § 2000bb-1(a). It applies to "any exercise of religion, whether or not compelled by, or central to, a system of religious belief," *see* §§ 2000bb-2(4), 2000cc-5(7), and covers "individuals" as well as "corporations, companies, associations, firms, partnerships, societies, and joint stock companies," 1 U.S.C. § 1, including for-profit, closely-held corporations like those involved in *Hobby Lobby*, 134 S. Ct. at 2768.

Subject to the exceptions identified below, a law "substantially burden[s] a person's exercise of religion," 42 U.S.C. § 2000bb-1, if it bans an aspect of the adherent's religious observance or practice, compels an act inconsistent with that observance or practice, or substantially pressures the adherent to modify such observance or practice, *see Sherbert*, 374 U.S. at 405–06. The "threat of criminal sanction" will satisfy these principles, even when, as in *Yoder*, the prospective punishment is a mere $5 fine. 406 U.S. at 208, 218. And the denial of, or condition on the receipt of, government benefits may substantially burden the exercise of religion under these principles. *Sherbert*, 374 U.S. at 405–06; *see also Hobbie v. Unemployment Appeals Comm'n of Fla.*, 480 U.S. 136, 141 (1987); *Thomas*, 450 U.S. at 717–18. But a law that infringes, even severely, an aspect of an adherent's religious observance or practice that the adherent himself

regards as unimportant or inconsequential imposes no substantial burden on that adherent. And a law that regulates only the government's internal affairs and does not involve any governmental compulsion on the religious adherent likewise imposes no substantial burden. *See, e.g.*, *Lyng v. Nw. Indian Cemetery Protective Ass'n*, 485 U.S. 439, 448–49 (1988); *Bowen v. Roy*, 476 U.S. 693, 699–700 (1986).

As with claims under the Free Exercise Clause, RFRA does not permit a court to inquire into the reasonableness of a religious belief, including into the adherent's assessment of the religious connection between a belief asserted and what the government forbids, requires, or prevents. *Hobby Lobby*, 134 S. Ct. at 2778. If the proffered belief is sincere, it is not the place of the government or a court to second-guess it. *Id.* A good illustration of the point is *Thomas v. Review Board of Indiana Employment Security Division*—one of the *Sherbert* line of cases, whose analytical test Congress sought, through RFRA, to restore, 42 U.S.C. § 2000bb. There, the Supreme Court concluded that the denial of unemployment benefits was a substantial burden on the sincerely held religious beliefs of a Jehovah's Witness who had quit his job after he was transferred from a department producing sheet steel that could be used for military armaments to a department producing turrets for military tanks. *Thomas*, 450 U.S. at 716–18. In doing so, the Court rejected the lower court's inquiry into "what [the claimant's] belief was and what the religious basis of his belief was," noting that no one had challenged the sincerity of the claimant's religious beliefs and that "[c]ourts should not undertake to dissect religious beliefs because the believer admits that he is struggling with his position or because his beliefs are not articulated with the clarity and precision that a more sophisticated person might employ." *Id.* at 714–15 (internal quotation marks omitted). The Court likewise rejected the lower court's comparison of the claimant's views to those of other Jehovah's Witnesses, noting that "[i]ntrafaith differences of that kind are not uncommon among followers of a particular creed, and the judicial process is singularly ill equipped to resolve such differences." *Id.* at 715. The Supreme Court reinforced this reasoning in *Hobby Lobby*, rejecting the argument that "the connection between what the objecting parties [were required to] do (provide health-insurance coverage for four methods of contraception that may operate after the fertilization of an egg) and the end that they [found] to be morally wrong (destruction of an embryo) [wa]s simply too attenuated." 134 S. Ct. at 2777. The Court explained that the plaintiff corporations had a sincerely-held religious belief that provision of the coverage was morally wrong, and it was "not for us to say that their religious beliefs are mistaken or insubstantial." *Id.* at 2779.

Government bears a heavy burden to justify a substantial burden on the exercise of religion. "[O]nly those interests of the highest order . . . can overbalance legitimate claims to the free exercise of religion." *Thomas*, 450 U.S. at 718 (quoting *Yoder*, 406 U.S. at 215). Such interests include, for example, the "fundamental, overriding interest in eradicating racial discrimination in education—discrimination that prevailed, with official approval, for the first 165 years of this Nation's history," *Bob Jones Univ. v. United States*, 461 U.S. 574, 604 (1983), and the interest in ensuring the "mandatory and continuous participation" that is "indispensable to the fiscal vitality of the social security system," *United States v. Lee*, 455 U.S. 252, 258–59 (1982). But "broadly formulated interests justifying the general applicability of government mandates" are insufficient. *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 431 (2006). The government must establish a compelling interest to deny an accommodation to the particular claimant. *Id.* at 430, 435–38. For example, the military may have a compelling interest in its

uniform and grooming policy to ensure military readiness and protect our national security, but it does not necessarily follow that those interests would justify denying a particular soldier's request for an accommodation from the uniform and grooming policy. *See, e.g.*, Secretary of the Army, Army Directive 2017-03, Policy for Brigade-Level Approval of Certain Requests for Religious Accommodation (2017) (recognizing the "successful examples of Soldiers currently serving with" an accommodation for "the wear of a hijab; the wear of a beard; and the wear of a turban or under-turban/patka, with uncut beard and uncut hair" and providing for a reasonable accommodation of these practices in the Army). The military would have to show that it has a compelling interest in denying that particular accommodation. An asserted compelling interest in denying an accommodation to a particular claimant is undermined by evidence that exemptions or accommodations have been granted for other interests. *See O Centro*, 546 U.S. at 433, 436–37; *see also Hobby Lobby*, 134 S. Ct. at 2780.

The compelling-interest requirement applies even where the accommodation sought is "an exemption from a legal obligation requiring [the claimant] to confer benefits on third parties." *Hobby Lobby*, 134 S. Ct. at 2781 n.37. Although "in applying RFRA 'courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries,'" the Supreme Court has explained that almost any governmental regulation could be reframed as a legal obligation requiring a claimant to confer benefits on third parties. *Id.* (quoting *Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005)). As nothing in the text of RFRA admits of an exception for laws requiring a claimant to confer benefits on third parties, 42 U.S.C. § 2000bb-1, and such an exception would have the potential to swallow the rule, the Supreme Court has rejected the proposition that RFRA accommodations are categorically unavailable for laws requiring claimants to confer benefits on third parties. *Hobby Lobby*, 134 S. Ct. at 2781 n.37.

Even if the government can identify a compelling interest, the government must also show that denial of an accommodation is the least restrictive means of serving that compelling governmental interest. This standard is "exceptionally demanding." *Hobby Lobby*, 134 S. Ct. at 2780. It requires the government to show that it cannot accommodate the religious adherent while achieving its interest through a viable alternative, which may include, in certain circumstances, expenditure of additional funds, modification of existing exemptions, or creation of a new program. *Id.* at 2781. Indeed, the existence of exemptions for other individuals or entities that could be expanded to accommodate the claimant, while still serving the government's stated interests, will generally defeat a RFRA defense, as the government bears the burden to establish that no accommodation is viable. *See id.* at 2781–82.

B. Religious Land Use and Institutionalized Persons Act of 2000 (RLUIPA)

Although Congress's leadership in adopting RFRA led many States to pass analogous statutes, Congress recognized the unique threat to religious liberty posed by certain categories of state action and passed the Religious Land Use and Institutionalized Persons Act of 2000 (RLUIPA) to address them. RLUIPA extends a standard analogous to RFRA to state and local government actions regulating land use and institutionalized persons where "the substantial burden is imposed in a program or activity that receives Federal financial assistance" or "the substantial burden affects, or removal of that substantial burden would affect, commerce with foreign nations, among the several States, or with Indian tribes." 42 U.S.C. §§ 2000cc(a)(2), 2000cc-1(b).

RLUIPA's protections must "be construed in favor of a broad protection of religious exercise, to the maximum extent permitted by [RLUIPA] and the Constitution." *Id.* § 2000cc-3(g). RLUIPA applies to "any exercise of religion, whether or not compelled by, or central to, a system of religious belief," *id.* § 2000cc-5(7)(A), and treats "[t]he use, building, or conversion of real property for the purpose of religious exercise" as the "religious exercise of the person or entity that uses or intends to use the property for that purpose," *id.* § 2000cc-5(7)(B). Like RFRA, RLUIPA prohibits government from substantially burdening an exercise of religion unless imposition of the burden on the religious adherent is the least restrictive means of furthering a compelling governmental interest. *See id.* § 2000cc-1(a). That standard "may require a government to incur expenses in its own operations to avoid imposing a substantial burden on religious exercise." *Id.* § 2000cc-3(c); *cf. Holt v. Hobbs*, 135 S. Ct. 853, 860, 864–65 (2015).

With respect to land use in particular, RLUIPA also requires that government not "treat[] a religious assembly or institution on less than equal terms with a nonreligious assembly or institution," 42 U.S.C. § 2000cc(b)(1), "impose or implement a land use regulation that discriminates against any assembly or institution on the basis of religion or religious denomination," *id.* § 2000cc(b)(2), or "impose or implement a land use regulation that (A) totally excludes religious assemblies from a jurisdiction; or (B) unreasonably limits religious assemblies, institutions, or structures within a jurisdiction," *id.* § 2000cc(b)(3). A claimant need not show a substantial burden on the exercise of religion to enforce these antidiscrimination and equal terms provisions listed in § 2000cc(b). *See id.* § 2000cc(b); *see also Lighthouse Inst. for Evangelism, Inc. v. City of Long Branch*, 510 F.3d 253, 262–64 (3d Cir. 2007), *cert. denied*, 553 U.S. 1065 (2008). Although most RLUIPA cases involve places of worship like churches, mosques, synagogues, and temples, the law applies more broadly to religious schools, religious camps, religious retreat centers, and religious social service facilities. Letter from U.S. Dep't of Justice Civil Rights Division to State, County, and Municipal Officials re: The Religious Land Use and Institutionalized Persons Act (Dec. 15, 2016).

C. Other Civil Rights Laws

To incorporate religious adherents fully into society, Congress has recognized that it is not enough to limit governmental action that substantially burdens the exercise of religion. It must also root out public and private discrimination based on religion. Religious discrimination stood alongside discrimination based on race, color, and national origin, as an evil to be addressed in the Civil Rights Act of 1964, and Congress has continued to legislate against such discrimination over time. Today, the United States Code includes specific prohibitions on religious discrimination in places of public accommodation, 42 U.S.C. § 2000a; in public facilities, *id.* § 2000b; in public education, *id.* § 2000c-6; in employment, *id.* §§ 2000e, 2000e-2, 2000e-16; in the sale or rental of housing, *id.* § 3604; in the provision of certain real-estate transaction or brokerage services, *id.* §§ 3605, 3606; in federal jury service, 28 U.S.C. § 1862; in access to limited open forums for speech, 20 U.S.C. § 4071; and in participation in or receipt of benefits from various federally-funded programs, 15 U.S.C. § 3151; 20 U.S.C. §§ 1066c(d), 1071(a)(2), 1087-4, 7231d(b)(2), 7914; 31 U.S.C. § 6711(b)(3); 42 U.S.C. §§ 290cc-33(a)(2), 300w-7(a)(2), 300x-57(a)(2), 300x-65(f), 604a(g), 708(a)(2), 5057(c), 5151(a), 5309(a), 6727(a), 9858l(a)(2), 10406(2)(B), 10504(a), 10604(e), 12635(c)(1), 12832, 13791(g)(3), 13925(b)(13)(A).

Invidious religious discrimination may be directed at religion in general, at a particular religious belief, or at particular aspects of religious observance and practice. *See, e.g.*, *Church of the Lukumi Babalu Aye*, 508 U.S. at 532–33. A law drawn to prohibit a specific religious practice may discriminate just as severely against a religious group as a law drawn to prohibit the religion itself. *See id.* No one would doubt that a law prohibiting the sale and consumption of Kosher meat would discriminate against Jewish people. True equality may also require, depending on the applicable statutes, an awareness of, and willingness reasonably to accommodate, religious observance and practice. Indeed, the denial of reasonable accommodations may be little more than cover for discrimination against a particular religious belief or religion in general and is counter to the general determination of Congress that the United States is best served by the participation of religious adherents in society, not their withdrawal from it.

1. Employment

i. Protections for Religious Employees

Protections for religious individuals in employment are the most obvious example of Congress's instruction that religious observance and practice be reasonably accommodated, not marginalized. In Title VII of the Civil Rights Act, Congress declared it an unlawful employment practice for a covered employer to (1) "fail or refuse to hire or to discharge any individual, or otherwise . . . discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's . . . religion," as well as (2) to "limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's . . . religion." 42 U.S.C. § 2000e-2(a); *see also* 42 U.S.C. § 2000e-16(a) (applying Title VII to certain federal-sector employers); 3 U.S.C. § 411(a) (applying Title VII employment in the Executive Office of the President). The protection applies "regardless of whether the discrimination is directed against [members of religious] majorities or minorities." *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 71–72 (1977).

After several courts had held that employers did not violate Title VII when they discharged employees for refusing to work on their Sabbath, Congress amended Title VII to define "[r]eligion" broadly to include "all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably accommodate to an employee's or prospective employee's religious observance or practice without undue hardship on the conduct of the employer's business." 42 U.S.C. § 2000e(j); *Hardison*, 432 U.S. at 74 n.9. Congress thus made clear that discrimination on the basis of religion includes discrimination on the basis of any aspect of an employee's religious observance or practice, at least where such observance or practice can be reasonably accommodated without undue hardship.

Title VII's reasonable accommodation requirement is meaningful. As an initial matter, it requires an employer to consider what adjustment or modification to its policies would effectively address the employee's concern, for "[a]n *ineffective* modification or adjustment will not *accommodate*" a person's religious observance or practice, within the ordinary meaning of that word. *See U.S. Airways, Inc. v. Barnett*, 535 U.S. 391, 400 (2002) (considering the ordinary

meaning in the context of an ADA claim). Although there is no obligation to provide an employee with his or her preferred reasonable accommodation, *see Ansonia Bd. of Educ. v. Philbrook*, 479 U.S. 60, 68 (1986), an employer may justify a refusal to accommodate only by showing that "an undue hardship [on its business] would *in fact* result from *each available* alternative method of accommodation." 29 C.F.R. § 1605.2(c)(1) (emphasis added). "A mere assumption that many more people, with the same religious practices as the person being accommodated, may also need accommodation is not evidence of undue hardship." *Id.* Likewise, the fact that an accommodation may grant the religious employee a preference is not evidence of undue hardship as, "[b]y definition, any special 'accommodation' requires the employer to treat an employee . . . differently, *i.e.*, preferentially." *U.S. Airways*, 535 U.S. at 397; *see also E.E.O.C. v. Abercrombie & Fitch Stores, Inc.*, 135 S. Ct. 2028, 2034 (2015) ("Title VII does not demand mere neutrality with regard to religious practices—that they may be treated no worse than other practices. Rather, it gives them favored treatment.").

Title VII does not, however, require accommodation at all costs. As noted above, an employer is not required to accommodate a religious observance or practice if it would pose an undue hardship on its business. An accommodation might pose an "undue hardship," for example, if it would require the employer to breach an otherwise valid collective bargaining agreement, *see, e.g.*, *Hardison*, 432 U.S. at 79, or carve out a special exception to a seniority system, *id.* at 83; *see also U.S. Airways*, 535 U.S. at 403. Likewise, an accommodation might pose an "undue hardship" if it would impose "more than a de minimis cost" on the business, such as in the case of a company where weekend work is "essential to [the] business" and many employees have religious observances that would prohibit them from working on the weekends, so that accommodations for all such employees would result in significant overtime costs for the employer. *Hardison*, 432 U.S. at 80, 84 & n.15. In general, though, Title VII expects positive results for society from a cooperative process between an employer and its employee "in the search for an acceptable reconciliation of the needs of the employee's religion and the exigencies of the employer's business." *Philbrook*, 479 U.S. at 69 (internal quotations omitted).

The area of religious speech and expression is a useful example of reasonable accommodation. Where speech or expression is part of a person's religious observance and practice, it falls within the scope of Title VII. *See* 42 U.S.C. §§ 2000e, 2000e-2. Speech or expression outside of the scope of an individual's employment can almost always be accommodated without undue hardship to a business. Speech or expression within the scope of an individual's employment, during work hours, or in the workplace may, depending upon the facts and circumstances, be reasonably accommodated. *Cf. Abercrombie*, 135 S. Ct. at 2032.

The federal government's approach to free exercise in the federal workplace provides useful guidance on such reasonable accommodations. For example, under the Guidelines issued by President Clinton, the federal government permits a federal employee to "keep a Bible or Koran on her private desk and read it during breaks"; to discuss his religious views with other employees, subject "to the same rules of order as apply to other employee expression"; to display religious messages on clothing or wear religious medallions visible to others; and to hand out religious tracts to other employees or invite them to attend worship services at the employee's church, except to the extent that such speech becomes excessive or harassing. Guidelines on Religious Exercise and Religious Expression in the Federal Workplace, § 1(A), Aug. 14, 1997 (hereinafter "Clinton

Guidelines"). The Clinton Guidelines have the force of an Executive Order. *See Legal Effectiveness of a Presidential Directive, as Compared to an Executive Order*, 24 Op. O.L.C. 29, 29 (2000) ("[T]here is no substantive difference in the legal effectiveness of an executive order and a presidential directive that is styled other than as an executive order."); *see also* Memorandum from President William J. Clinton to the Heads of Executive Departments and Agencies (Aug. 14, 1997) ("All civilian executive branch agencies, officials, and employees must follow these Guidelines carefully."). The successful experience of the federal government in applying the Clinton Guidelines over the last twenty years is evidence that religious speech and expression can be reasonably accommodated in the workplace without exposing an employer to liability under workplace harassment laws.

Time off for religious holidays is also often an area of concern. The observance of religious holidays is an "aspect[] of religious observance and practice" and is therefore protected by Title VII. 42 U.S.C. §§ 2000e, 2000e-2. Examples of reasonable accommodations for that practice could include a change of job assignments or lateral transfer to a position whose schedule does not conflict with the employee's religious holidays, 29 C.F.R. § 1605.2(d)(1)(iii); a voluntary work schedule swap with another employee, *id.* § 1065.2(d)(1)(i); or a flexible scheduling scheme that allows employees to arrive or leave early, use floating or optional holidays for religious holidays, or make up time lost on another day, *id.* § 1065.2(d)(1)(ii). Again, the federal government has demonstrated reasonable accommodation through its own practice: Congress has created a flexible scheduling scheme for federal employees, which allows employees to take compensatory time off for religious observances, 5 U.S.C. § 5550a, and the Clinton Guidelines make clear that "[a]n agency must adjust work schedules to accommodate an employee's religious observance—for example, Sabbath or religious holiday observance—if an adequate substitute is available, or if the employee's absence would not otherwise impose an undue burden on the agency," Clinton Guidelines § 1(C). If an employer regularly permits accommodation in work scheduling for secular conflicts and denies such accommodation for religious conflicts, "such an arrangement would display a discrimination against religious practices that is the antithesis of reasonableness." *Philbrook*, 479 U.S. at 71.

Except for certain exceptions discussed in the next section, Title VII's protection against disparate treatment, 42 U.S.C. § 2000e-2(a)(1), is implicated *any time* religious observance or practice is a motivating factor in an employer's covered decision. *Abercrombie*, 135 S. Ct. at 2033. That is true even when an employer acts without actual knowledge of the need for an accommodation from a neutral policy but with "an unsubstantiated suspicion" of the same. *Id.* at 2034.

ii. Protections for Religious Employers

Congress has acknowledged, however, that religion sometimes *is* an appropriate factor in employment decisions, and it has limited Title VII's scope accordingly. Thus, for example, where religion "is a bona fide occupational qualification reasonably necessary to the normal operation of [a] particular business or enterprise," employers may hire and employ individuals based on their religion. 42 U.S.C. § 2000e-2(e)(1). Likewise, where educational institutions are "owned, supported, controlled or managed, [in whole or in substantial part] by a particular religion or by a particular religious corporation, association, or society" or direct their curriculum "toward the

propagation of a particular religion," such institutions may hire and employ individuals of a particular religion. *Id.* And "a religious corporation, association, educational institution, or society" may employ "individuals of a particular religion to perform work connected with the carrying on by such corporation, association, educational institution, or society of its activities." *Id.* § 2000e-1(a); *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 335–36 (1987).

Because Title VII defines "religion" broadly to include "all aspects of religious observance and practice, as well as belief," 42 U.S.C. § 2000e(j), these exemptions include decisions "to employ only persons whose beliefs and conduct are consistent with the employer's religious precepts." *Little v. Wuerl*, 929 F.2d 944, 951 (3d Cir. 1991); *see also Killinger v. Samford Univ.*, 113 F.3d 196, 198–200 (11th Cir. 1997). For example, in *Little*, the Third Circuit held that the exemption applied to a Catholic school's decision to fire a divorced Protestant teacher who, though having agreed to abide by a code of conduct shaped by the doctrines of the Catholic Church, married a baptized Catholic without first pursuing the official annulment process of the Church. 929 F.2d at 946, 951.

Section 702 broadly exempts from its reach religious corporations, associations, educational institutions, and societies. The statute's terms do not limit this exemption to non-profit organizations, to organizations that carry on only religious activities, or to organizations established by a church or formally affiliated therewith. *See* Civil Rights Act of 1964, § 702(a), *codified at* 42 U.S.C. § 2000e-1(a); *see also Hobby Lobby*, 134 S. Ct. at 2773–74; *Corp. of Presiding Bishop*, 483 U.S. at 335–36. The exemption applies whenever the organization is "religious," which means that it is organized for religious purposes and engages in activity consistent with, and in furtherance of, such purposes. Br. of Amicus Curiae the U.S. Supp. Appellee, *Spencer v. World Vision, Inc.*, No. 08-35532 (9th Cir. 2008). Thus, the exemption applies not just to religious denominations and houses of worship, but to religious colleges, charitable organizations like the Salvation Army and World Vision International, and many more. In that way, it is consistent with other broad protections for religious entities in federal law, including, for example, the exemption of religious entities from many of the requirements under the Americans with Disabilities Act. *See* 28 C.F.R. app. C; 56 Fed. Reg. 35544, 35554 (July 26, 1991) (explaining that "[t]he ADA's exemption of religious organizations and religious entities controlled by religious organizations is very broad, encompassing a wide variety of situations").

In addition to these explicit exemptions, religious organizations may be entitled to additional exemptions from discrimination laws. *See, e.g.*, *Hosanna-Tabor*, 565 U.S. at 180, 188–90. For example, a religious organization might conclude that it cannot employ an individual who fails faithfully to adhere to the organization's religious tenets, either because doing so might itself inhibit the organization's exercise of religion or because it might dilute an expressive message. *Cf. Boy Scouts of Am. v. Dale*, 530 U.S. 640, 649–55 (2000). Both constitutional and statutory issues arise when governments seek to regulate such decisions.

As a constitutional matter, religious organizations' decisions are protected from governmental interference to the extent they relate to ecclesiastical or internal governance matters. *Hosanna-Tabor*, 565 U.S. at 180, 188–90. It is beyond dispute that "it would violate the First Amendment for courts to apply [employment discrimination] laws to compel the ordination of

women by the Catholic Church or by an Orthodox Jewish seminary." *Id.* at 188. The same is true for other employees who "minister to the faithful," including those who are not themselves the head of the religious congregation and who are not engaged solely in religious functions. *Id.* at 188, 190, 194–95; *see also* Br. of Amicus Curiae the U.S. Supp. Appellee, *Spencer v. World Vision, Inc.*, No. 08-35532 (9th Cir. 2008) (noting that the First Amendment protects "the right to employ staff who share the religious organization's religious beliefs").

Even if a particular associational decision could be construed to fall outside this protection, the government would likely still have to show that any interference with the religious organization's associational rights is justified under strict scrutiny. *See Roberts v. U.S. Jaycees*, 468 U.S. 609, 623 (1984) (infringements on expressive association are subject to strict scrutiny); *Smith*, 494 U.S. at 882 ("[I]t is easy to envision a case in which a challenge on freedom of association grounds would likewise be reinforced by Free Exercise Clause concerns."). The government may be able to meet that standard with respect to race discrimination, *see Bob Jones Univ.*, 461 U.S. at 604, but may not be able to with respect to other forms of discrimination. For example, at least one court has held that forced inclusion of women into a mosque's religious men's meeting would violate the freedom of expressive association. *Donaldson v. Farrakhan*, 762 N.E.2d 835, 840–41 (Mass. 2002). The Supreme Court has also held that the government's interest in addressing sexual-orientation discrimination is not sufficiently compelling to justify an infringement on the expressive association rights of a private organization. *Boy Scouts*, 530 U.S. at 659.

As a statutory matter, RFRA too might require an exemption or accommodation for religious organizations from antidiscrimination laws. For example, "prohibiting religious organizations from hiring only coreligionists can 'impose a significant burden on their exercise of religion, even as applied to employees in programs that must, by law, refrain from specifically religious activities.'" *Application of the Religious Freedom Restoration Act to the Award of a Grant Pursuant to the Juvenile Justice and Delinquency Prevention Act*, 31 Op. O.L.C. 162, 172 (2007) (quoting *Direct Aid to Faith-Based Organizations Under the Charitable Choice Provisions of the Community Solutions Act of 2001*, 25 Op. O.L.C. 129, 132 (2001)); *see also Corp. of Presiding Bishop*, 483 U.S. at 336 (noting that it would be "a significant burden on a religious organization to require it, on pain of substantial liability, to predict which of its activities a secular court w[ould] consider religious" in applying a nondiscrimination provision that applied only to secular, but not religious, activities). If an organization establishes the existence of such a burden, the government must establish that imposing such burden on the organization is the least restrictive means of achieving a compelling governmental interest. That is a demanding standard and thus, even where Congress has not expressly exempted religious organizations from its antidiscrimination laws—as it has in other contexts, *see, e.g.*, 42 U.S.C. §§ 3607 (Fair Housing Act), 12187 (Americans with Disabilities Act)—RFRA might require such an exemption.

2. Government Programs

Protections for religious organizations likewise exist in government contracts, grants, and other programs. Recognizing that religious organizations can make important contributions to government programs, *see, e.g.*, 22 U.S.C. § 7601(19), Congress has expressly permitted religious organizations to participate in numerous such programs on an equal basis with secular

organizations, *see, e.g.*, 42 U.S.C. §§ 290kk-1, 300x-65 604a, 629i. Where Congress has not expressly so provided, the President has made clear that "[t]he Nation's social service capacity will benefit if all eligible organizations, including faith-based and other neighborhood organizations, are able to compete on an equal footing for Federal financial assistance used to support social service programs." Exec. Order No. 13559, § 1, 75 Fed. Reg. 71319, 71319 (Nov. 17, 2010) (amending Exec. Order No. 13279, 67 Fed. Reg. 77141 (2002)). To that end, no organization may be "discriminated against on the basis of religion or religious belief in the administration or distribution of Federal financial assistance under social service programs." *Id.* "Organizations that engage in explicitly religious activities (including activities that involve overt religious content such as worship, religious instruction, or proselytization)" are eligible to participate in such programs, so long as they conduct such activities outside of the programs directly funded by the federal government and at a separate time and location. *Id.*

The President has assured religious organizations that they are "eligible to compete for Federal financial assistance used to support social service programs and to participate fully in the social services programs supported with Federal financial assistance without impairing their independence, autonomy, expression outside the programs in question, or religious character." *See id.*; *see also* 42 U.S.C. § 290kk-1(e) (similar statutory assurance). Religious organizations that apply for or participate in such programs may continue to carry out their mission, "including the definition, development, practice, and expression of . . . religious beliefs," so long as they do not use any "direct Federal financial assistance" received "to support or engage in any explicitly religious activities" such as worship, religious instruction, or proselytization. Exec. Order No. 13559, § 1. They may also "use their facilities to provide social services supported with Federal financial assistance, without removing or altering religious art, icons, scriptures, or other symbols from these facilities," and they may continue to "retain religious terms" in their names, select "board members on a religious basis, and include religious references in . . . mission statements and other chartering or governing documents." *Id.*

With respect to government contracts in particular, Executive Order 13279, 67 Fed. Reg. 77141 (Dec. 12, 2002), confirms that the independence and autonomy promised to religious organizations include independence and autonomy in religious hiring. Specifically, it provides that the employment nondiscrimination requirements in Section 202 of Executive Order 11246, which normally apply to government contracts, do "not apply to a Government contractor or subcontractor that is a religious corporation, association, educational institution, or society, with respect to the employment of individuals of a particular religion to perform work connected with the carrying on by such corporation, association, educational institution, or society of its activities." Exec. Order No. 13279, § 4, *amending* Exec. Order No. 11246, § 204(c), 30 Fed. Reg. 12319, 12935 (Sept. 24, 1965).

Because the religious hiring protection in Executive Order 13279 parallels the Section 702 exemption in Title VII, it should be interpreted to protect the decision "to employ only persons whose beliefs and conduct are consistent with the employer's religious precepts." *Little*, 929 F.2d at 951. That parallel interpretation is consistent with the Supreme Court's repeated counsel that the decision to borrow statutory text in a new statute is "strong indication that the two statutes should be interpreted pari passu." *Northcross v. Bd. of Educ. of Memphis City Sch.*, 412 U.S. 427 (1973) (per curiam); *see also Jerman v. Carlisle, McNellie, Rini, Kramer & Ulrich L.P.A.*, 559

U.S. 573, 590 (2010). It is also consistent with the Executive Order's own usage of discrimination on the basis of "religion" as something distinct and more expansive than discrimination on the basis of "religious belief." *See, e.g.*, Exec. Order No. 13279, § 2(c) ("No organization should be discriminated against on the basis of religion *or* religious belief . . . " (emphasis added)); *id.* § 2(d) ("All organizations that receive Federal financial assistance under social services programs should be prohibited from discriminating against beneficiaries or potential beneficiaries of the social services programs on the basis of religion or religious belief. Accordingly, organizations, in providing services supported in whole or in part with Federal financial assistance, and in their outreach activities related to such services, should not be allowed to discriminate against current or prospective program beneficiaries on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice."). Indeed, because the Executive Order uses "on the basis of religion or religious belief" in both the provision prohibiting discrimination against religious organizations and the provision prohibiting discrimination "against beneficiaries or potential beneficiaries," a narrow interpretation of the protection for religious organizations' hiring decisions would lead to a narrow protection for beneficiaries of programs served by such organizations. *See id.* §§ 2(c), (d). It would also lead to inconsistencies in the treatment of religious hiring across government programs, as some program-specific statutes and regulations expressly confirm that "[a] religious organization's exemption provided under section 2000e-1 of this title regarding employment practices shall not be affected by its participation, or receipt of funds from, a designated program." 42 U.S.C. § 290kk-1(e); *see also* 6 C.F.R. § 19.9 (same).

Even absent the Executive Order, however, RFRA would limit the extent to which the government could condition participation in a federal grant or contract program on a religious organization's effective relinquishment of its Section 702 exemption. RFRA applies to all government conduct, not just to legislation or regulation, *see* 42 U.S.C. § 2000bb-1, and the Office of Legal Counsel has determined that application of a religious nondiscrimination law to the hiring decisions of a religious organization can impose a substantial burden on the exercise of religion. *Application of the Religious Freedom Restoration Act to the Award of a Grant*, 31 Op. O.L.C. at 172; *Direct Aid to Faith-Based Organizations*, 25 Op. O.L.C. at 132. Given Congress's "recognition that religious discrimination in employment is permissible in some circumstances," the government will not ordinarily be able to assert a compelling interest in prohibiting that conduct as a general condition of a religious organization's receipt of any particular government grant or contract. *Application of the Religious Freedom Restoration Act to the Award of a Grant*, 31 Op. of O.L.C. at 186. The government will also bear a heavy burden to establish that requiring a particular contractor or grantee effectively to relinquish its Section 702 exemption is the least restrictive means of achieving a compelling governmental interest. *See* 42 U.S.C. § 2000bb-1.

The First Amendment also "supplies a limit on Congress' ability to place conditions on the receipt of funds." *Agency for Int'l Dev. v. All. for Open Soc'y Int'l, Inc.*, 133 S. Ct. 2321, 2328 (2013) (internal quotation marks omitted)). Although Congress may specify the activities that it wants to subsidize, it may not "seek to leverage funding" to regulate constitutionally protected conduct "outside the contours of the program itself." *See id.* Thus, if a condition on participation in a government program—including eligibility for receipt of federally backed student loans—would interfere with a religious organization's constitutionally protected rights, *see, e.g.*,

Hosanna-Tabor, 565 U.S. at 188–89, that condition could raise concerns under the "unconstitutional conditions" doctrine, *see All. for Open Soc'y Int'l, Inc.*, 133 S. Ct. at 2328.

Finally, Congress has provided an additional statutory protection for educational institutions controlled by religious organizations who provide education programs or activities receiving federal financial assistance. Such institutions are exempt from Title IX's prohibition on sex discrimination in those programs and activities where that prohibition "would not be consistent with the religious tenets of such organization[s]." 20 U.S.C. § 1681(a)(3). Although eligible institutions may "claim the exemption" in advance by "submitting in writing to the Assistant Secretary a statement by the highest ranking official of the institution, identifying the provisions . . . [that] conflict with a specific tenet of the religious organization," 34 C.F.R. § 106.12(b), they are not required to do so to have the benefit of it, *see* 20 U.S.C. § 1681.

3. Government Mandates

Congress has undertaken many similar efforts to accommodate religious adherents in diverse areas of federal law. For example, it has exempted individuals who, "by reason of religious training and belief," are conscientiously opposed to war from training and service in the armed forces of the United States. 50 U.S.C. § 3806(j). It has exempted "ritual slaughter and the handling or other preparation of livestock for ritual slaughter" from federal regulations governing methods of animal slaughter. 7 U.S.C. § 1906. It has exempted "private secondary school[s] that maintain[] a religious objection to service in the Armed Forces" from being required to provide military recruiters with access to student recruiting information. 20 U.S.C. § 7908. It has exempted federal employees and contractors with religious objections to the death penalty from being required to "be in attendance at or to participate in any prosecution or execution." 18 U.S.C. § 3597(b). It has allowed individuals with religious objections to certain forms of medical treatment to opt out of such treatment. *See, e.g.*, 33 U.S.C. § 907(k); 42 U.S.C. § 290bb-36(f). It has created tax accommodations for members of religious faiths conscientiously opposed to acceptance of the benefits of any private or public insurance, *see, e.g.*, 26 U.S.C. §§ 1402(g), 3127, and for members of religious orders required to take a vow of poverty, *see, e.g.*, 26 U.S.C. § 3121(r).

Congress has taken special care with respect to programs touching on abortion, sterilization, and other procedures that may raise religious conscience objections. For example, it has prohibited entities receiving certain federal funds for health service programs or research activities from requiring individuals to participate in such program or activity contrary to their religious beliefs. 42 U.S.C. § 300a-7(d), (e). It has prohibited discrimination against health care professionals and entities that refuse to undergo, require, or provide training in the performance of induced abortions; to provide such abortions; or to refer for such abortions, and it will deem accredited any health care professional or entity denied accreditation based on such actions. *Id.* § 238n(a), (b). It has also made clear that receipt of certain federal funds does not require an individual "to perform or assist in the performance of any sterilization procedure or abortion if [doing so] would be contrary to his religious beliefs or moral convictions" nor an entity to "make its facilities available for the performance of" those procedures if such performance "is prohibited by the entity on the basis of religious beliefs or moral convictions," nor an entity to "provide any personnel for the performance or assistance in the performance of" such procedures if such performance or assistance "would be contrary to the religious beliefs or moral convictions of such

personnel." *Id.* § 300a-7(b). Finally, no "qualified health plan[s] offered through an Exchange" may discriminate against any health care professional or entity that refuses to "provide, pay for, provide coverage of, or refer for abortions," § 18023(b)(4); *see also* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, § 507(d), 129 Stat. 2242, 2649 (Dec. 18, 2015).

Congress has also been particularly solicitous of the religious freedom of American Indians. In 1978, Congress declared it the "policy of the United States to protect and preserve for American Indians their inherent right of freedom to believe, express, and exercise the traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but not limited to access to sites, use and possession of sacred objects, and the freedom to worship through ceremonials and traditional rites." 42 U.S.C. § 1996. Consistent with that policy, it has passed numerous statutes to protect American Indians' right of access for religious purposes to national park lands, Scenic Area lands, and lands held in trust by the United States. *See, e.g.*, 16 U.S.C. §§ 228i(b), 410aaa-75(a), 460uu-47, 543f, 698v-11(b)(11). It has specifically sought to preserve lands of religious significance and has required notification to American Indians of any possible harm to or destruction of such lands. *Id.* § 470cc. Finally, it has provided statutory exemptions for American Indians' use of otherwise regulated articles such as bald eagle feathers and peyote as part of traditional religious practice. *Id.* §§ 668a, 4305(d); 42 U.S.C. § 1996a.

* * *

The depth and breadth of constitutional and statutory protections for religious observance and practice in America confirm the enduring importance of religious freedom to the United States. They also provide clear guidance for all those charged with enforcing federal law: The free exercise of religion is not limited to a right to hold personal religious beliefs or even to worship in a sacred place. It encompasses all aspects of religious observance and practice. To the greatest extent practicable and permitted by law, such religious observance and practice should be reasonably accommodated in all government activity, including employment, contracting, and programming. *See Zorach v. Clauson*, 343 U.S. 306, 314 (1952) ("[Government] follows the best of our traditions . . . [when it] respects the religious nature of our people and accommodates the public service to their spiritual needs.").

Exhibit 61

National Council of Jewish Women

To:
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, DC 20201

From:
Carly Manes
Director, Commission on Social Action of Reform Judaism
Associate Director, Religious Action Center of Reform Judaism
1707 L St. NW
Washington, D.C. 20036

Re: RIN 0945-ZA03
DT: March 27, 2018

To whom it may concern:

I am writing on behalf of the National Council of Jewish Women (NCJW) in response to the proposed rule from the U.S. Department of Health and Human Services, RIN 0945-ZA03, titled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children, and families and by safeguarding individual rights and freedoms.

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 the reasons outlined below, the National Council of Jewish Women 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)."[1] Read in conjunction with 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.[2] 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.[3] 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.[4] 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

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[1] *See id.* at 12.

[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/; 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.

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

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

example, the definition of "assist in the performance" greatly expands the types of services that can be refused to include merely "making arrangements for the procedure" no matter how tangential.[5] 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.[6]

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.[7] 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.[8] 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.[9]

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."[10] 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."[11] 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 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.[12] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage

[5] *Id.* at 180.
[6] *Id.* at 183.
[7] 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).
[8] *See* Rule *supra* note 1, at 182.
[9] 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.
[10] *See* Rule *supra* note 1, at 180.
[11] *Id.*
[12] *See, e.g.*, *supra* note 3.

management she needed because the hospital objected to this care.[13] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[14] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[15] 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.[16] 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.[17]

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.[18] 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.[19] In rural areas there may be no other sources of health and life preserving medical care.[20] In developing countries

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[13] *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.

[14] *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.

[15] *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.

[16] *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.

[17] *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.

[18] 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.

[19] 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.

[20] 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/.

where many health systems are weak, health care options and supplies are often unavailable.[21] 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 states, women of color are more likely than white women to give birth in Catholic hospitals.[22] 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.[23] 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.[24] 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.[25]

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.[26]

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."[27] The Proposed Rule plainly fails on both counts. Although the Proposed Rule attempts to quantify the costs of compliance, it

[21] *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.

[22] *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.

[23] *See id.* at 10-13.

[24] 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/.

[25] *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.

[26] *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/.

[27] 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.

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.[28]

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.[29] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[30]

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.[31] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[32] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[33] 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 funds are generally conditioned.[34] 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.[35] 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

[28] *See* Rule *supra* note 1, at 94-177.

[29] 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).

[30] 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.

[31] *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.

[32] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).

[33] *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).

[34] *See, e.g.*, Rule *supra* note 1, at 180-185.

[35] *See* NFPRHA *supra* note 34.

under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[36]

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.[37] 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.[38] 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 altogether.[39] 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.[40]

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.[41] Individuals seeking reproductive health care, regardless of their reasons for

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[36] *See id.*

[37] *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.

[38] *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).

[39] *See id.*

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

[41] 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).

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.[42] No health care professional should face 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.[43] 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.[44] 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.[45] 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, segregation of people with disabilities in health care facilities, categorical insurance coverage denials of

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

[43] *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.").

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

[45] 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.

care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[46]

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.[47] 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.[48] Further, the disparity in maternal mortality is growing rather than decreasing,[49] 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.[50] 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.[51] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[52] Eight percent of 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.[53]

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

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[46] *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.

[47] *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.

[48] *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.

[49] *See id.*

[50] *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).

[51] *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).

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

[53] *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.

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.[54]

Conclusion

The Proposed Rule will allow personal moral and 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 all of these reasons the National Council of Jewish Women calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

Jody Rabhan

Director of Washington Operations, National Council of Jewish Women

Exhibit 62

NATIONAL IMMIGRATION LAW CENTER

VIA ELECTRONIC SUBMISSION AT REGULATIONS.GOV

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 209F
200 Independence Avenue SW
Washington, DC 20201

RE: RIN 0945-ZA03
Comments on DHHS Notice of Proposed Rulemaking Concerning "Protecting Statutory Conscience Rights" in Health Care; Delegations of Authority

Dear Director Severino:

The National Immigration Law Center ("NILC") submits the following 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 (83 Fed, Reg. 3880 (Jan. 26, 2018)).

NILC specializes in the intersection of health care and immigration laws and policies, providing technical assistance, training, and publications to government agencies, labor unions, non-profit organizations, and health care providers across the country. For over 30 years, NILC has worked to promote and ensure access to health services for low-income immigrants and their family members.

As an organization focused on defending and advancing the rights of low income immigrants, we are deeply concerned with the ways in which these regulations fail to account for the significant burden that will fall disproportionately on immigrants and all people of color. Immigrant women and immigrants who identify as Lesbian, Gay, Bisexual, Transgender, and Queer ("LGBTQ") already experience severe health disparities and discrimination, conditions that will be exacerbated by the proposed rule, resulting in in poorer health outcomes.

We object to the proposal that OCR direct its limited resources toward the subject of this rule, and to the newly created "Conscience and Religious Freedom Division" 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. Immigrant communities rely on OCR to enforce regulations implementing the Title VI protection that individuals with Limited English Proficiency (LEP) are not subject to discrimination based on national origin. [1] According to the Pew Research Center 49 percent of foreign born individuals are not proficient English speakers (data from the 2010 Census and 2013-15 American Community Surveys).[2] Yet OCR's enforcement of the Title VI protection is inadequate, with the result that LEP patients have been consistently shown to receive lower quality health care than English-proficient patients on various measures: understanding of treatment plans and disease processes, satisfaction, and incidence of medical errors resulting in physical harm.[3] For these reasons, NILC calls on the Department and OCR to withdraw the proposed rule in its entirety.

I. The proposed regulation would divert OCR from its agency mission by shifting resources that should be used to address the rights of populations subject to acute discrimination and health disparities.

The proposed regulation would inappropriately favor the supposed protection of individuals with certain religious and moral convictions at the expense of protections against the kind of documented experiences of discrimination leading to health disparities which OCR is designed by statute to address, notably under Title VI and Section 1557 of the Patient Protection and Affordable Care Act ("ACA").[4] With its origin in protecting against this type of discrimination, the agency must look closely at how any changes would affect this mission before creating new regulations.

As many other commentators will likely note, discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[5] Numerous federal courts have found that

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[1] 42 U.S.C. §2000d (stating that "no person in the United States shall, on the grounds of race, color, or national origin" be subject to discrimination in federally funded program), § 200d-1 (authorizing the establishment of the regulations and offices for civil rights within federal agencies to enforce prohibitions on discrimination).

[2] Gustavo López and Kristen Bialik, *Key findings about U.S. immigrants*, PEW RESEARCH CENTER (May 3, 2017), http://www.pewresearch.org/fact-tank/2017/05/03/key-findings-about-u-s-immigrants.

[3] Alexander R. Green, MD, MPH, and Chijioke Nze, Language-Based Inequity in Health Care: Who Is the "Poor Historian"?**,** *AMA Journal of Ethics.* March 2017, Volume 19, Number 3: 263-271.

[4] 42 U.S.C. § 18116 (tasking HHS with enforcing a number of civil rights laws which ban discrimination on additional discriminations, such as gender).

[5] *See, e.g.*, *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018).

federal sex discrimination statutes reach these forms of gender-based discrimination.[6] 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."[7] This is a serious civil rights violation that OCR, under Section 1557 of the ACA, should be addressing.

The agency must therefore consider the impact on these populations in considering whether the proposed regulation is an appropriate action for the agency. As national advocates focused on the health of immigrants, NILC urges OCR and the Department to consider how particular sectors of the immigrant population would be harmed by this rule. Immigrants are among the most disproportionately uninsured people in the United States, a harm which is compounded by disparities in health disparities among women and LGBTQ persons. The uninsured rates for citizens (9 percent) is nearly half of lawfully present immigrants (17 percent), even though many of the latter are eligible for health coverage programs but not enrolled. In fact, according to the Kaiser Family Foundation, a larger percentage of unenrolled citizens have a factor making them ineligible for coverage or financial assistance (38 percent) than lawfully present immigrants (31 percent).[8] This is compounded by dynamics of an individual's race and sexual orientation: 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.[9] These are documented health disparities, which OCR can and should be doing more to investigate under Section 1557 of the ACA.

II. The proposed regulation would harm the health outcomes of immigrant women and women of color by allowing further divergence of access to certain services for these populations.

Among individuals with access to health care, women's race and immigration status play a role in how they receive health services, access which would be harmed further by this rule. 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

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[6] *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).

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

[8] *Health Coverage of Immigrants*, KAISER FAMILY FOUNDATION (Dec. 13, 2017), https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants.

[9] 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.

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] Moreover, the Centers for Disease Control and Prevention reports that black mothers experience maternal mortality at three times the rate of whites.[12]

New research also shows that women of color in many states disproportionately receive their care at Catholic hospitals.[13] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs), which provide 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.[14] The proposed rule will give health care providers, such as Catholic hospitals, a license 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.

This problem is particularly acute for immigrant, Latina women and their families who often face cultural and linguistic barriers to care, especially in rural areas.[15] These women often lack access to transportation and may have to travel great distances to get the care

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[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.

[12] Centers for Disease Control and Prevention, Trends in Pregnancy-Related Deaths, available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

[13] 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.

[14] 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/.

[15] 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.

they need.[16] 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. This is the kind of discrimination OCR should be protecting against.

III. The proposed regulation would allow OCR to turn a blind eye to the rampant discrimination faced by LGBTQ individuals, which would cause particular harm to LGBTQ immigrants.

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."[17] A survey conducted by Lambda Legal found that in 2009, lesbian, gay, and bisexual immigrants and immigrants living with HIV reported higher levels of discrimination than non-immigrant individuals, and the numbers were especially high for immigrants of color.[18] 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.[19] 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.[20]

There are documented outcomes of discrimination against LGBTQ people:

- Twenty-nine percent of transgender individuals experienced a health care provider's refusal to see them on the basis of their perceived or actual gender identity, and 29 percent experienced unwanted physical contact from a health care provider.[21]

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[16] 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.

[17] *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).

[18] *LGBT Immigrants and Immigrants living with HIV*, LAMBDA LEGAL, https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_lgbt-immigrants-and-immigrants-living-with-hiv.pdf.

[19] 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.

[20] *Id*.

[21] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AMERICAN PROGRESS, (Jan. 18, 2018),

- 23 percent of respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[22]
- 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.[23]
- Almost ten percent of lesbian, gay, or bisexual respondents reported that they had been denied necessary health care expressly because of their sexual orientation.[24]

Many LGBTQ people lack insurance and providers are not competent in health care issues and obstacles that the LGBTQ community experiences.[25] LGBTQ people still face discrimination and often avoid care due to fear of discrimination. This discrimination based on lack of competent care is only furthered when the addition of language and cultural differences exist.

This is the kind of discrimination that OCR has been successful in opposing, and it must continue to do so. As data obtained by the Center for American Progress shows, when the agency was enforcing its regulation against these forms of discrimination from 2012-16, it was effective at identifying discrimination, including 30 percent of cases that were based on denial of care because of gender identity, not related to gender transition.[26] The proposed rule allowing providers to deny needed care would reverse recent gains in combatting discrimination and health care disparities for LGBTQ 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, and OCR should ensure that this happens.

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https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[22] 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*].

[23] Mirza, *supra* note 21.

[24] 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.

[25] 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.

[26] Mirza, et al., note 21.

IV. The proposed rule is overly broad, vague, and will cause confusion

NILC supports the comments submitted by the National Health Law Program, particularly in their analysis of the ways in which the proposed rule is broad, vague, and will cause confusion in the health care delivery system. 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. The regulations dangerously expand the application of the underlying statutes by offering an extremely broad definition of who can refuse to provide health services and what they can refuse to do.

While the proposed regulations purport to provide clarity and guidance in implementing existing federal religious exemptions, in reality they are vague and confusing. This lack of clarity may make it more difficult for people experiencing discrimination to understand and enforce their rights. This concern is particularly relevant to immigrant populations who have limited English proficiency and may be unfamiliar with the U.S. health care system.

V. Conclusion

NILC opposes the proposed rule as it expands religious refusals in a way that fails to protect immigrant women and LGBTQ immigrants from discrimination, to the detriment of patients' health and well-being. The outcome of this regulation will harm communities who already lack access to care and endure discrimination. For these reasons, we urge the agency to withdraw the rule in its entirety.

Thank you for your attention to our comments. If you have any questions, reach out to Matthew Lopas at lopas@nilc.org or 202-609-9962.

Sincerely,

Matthew Lopas
Health Policy Attorney
National Immigration Law Center

Exhibit 63

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

March 27, 2018

Office for Civil Rights
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, D.C. 20201

Submitted Electronically

Attention: Comments in Response to Department of Health and Human Services, Office for Civil Rights, Conscience NPRM, RIN 0945-ZA03

Dear Secretary Azar,

The National Women's Law Center ("the Center") is writing to comment on the Department of Health and Human Services' ("the Department") and the Office for Civil Rights' ("OCR") proposed rule "Protecting Statutory Rights in Health Care" ("Proposed Rule").[1] Since 1972, the Center has worked to protect and advance the progress of women and their families in core aspects of their lives, including income security, employment, education, and reproductive rights and health, with an emphasis on the needs of low-income women and those who face multiple and intersecting forms of discrimination. To that end, the Center has long worked to end sex discrimination and to ensure all people have equal access to the full range of health care, including abortion and birth control, regardless of income, age, race, sex, sexual orientation, gender identity, ethnicity, geographic location, or type of insurance coverage.

Despite the Department's claims, the Proposed Rule is unnecessary. It is also illegal. The Proposed Rule attempts to create new rights for individuals and entities to refuse to provide patient care by expanding existing, harmful religious exemption laws in ways that exceed and conflict with both the plain language of the statutes and Congressional intent. The Proposed Rule also asserts authority over other federal laws, attempting to create new refusals to provide care. In creating these new rights and expanding its reach, the Proposed Rule conflicts with federal law thereby fostering confusion and chaos.

The Proposed Rule emboldens discrimination. By making it easier for institutions and individuals to refuse to provide comprehensive health care, the Proposed Rule endangers the health and lives of women and lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people across the country. While the Center's comments focus in particular on the harm to women and access to reproductive health care, it is clear that the Proposed Rule will undermine the provision of health care and exacerbate health disparities for many patient populations, as other commentators will discuss. And yet the Department fails to take this harm into account. Contrary

[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*].

to the Department's claims, the Proposed Rule harms rather than helps the provider-patient relationship and burdens providers who want to provide comprehensive care.

For all of these reasons, explained in more detail below, the Center is strongly opposed to the Proposed Rule and calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

I. Despite the Department's Claims, the Proposed Rule is Unnecessary, Emboldens Discrimination in Health Care, and Goes Far Beyond the 2008 Rule.

The Department claims that the Proposed Rule is necessary to protect individuals and health care providers from "discrimination, coercion, and intolerance."[2] But there is no need to address the so-called discrimination the Department purports to protect against. There are already ample religious exemptions in federal law, including in Title VII,[3] the Americans with Disabilities Act,[4] and the "ministerial exception" courts have read into the U.S. Constitution.[5] In addition, there are already a number of existing federal religious exemption laws that unfortunately allow individuals and entities to opt of providing critical health care services, in particular abortion and sterilization.[6] The Proposed Rule claims that more authority and enforcement of the religious exemption laws is needed, but the Notice of Proposed Rulemaking cites only forty-four complaints in ten years, which OCR is capable of handling without additional resources or authority.[7] Moreover, OCR already has authority to investigate complaints and, where appropriate, either collect funds wrongfully given while the entity was not in compliance or terminate funding altogether, and already educates providers about their rights under these laws.[8]

The reality is that the Department is seeking not to enforce existing laws but to expand them and create new rights under these laws. As explained below, this is unlawful and creates conflicts with other federal laws. Further, the Proposed Rule does not merely expand rights under existing refusal of care laws. Instead, it pulls in a host of new laws over which OCR has never before had authority, creating new rights and enforcement powers under these laws as well.

In so doing, the Proposed Rule does not address discrimination in health care, it emboldens it. The Proposed Rule intends to change existing law in order to allow any individual or entity involved in a patient's care – from a hospital's board of directors, to an insurance company, to the receptionist that schedules procedures – to use their personal beliefs to determine a patient's access to care. The Proposed Rule would further entrench discrimination against women and

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[2] *Id.* at 3903.
[3] 42 U.S.C. § 2000e-2 (1964).
[4] 42 U.S.C. § 12101 (1990).
[5] *See* Hosanna-Tabor Evangelical Lutheran Church v. Equal Emp't. Opportunity Comm'n, 132 S. Ct. 694, 704 (2012) (holding for the first time that the First Amendment requires a "ministerial exception").
[6] "Weldon Amendment", Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018); "Church Amendments" 42 U.S.C. § 300a-7 (2018); "Coats Amendment" 42 U.S.C. § 238n (2017).
[7] *Rule*, *supra* note 1, at 3886.
[8] *See* Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 45 C.F.R. pt. 88 (2011).

LGBTQ patients who already face high rates of discrimination in health care, including as a result of providers' religious beliefs. As explained in more detail below, this not only harms individuals and subjects them to discrimination, it is unlawful.

The Department tries to hide how far-reaching and dramatic this Proposed Rule is by claiming it is merely a reinstatement of the rule promulgated by the Bush Administration in 2008 and later rescinded by the Obama Administration in 2011.[9] Even if this was the case, the Proposed Rule would be dangerous. The 2008 rule was the subject of widespread opposition, including from 28 U.S. Senators and 131 Members of the U.S. House of Representatives, 14 state attorneys general, 27 state medical societies, the American Medical Association (AMA), American Hospital Association, National Association of Community Health Centers, American College of Emergency Physicians, and commissioners on the Equal Employment Opportunity Commission.[10] In fact, the AMA and several leading medical organizations argued the 2008 Rule would "seriously undermine patients' access to necessary health services and information, negatively impact federally-funded biomedical research activities, and create confusion and uncertainty among physicians, other health care professionals, and health care institutions."[11] But, the Proposed Rule reaches much further than the 2008 Rule. When compared to the 2008 Rule, the Proposed Rule seeks to allow more individuals and more entities to refuse care to patients and allow more services, or even information, to be refused, forces more entities to allow their employees to refuse care, imposes additional, unnecessary notice and compliance requirements, and invites states to further expand refusal laws.

II. The Proposed Rule Unlawfully Creates and Expands Rights to Refuse to Provide Care.

Under the Proposed Rule the Department intends to extend the reach of already harmful religious exemption laws so that any individual or entity, no matter how attenuated their involvement, can refuse to provide, participate in, or give information about any part of any health care service based on the assertion of a religious or moral belief. Furthermore, the Proposed Rule hamstrings the ability of an enormous range of entities to ensure that patients get the care they need. These expansions represent unlawful overreach by the Department and contradict the plain language of underlying federal law and Congressional intent.

a. The Proposed Rule Expands Existing Harmful Religious Exemption Laws

Although the Proposed Rule purports to merely interpret existing harmful federal laws that allow health care providers to refuse to treat an individual seeking an abortion and/or sterilization –

[9] *Rule, supra* note 1, at 3885. *See also* Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law 73 Fed. Reg. 78,071(Dec. 19, 2009) (2008 Rule) (rescinded in large part by 76 Fed. Reg. 9,968 (Feb. 23, 2011)(codified at 45 C.F.R. pt. 88)).
[10] Comment Letters on Proposed Rule Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law 73 Fed. Reg. 50,274 (Aug. 26, 2008) (on file with National Women's Law Center).
[11] American Medical Assoc. et al. Comment Letter on Proposed Rule 73. Fed. Reg. 50,274 (Aug. 26, 2008)(on file with National Women's Law Center).

namely the so-called Church, Coats, and Weldon Amendments – in fact it creates new rights that are not specifically and currently enumerated in those laws.

It does this in part by redefining words in harmful, expansive ways that belie common understandings of the terms in order to create new rights. For example:

- The Proposed Rule's definition of "assist in the performance" greatly expands not only the types of services that can be refused, but also the individuals who can refuse. It includes those merely making "arrangements for the procedure" no matter how tangential and could be read to include individuals such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees. In fact, the definition includes participation "in any program or activity with an *articulable connection* to a procedure…" (emphasis added).[12] While what is meant by "articulable connection" is not clear, the use of the term in case law indicates an intention for it to be interpreted broadly – a mere connection that one can articulate may suffice.[13]
- Through a broad definition of "entity" the Proposed Rule attempts to expand the individuals and types of entities covered by religious exemption laws and allow an even broader swath of individuals within those entities to refuse to do their jobs.[14] For example, under the Proposed Rule a Department grantee that provides health care transportation services for individuals with disabilities could attempt to claim a right to refuse to provide that service to a person who needs a sterilization procedure. Or an employee at a research and development laboratory could claim the right to refuse to accept the delivery of biomedical waste donated from a hospital with an obstetrics and gynecology practice that performs abortions.
- The Proposed Rule's definition of "referral" goes beyond any common understanding of the term, allowing refusals to provide any information that could help an individual to get the care they need. [15] The Proposed Rule does not even require that patients be informed of the individual's or entity's refusal to provide care, information, referrals, or other services, leaving patients unaware that their health care providers is not providing the care or information they need.
- The Proposed Rule's definition of "workforce" attempts to expand refusals of care to an even broader range of people and would allow almost all staff levels within an entity, including volunteers or trainees, to assert a new right to refuse to do their job.[16] For example, a volunteer at a hospital could claim a right to refuse to deliver medicine to a patient's room or even deliver meals to a patient who is recovering from a surgery to which the volunteer objects.

[12] *Rule, supra* note 1, at 3923.
[13] *Cf.* Jamerson v. Runnels, 713 F.3d 1218, 1229 (9th Cir. 2013) (describing the standard for evaluating whether a peremptory challenge was impermissibly based on race as "require[ing] only that the prosecutor express a believable and *articulable connection* between the race-neutral characteristic identified and the desirability of a prospective juror…"(emphasis added)).
[14] *Rule, supra* note 1, at 3924.
[15] *Id.*
[16] *Id.*

b. These New Rights are Contrary to Existing Law and Congressional Intent

The expansions and new and unwarranted definitions exceed and conflict with the existing federal laws the Proposed Rule seeks to enforce. For example, the Proposed Rule expands the definition of "health care entity" under existing law to include plan sponsors and third-party administrators.[17] Adding plan sponsors to the definition of "health care entity" under the Weldon Amendment is a blatant attempt to add words that plainly do not exist in the underlying federal law.[18] Indeed, just two years ago, OCR determined that the Weldon Amendment – according to its plain text – does not apply to plan sponsors.[19] This also holds true for the other ways in which the Proposed Rule attempts to expand the definition of "health care entity." Under the Coats and Weldon Amendments, "health care entity" is defined to encompass a limited and specific range of individuals and entities.[20] The Proposed Rule attempts to create a new definition of this term by combining statutory definitions of "health care entity" found in different statutes and applicable in different circumstances. Such an attempt to expand the meaning of a statutory term Congress already took the time to define goes directly against Congressional intent.[21]

The legislative history of the existing federal refusal of care laws reinforces that the Proposed Rule violates Congressional intent. For example, Congress adopted the Coats Amendment in response to a decision by the accrediting body for graduate medical education to rightfully require obstetrics and gynecology residency programs to provide abortion training. The legislative history of Coats states, "[p]roviders will continue to train the management of complications of induced abortion as well as train to handle [a] situation involving miscarriage and still birth or a threat to the life of the mother. The amendment requires no change in the practice of good obstetrics and gynecology."[22] The attempted expansion under the Proposed Rule to allow anyone to refuse to provide abortion regardless of the circumstances was clearly not intended. Similarly, proponents of the Weldon Amendment made "modest" claims about the Amendment, suggesting that the additional language was necessary only to clarify existing "conscience protections" not for it to be the sweeping license to refuse the Proposed Rule attempts to create.[23]

The Proposed Rule's expanded use of sections (c)(2) and (d) of the Church Amendments also violates Congressional Intent. These two sections were passed under Title II of the National Research Services Act in 1974, which specifically dealt with biomedical and behavioral research.[24] This Act was designed to ensure that research projects involving human subjects are

[17] *Id.*
[18] *See* Weldon Amendment, *supra* note 6.
[19] *See* Letter from Jocelyn Samuels, Director of Office for Civil Rights, to Catherine W. Short, Esq. et al. (June 21, 2016), *available at* http://www.adfmedia.org/files/CDMHCInvestigationClosureLetter.pdf.
[20] Weldon Amendment, *supra* note 6; Coats Amendment, *supra* note 6.
[21] The doctrine of *expressio 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.
[22] 141CONG. REC. S17293 (June 27, 1995) (statement of Rep. Coats).
[23] 150 CONG. REC. H10090 (Nov. 20, 2004) (statement of Rep. Weldon).
[24] National Research Services Act of 1974, Pub. L. No, 93-348, 88 Stat. 348 § 214.

performed in an ethical manner.[25] Congress did not intend, as the Proposed Rule implies, to allow health care personnel to refuse to participate in any health care service. Such an expansion of the meaning of the Church Amendment was clearly not intended by Congress in the passage of the statute and would turn Congress' intent to protect patients on its head.

In other words, in greatly expanding the existing federal refusal laws relating to treating an individual seeking abortion or sterilization or refusing in the biomedical or behavioral research context, the Proposed Rule exceeds the scope of federal law and conflicts with congressional intent. It is therefore unlawful.

c. The Proposed Rule Overreaches Into Other Federal Laws, Undermining Congressional Intent

However, the Department does not limit its overreach to the aforementioned laws. Instead, under the Proposed Rule, the Department has unlawfully asserted authority over a greater number of federal statutes in an attempt to create new refusal provisions and to give the Department authority it previously did not have. For example, the Proposed Rule would prohibit a State agency that administers a Medicaid managed care program from requiring an organization "to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization objects."[26] However, the underlying Medicaid statute merely provides a rule of statutory construction which states that nothing in the statute should be construed to require a state agency that administers a Medicaid managed care program to use its funds for such purposes.[27] By misrepresenting the limited scope of this provision in order to create a new refusal provision, the Proposed Rule directly contradicts Congressional intent.

By attempting to create new refusal provisions, the Department also seeks to give OCR unlawful enforcement authority over these provisions. For many of these, Congress already established an enforcement scheme in the statute at issue. The Department should be reminded that "regardless of how serious the problem an administrative agency seeks to address … it may not exercise its authority 'in a manner that is inconsistent with the administrative structure that Congress enacted into law.'"[28] Not only is it unlawful for the Department to alter the enforcement mechanisms contemplated by the statute, in many cases it would be nonsensical. For example, the Proposed Rule is attempting to re-delegate oversight of youth suicide early intervention and prevention strategies to OCR, despite the specific existing authority held by the Center for Substance Abuse Treatment.[29] Congress specifically created a "Center for Substance Abuse Treatment," the director of which is already charged with administering block grants and ensuring compliance with applicable law for development of youth suicide early intervention and prevention strategies.[30] The Department's attempt to alter this statutory scheme by attempting to give OCR

[25] *See, e.g.*, Todd W. Rice, *The Historical, Ethical, and Legal Background of Human-Subjects Research*, 53 RESPIRATORY CARE 2325 (2008), http://rc.rcjournal.com/content/respcare/53/10/1325.full.pdf.
[26] *Rule*, *supra* note 1, at 3926.
[27] *See* 42 U.S.C. § 1395w-22 (2010).
[28] *See* Food and Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 125-26 (2000).
[29] *See Rule*, *supra* note 1, at 3927.
[30] *See* Center for Substance Abuse Treatment, 42 U.S.C. § 290bb (2016); Youth Suicide Early Intervention and Prevention Strategies, 42 U.S.C. § 290bb-36 (2004).

authority to enforce certain provisions of the block grant is unlawful. Moreover, this change is nonsensical, given that the provision of statutory construction found within the statute outlining the program's requirement was never intended to be used to create a right to refuse.[31]

III. The Proposed Rule Conflicts with Federal Laws.

The Proposed Rule generates conflict and confusion, creating chaos with existing federal laws. It appropriates language from landmark civil rights laws while entirely failing to even mention important laws that protect patients from discrimination and unreasonable barriers to health care access, that already govern employment discrimination based on religious belief, and that ensure patients get the care they need, particularly in emergency situations. By unilaterally attempting to broaden existing refusal of care laws, the Department jettisons the careful balance present in existing federal law. The Department attempts to upset this existing federal balance without legitimate statutory authority or even a reasoned explanation.

a. The Proposed Rule Would Subvert Civil Rights Statutes by Attempting to Appropriate their Language

The Department has exceeded its authority by appropriating language from civil rights statutes and regulations that were intended to improve access to health care and applying 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 unlawful, but is nonsensical and 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. They will place a significant and burdensome requirement on health care providers, taking resources away from patient care without adding any benefit.

Moreover, the Proposed Rule defines "discrimination" for the first time[32] and does so in a way that subverts the language of landmark civil rights statutes to shield those who would discriminate rather than to protect against discrimination. In this context, this broad definition is inappropriate. Further such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements thereby fostering confusion.

b. The Proposed Rule Conflicts with Sections 1554 and 1557 of the Affordable Care Act

The Proposed Rule conflicts with two provisions of the Affordable Care Act.

Section 1554 of the Affordable Care Act prohibits the Secretary of Health and Human Services from promulgating any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care."[33] As discussed in more detail below, religious refusals have been used to discriminate and deny patients the care they need based on the assertion of a religious or personal belief. By expanding the reach of refusals and permitting

[31] *See* 42 U.S.C. § 290bb-36 (2004).
[32] *Id.* at 3923-924.
[33] 42 U.S.C. § 18114(1) (2010).

objecting individuals and health care entities to deny patients needed health care services, the Proposed Rule erects unreasonable barriers to medical care and impedes access to health care services such as abortion and sterilization.[34]

Section 1557 of the Affordable Care Act prohibits discrimination in health care programs or activities on the basis of race, color, national origin, sex, age, or disability.[35] Prior to Section 1557, no broad federal protections against sex discrimination in health care existed. The ACA was intended to remedy this, as evidenced not only by the robust protection provided by Section 1557 itself, but also by the ACA's particular focus on addressing the obstacles women faced in obtaining health insurance and accessing health care.[36] As discussed in more detail below, by emboldening refusals for services that women and LGBTQ patients disproportionately or exclusively need, the Proposed Rule entrenches sex discrimination in health care and undermines the express purpose of Section 1557.

c. The Proposed Rule Conflicts with Title VII

The Proposed Rule makes no mention of Title VII, the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[37] 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.[38] 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

[34] The Proposed Rule therefore also violates § 706(2) of the APA, which instructs a reviewing court under arbitrary and capricious standard of review to consider and hold unlawful agency action found to be (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (D) without observance of procedure required by law; (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

[35] 42 U.S.C. § 18116 (2010).

[36] *See* 42 U.S.C. § 300gg(a) (2015) (allowing rating based only on family size, tobacco use, geographic area, and age, but not sex); 45 C.F.R. § 147.104(e) (2015) (prohibiting discrimination in marketing and benefit design, including on the basis of sex); *see also, e.g.*, 156 CONG. REC. H1632-04 (daily ed. March 18, 2010) (statement of Rep. Lee) ("While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children."); 156 CONG. REC. H1891-01 (daily ed. March 21, 2010) (statement of Rep. Pelosi) ("It's personal for women. After we pass this bill, being a woman will no longer be a preexisting medical condition."); 155 CONG. REC. S12026 (daily ed. Oct. 8, 2009) (statements of Sen. Mikulski) ("[H]ealth care is a women's issue, health care reform is a must-do women's issue, and health insurance reform is a must-change women's issue because . . . when it comes to health insurance, we women pay more and get less."); 155 CONG. REC. S10262-01 (daily ed. Oct. 8, 2009) (statement of Sen. Boxer) ("Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform."); 156 CONG. REC. H1854-02 (daily ed. March 21, 2010) (statement of Rep. Maloney) ("Finally, these reforms will do more for women's health . . . than any other legislation in my career.").

[37] *See* 42 U.S.C. § 2000e-2 (1964); 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.

[38] *Id.*

obligations.[39] 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 the Proposed Rule and Title VII. Indeed, when similar regulations were proposed in 2008, EEOC commissioners and the Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[40]

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 who refuses to provide non-directive options counseling to women with positive pregnancy tests even though it is an essential job function. The employer would not be required to do so under Title VII. 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.

d. The Proposed Rule Conflicts with Federal Law on Treatment of Patients Facing Emergency Situations

The Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion. 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.[41]

Because the Proposed Rule does not contain an explicit exception for situations in which an abortion – or other health service the Proposed Rule may empower individuals or entities to refuse – is needed to protect the health or life of a patient, the Proposed Rule is confusing to institutions regarding their obligations under the Proposed Rule as they relate to EMTALA. Every hospital is required to comply with EMTALA; even a religiously-affiliated hospital with an institutional objection to abortion must provide the care required in emergency situations.[42]

e. The Proposed Rule Violates the Establishment Clause

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[39] *Id.*

[40] Equal Emp't. Opportunity Comm'n. Legal Counsel Comment Letter on Proposed Rule 73 Fed. Reg. 50,274 (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html; Equal Emp't Opportunity Commissioners Christine Griffiin, Stuart Ishimaru Comment Letter on Proposed Rule 73 Fed. Reg. 50,274 (on file with National Women's Law Center).

[41] *See* 42 U.S.C. § 1395dd(a)-(c) (2003).

[42] 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. & Healthcare Servs., No. Civ. 02–4232JNEJGL, 2004 WL 326694, at *2 (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 Proposed Rule unlawfully establishes and adopts one subset of religious views while denying health care to those with differing views. In fact, staff within the Department have indicated that the Department intends to support evangelical beliefs over others.[43] These statements are consistent with the Department's actions.[44] The Department cannot promulgate proposed rules in reliance on unconstitutional preferences such as religious beliefs. Such actions are unlawful and out of line with the Department's historical mission.[45]

IV. The Proposed Rule Will Harm Patients, and the Department Has Failed to Take This Into Account.

The Proposed Rule is contrary to the Department's stated mission: "to enhance and protect the health and well-being of all Americans." In order to achieve that mission, one of the Department's primary goals is to "eliminate[ ] disparities in health, as well as [to increase] health care access and quality."[46] In its singular focus on what the Department claims is discrimination on the basis of religious or moral beliefs, it abdicates its mission. The Department ignores the pervasive discrimination in health programs and activities that individuals face, particularly those who seek reproductive health care, or because of their sex, gender identity, or sexual orientation. The Department unlawfully ignores how this discrimination is compounded by refusals of care based on personal beliefs and how the Proposed Rule will amplify that harm.

a. Certain Groups of Patients Routinely Face Discrimination in Health Care

Women have long been the subject of discrimination in health care.[47] Despite the historic achievements of the Affordable Care Act, women are still more likely to forego care because of cost,[48] and women – particularly Black women – are far more likely to be harassed by a

[43] Dan Diamond, *The Religious Activists on the Rise Inside Trump's Health Department*, POLITICO (Jan. 22, 2018), https://www.politico.com/story/2018/01/22/trump-religious-activists-hhs-351735.
[44] *See, e.g.*, Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding, 82 Fed. Reg. 49,300 (proposed Oct. 25, 2017); Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47, 792 (proposed Oct. 13, 2017).
[45] *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.").
[46] *See HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, DEP'T OF HEALTH AND HUMAN SERVS., at 7, https://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.
[47] Prior to the Affordable Care Act (ACA), women were charged more for health care on the basis of sex and were continually denied health insurance coverage for services that only ciswomen, transgender, and gender non-conforming patients need. *See Turning to Fairness*, NAT'L WOMEN'S L. CTR. 1, 3-4 (2012), https://nwlc.org/wp-content/uploads/2015/08/nwlc_2012_turningtofairness_report.pdf (noting that while the ACA changed the health care landscape for women in significant ways, women still face additional hurdles).
[48] *See* Shartzer, et al., *Health Reform Monitoring Survey*, URBAN INST. HEALTH POLICY CTR. (Jan. 2015), http://hrms.urban.org/briefs/Health-Care-Costs-Are-a-Barrier-to-Care-for-Many-Women.html.

provider.[49] These barriers mean women are more likely not to receive routine and preventive care than men. Moreover, when women are able to see a provider, women's pain is routinely undertreated and often dismissed.[50] And due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[51]

LGBTQ individuals encounter high rates of discrimination in health care. According to one survey, eight 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 seven percent experienced unwanted physical contact and violence from a health care provider.[52] 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 in the previous year.[53] Additionally, the 2015 U.S. Transgender Survey found that 23 percent of respondents did not see a provider for needed health care in the previous year because of fears of mistreatment or discrimination.[54]

And these barriers disproportionately impact those facing multiple and intersecting forms of discrimination, including women of color, LGBTQ persons of color, and individuals living with disabilities and those struggling to make ends meet. In one report, Black women disclosed that their doctors failed to inform them of the full range of reproductive health options regarding labor or delivery possibly due to stereotypes about Black women's sexuality.[55] 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.[56] These barriers also are often made worse by the complex web of

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[49] *See Discrimination in America: Experiences and Views of American Women*. NPR & HARVARD T.H. CHAN SCH. OF PUB. HEALTH (Dec. 2017), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2017/12/NPR-RWJF-HSPH-Discrimination-Women-Final-Report.pdf.

[50] *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).

[51] *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).

[52] 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.

[53] *Id*.

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

[55] *See The State of Black Women & Reproductive Justice*, IN OUR OWN VOICE (2017), http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

[56] 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*, THINK PROGRESS, Oct. 1, 2015, https://thinkprogress.org/why-reproductive-health-can-be-a-special-struggle-for-women-with-disabilities-73ececea23c4/.

federal and state laws and policies that restrict access to care, particularly around certain health services like abortion.

b. Refusals of Care Based on Personal Beliefs Compound the Harm to Patients

This discrimination in health care against women, LGBTQ persons, and those facing multiple and intersecting forms of discrimination is exacerbated by providers invoking personal beliefs to deny access to health insurance and an increasingly broad range of health care services, including birth control, sterilization, certain infertility treatments, abortion, transition-related care, and end of life care.[57] For example, one woman experiencing pregnancy complications was 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.[58] A transgender man was denied gender affirming surgery at a religiously-affiliated hospital that refused to provide him a hysterectomy.[59] A woman called an ambulance after experiencing abdominal pain, but the ambulance driver refused to take her to get the care she needed.[60]

When refusals of care happen, many patients are forced to delay or forego necessary care, which can pose a threat not only to their health, but their lives. This is particularly true for patients with limited resources and options. For many patients, such refusals do not merely represent an inconvenience but can result in necessary or even emergent care being delayed or denied outright. These refusals are particularly dangerous in situations where individuals have limited options, such as in emergencies, when needing specialized services, in rural areas, or in areas where religiously-affiliated hospitals are the primary or sole hospital serving a community. The reach of these types of refusals to provide care continues to grow 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.[61]

c. The Proposed Rule Will Further Harm Patients, Yet the Department Unlawfully Ignores that Harm

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[57] Directive 24 denies respect for advance medical directives. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), 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. Moreover, religiously-affiliated individuals have challenged key provisions of the federal law and implementing regulations that prohibit discrimination on the basis of sex, gender identity, or sexual orientation in health care. *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care*, NAT'L WOMEN'S LAW CTR. (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf.; *see also Health Care Denied*, AM. CIVIL LIBERTIES UNION (May 2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[58] *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.

[59] *See id.* at 29.

[60] *Put Patient Health First*, NAT'L WOMEN'S LAW CENTER 1 (August 2017), https://nwlc.org/resources/continued-efforts-to-undermine-womens-access-to-health-care/.

[61] *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.

By stretching refusals of care far beyond their current reach, the Proposed Rule leaves patients seeking reproductive or sexual health care services facing even greater threats to their health, life, and future fertility than they did before. In addition, the expansion of refusals of care under the Proposed Rule has far reaching implications for those providing or seeking services and information in a wide range of areas including HIV, drug addiction, infertility, vaccinations, psychology, sexually transmitted infections and end-of-life care, among others. This means that the Proposed Rule will compound harm to patients in multiple new ways, imposing additional hurdles patients must overcome to get the care they need. For example, young people in federal custody, including foster youth and unaccompanied immigrant children, already face enormous hurdles to accessing health care. Yet, the Proposed Rule seeks to allow foster parents, social service agencies, and shelters that provide services to young people to refuse even minor assistance to a young person in their care who needs health services, including STI testing or treatment and abortion care.

The reach of the Proposed Rule will create a vicious cycle where those already subject to multiple forms of discrimination in the health care system may be the most likely to find themselves seeking care from a health care professional who refuses to provide it. For example, in many states women of color are more likely than white women to give birth at a Catholic hospital.[62] By expanding refusals of care, the Proposed Rule will exacerbate the barriers to health care services patients need.

Yet despite the overwhelming evidence of discrimination against patients seeking health care services and the harm of refusals of care that are based on personal beliefs, the Department issued this Proposed Rule. The Department fails entirely to consider the impact of the Proposed Rule on patients, particularly individuals seeking reproductive health care, patients of color, and LGBTQ individuals. At no point does the Proposed Rule acknowledge the many ways it will harm patients. This consideration is required by law and by the U.S. Constitution, and the Department's failure to account for these requirements renders the Proposed Rule invalid and unlawful.

III. The Proposed Rule Erodes the Core Tenants of the Medical System.

The Proposed Rule undermines the trust in the provider-patient relationship and unduly burdens those health care providers who want to fulfill their obligations to provide patients with the care they need.

a. The Proposed Rule Undermines the Provider-Patient Relationship

A strong provider-patient relationship is the foundation of our medical system. Patients rely on their providers to give full information about their treatment options and to provide medical advice and treatment in line with the standards of care established by the medical community. Yet, the Proposed Rule allows providers to do the opposite, threatening informed consent,

[62] *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.

undermining standards of care, and eroding patient trust in their providers and ultimately the medical system.

Informed consent is intended to help address the knowledge and power imbalance between providers and their patients, so patients can make their own competent and meaningful decisions about their treatment options.[63] The Proposed Rule acknowledges the importance of open, honest conversations in health care, stating "open communication in the doctor-patient relationship will foster better over-all care for patients."[64] Yet, it would allow providers, including hospitals and health care institutions, to ignore the patient's right to receive information and refuse to disclose relevant and medically accurate information about treatment options and alternatives. To make matters worse, the Proposed Rule includes provisions that specifically remove statutory requirements that health care entities at least notify patients they may be refused health care services or information. For example, it omits requirements enumerated in the counseling and referral provisions of the Medicaid managed care statute. These provisions require organizations that decline to cover certain treatments to notify enrollees of the policy.[65] The Department's attempts to affirmatively remove notice requirements underscore how little it cares about patients receiving full information. Allowing refusals to provide information and then barring patients from receiving any notice that they may not be given full information makes open communication impossible.

In addition to receiving non-biased information from their providers, patients also expect to receive treatment in line with medical practice guidelines and standards of care. Yet, the Proposed Rule seeks to allow providers, including hospitals and other health care institutions, to ignore the standards of care, particularly surrounding reproductive and sexual health. This completely undermines the provider-patient relationship and will create uncertainty and doubt where there should be trust and respect.

b. The Proposed Rule Burdens Providers that Want to Uphold the Hippocratic Oath and Provide Comprehensive Care

As the American Medical Association Code of Medical Ethics states, "the relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest."[66] Yet, the Proposed Rule flips this principle on its head – attempting to expand the ability of institutions to use personal beliefs to dictate patient care. In doing so, the Department allows institutions to block providers that want to provide patients with necessary or comprehensive care.

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[63] As the AMA Code of Ethics makes clear, "Informed Consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care." *Informed Consent*, AMERICAN MED. ASSOC., https://www.ama-assn.org/delivering-care/informed-consent (last visited Mar. 23, 2018).

[64] *Rule*, *supra* note 1, at 3917.

[65] The requirements of 42 U.S.C. § 1396u-2(b)(3)(B)(ii) excluded from the Proposed Rule's requirements surrounding Medicaid managed care organization. *See Rule*, *supra* note 1, at 3926.

[66] *Code of Medical Ethics: Patient-Physician Relationships*, AMERICAN MED. ASSOC., https://www.ama-assn.org/delivering-care/code-medical-ethics-patient-physician-relationships (last visited Mar. 23, 2018).

Most providers believe they should and must treat patients according to medical standards regardless of their personal beliefs. Moreover, many providers have deeply held moral convictions that affirmatively motivate them to provide patients with certain services, including abortion, transition-related care, and end-of-life care. Existing refusal of care laws already burden these providers. 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. The Proposed Rule would exacerbate these problems by expanding the number and types of institutions that can bind the hands of providers and limit the types of care, or even information, they can provide.

The Proposed Rule egregiously misuses research to falsely claim that a majority of obstetrician-gynecologists are unwilling to provide abortion.[67] In fact, the survey underlying the cited study found that over 80% of obstetrician-gynecologists are willing to help a patient obtain an abortion in the vast majority of cases. The survey also found that even where providers had a moral objection to providing abortion in a particular situation, a majority would still help the patient obtain an abortion.[68] Hospitals already discriminate against health care providers by preventing them from providing certain health care services, particularly abortion, even in life-threatening situations.[69] In fact, researchers have found that over a third of obstetrician-gynecologists experience conflict with their employers over religiously based patient care policies, with a majority of obstetrician-gynecologists at Catholic institutions reporting such conflicts.[70]

The Proposed Rule's expansion of entities that can constrain their employees not only ignores the barriers facing health care professionals who are committed to providing patients with comprehensive care regardless of personal beliefs, but it also ignores the Department's duty to enforce federal law that protects those who support abortion or sterilization. The Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services. No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion. But instead of acting to protect health care providers who put patients first, the Proposed Rule allows more institutions to interfere and prevent employees from providing care.

IV. The Proposed Rule Burdens States that Want to Protect Patient Access to Care.

As the Department recognized in the preamble of the Proposed Rule, forty-seven states have laws that allow health care providers and/or institutions to refuse health care to individuals based on personal beliefs.[71] These harmful existing state laws have already undoubtedly resulted in the

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[67] *Rule*, *supra* note 1, at 3916.
[68] Lisa Harris et al., *Obstetrician-Gynecologists' Objections to and Willingness to Help Patients Obtain an Abortion*, 118 OBSTETRICS & GYNECOLOGY 905 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4185126/.
[69] *Discrimination Against Health Care Professionals Who Provide or Support Abortion* NAT'L WOMEN'S LAW CENTER (August 2017), https://nwlc.org/resources/discrimination-against-health-care-professionals-who-provide-or-support-abortion/.
[70] Stulberg et al., *Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient Care Policies*, 73 AM. J. OF OBSTETRICS AND GYNECOLOGY e1 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3383370/
[71] *Rule*, *supra* note 1, at 3931; *see also Refusing to Provide Health Services*, GUTTMACHER INSTITUTE (Feb. 2018), https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services.

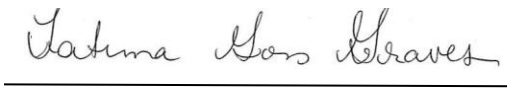
denial of health care, and in particular have endangered women's health. Now, the Proposed Rule is inviting states to enact even more sweeping laws.[72] The Proposed Rule encourages states to pass laws that go even further than the Proposed Rule does in allowing for refusals of health care. While it is clear that federal laws generally provide a minimum level of protection and allow states to enact more substantial protections, those protections are usually for the purpose of protecting individuals from discrimination and/or ensuring access to important services or benefits. As discussed above, the Proposed Rule subverts this entirely, entrenching discrimination and taking away access to health care services and benefits.

The Proposed Rule also creates a chilling effect on the enforcement of and passage of state laws that protect patient access to health care. The Department argues that the Proposed Rule is needed in order to clarify how federal religious exemption laws interact with state and local laws. To illustrate this purported need, the preamble cites several state laws intended to protect access to care. These include laws that require anti-abortion counseling centers to provide information about the full range of reproductive health care options and inform patients if the facility employs medical providers as well as state laws that ensure that individuals have comprehensive health insurance that includes abortion coverage. The discussion implies these and other laws that protect patient access to care conflict with the Proposed Rule, particularly when read in conjunction with several of the leading questions regarding state law posed in the preamble. This puts states in the untenable position of choosing between passing laws that protect their people and potentially losing millions of dollars in critical federal funding, likely resulting in a chilling effect on states attempting to pass or enforce laws intended to protect patients.

Conclusion

The Proposed Rule is illegal and harmful. It attempts to 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 all of these reasons, the Center unequivocally calls on the Department to withdraw the Proposed Rule.

Sincerely,



Fatima Goss Graves
President and CEO, National Women's Law Center

[72] *See e.g., Rule, supra* note 1, at 3888-89.

Exhibit 64

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Via electronic submission

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority Doc et No : HHS CR

To Whom It May Concern:

The New York City Commission on Human Rights, the New York City Department of Health and Mental Hygiene, the New York City Department of Social Services, and NYC Health + Hospitals write to express our opposition to the United States Department of Health and Human Services' (HHS) proposed regulations entitled, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.

HHS' proposed rule will cause serious harm to the health and well-being of New Yorkers. It will erect barriers to the delivery and receipt of timely, high quality health care. It will foster a new standard of selective and discriminatory treatment for many of our most vulnerable populations. It will also multiply the administrative burdens that health care organizations shoulder to address time-sensitive health conditions. Finally, it will infringe on the ability of state and local governments to enforce their laws and policies. In the face of these significant harms, we urge HHS to rescind this rule.

The Proposed Rule Will Harm Patients

The proposed rule elevates healthcare providers' personal beliefs over patient health. It gives providers wide latitude in opting out of treating patients. Undoubtedly, providers will deny care to patients who need it. At a minimum, a denial will mean that patients who are turned away will experience delays and increased expenses in receiving care. But in many cases, delay will effectively mean denial, particularly where time is of the essence or locating a suitable alternate provider is not feasible. The denial of care will be the end of the road in many patients' search for treatment.

Indeed, finding an alternate provider is no simple task. Health plans have limited provider networks, caps on the number of specialty visits, and steep cost-sharing obligations. Workers have limited or no sick leave, and forcing them to visit a second provider to accommodate the first provider's beliefs means that many patients will have to decide between taking care of their health and making a living. That is no choice at all, and many patients will forego care that they otherwise would have received.

Similarly, many people live in areas with a limited number of primary care doctors, specialists, and specialty care facilities. They may be forced to travel great distances to find a provider willing to treat them. Patients who are elderly, patients with disabilities, and patients under the age of

majority may be completely unable to access an alternate healthcare provider if refused care. During an emergency such as a national disaster, there may be only one accessible provider.

The denials of care that will result if the proposed rule is adopted will have severe and often irreversible consequences: unintended pregnancies, disease transmission, medical complications and anguish in the last days of life, and death. For example:

- Post-exposure prophylaxis for HIV should be initiated within 36 hours, but not beyond 72 hours after potential exposure.
- Emergency contraception is most effective at preventing pregnancy if taken as soon as possible after sexual intercourse.
- Contraceptives and pre-exposure prophylaxis for HIV are effective only if accessed prior to a sexual encounter.
- There is a window for a safe, legal abortion, and a narrower window for medication abortion. In the case of ectopic pregnancy or other life-threatening complication, an abortion may need to be performed immediately.
- Opiate users denied methadone or buprenorphine remain at increased risk of overdose, and naloxone must be administered quickly to reverse drug overdose.
- Persons with suicidal ideation need immediate care to prevent self-harm.
- Refusing to honor a person's end-of-life wishes prolongs suffering.

In short, the proposed rule will cause long-lasting and irreparable harm to patients.

The breadth of the proposed rule is extraordinary, all but guaranteeing that patients will be denied essential health care. Extending protections to health plans, plan sponsors, and third-party administrators that receive federal funds may prompt health plans to cease coverage for abortion, contraceptives, health care related to gender transition, and other services. Allowing anyone "with an articulable connection to a procedure, health service, health program or research activity" to raise an alleged conscience objection, means that the myriad of participants in a healthcare encounter—from intake and billing staff to pharmacists, translators, radiology technicians, and phlebotomists—can refuse to participate in service delivery. This will cause untold disruptions and delays for patients. And the expansive definitions of "assist in the performance" and "referral" mean that healthcare providers – after refusing to care for a patient – will not even need to provide a referral or other necessary information for a patient to seek care elsewhere.

The negative health impact of denied care is profound. In the case of infectious disease, there is societal impact: delays in diagnosis, prophylaxis and treatment increase the likelihood of individual disease progression and transmission to others. The consequences of untreated substance use disorders are likewise far-reaching. Compounding matters, the harmful effects of the proposed rules will be felt most acutely by individuals and communities that already face great challenges accessing the care that they need: people of color, low-income persons, women, children, people with substance use disorders, and lesbian, gay, bisexual, transgender, queer, intersex and gender nonconforming ("LGBTQI") persons.

The Proposed Rule Will Lead to Discrimination Against Already Vulnerable Populations

The rule gives healthcare providers a free pass to discriminate based on a patient's identity and against any patient whose actions or decisions conflict with the provider's alleged conscience objection.

Discrimination by health care providers marginalizes and stigmatizes patients, driving them away from care systems. It has long-term destructive consequences for the health and well-being of patients and communities that already bear the brunt of discrimination. Women and LGBTQI people will find themselves denied care at alarming rates. Providers may refuse to prescribe contraceptives to women who are not married, fertility treatment to same-sex couples, pre-exposure prophylaxis to gay men, or counseling to LGBTQI survivors of hate or intimate partner violence. Transgender patients are likely to be refused medically necessary care like hormone therapy, and substance users may be denied medications to treat addiction or reverse drug overdose.

The impact of such discrimination extends far beyond the individual patient encounter. For example, LGBTQI youth that are denied services and psychosocial support show a lasting distrust of systems of care.[i] Concerns regarding stigma may also make patients reluctant to reach out to loved ones for support, as has been shown with women who have had abortions.[ii]

This never-before-seen license to pick and choose the type of patient and nature of care that a clinician or organization will provide runs counter to principles of comprehensiveness and inclusion that have long guided the federal government's oversight of key health care programs and the operation of the country's health care delivery system.

The Proposed Rule Creates New Administrati e urdens for a Strained Health Care System

The extraordinary breadth of the proposed rule will result in significant and costly administrative burdens on an already-strained healthcare system. The proposed rule places healthcare entities in the precarious position of having to accommodate various ethical beliefs held by thousands of staff, regardless of how tenuous those staffs' connection to the clinical encounter. Also, by prohibiting employers from withholding or restricting any title, position or status from staff that refuse to participate in care, healthcare entities are limited in being able to move staff into positions where they will not disrupt care and harm patients. Thus, doctors in private practice will be prohibited from firing any staff who refuses to assist, and thereby stigmatizes and harms, LGBTQI patients. Emergency departments, ambulance corps, mental health hotlines, and other urgent care settings may need to increase the number of shift staff to ensure sufficient coverage in case of a refusal to work with a patient. This will have a very real financial impact on healthcare facilities, including government-run and subsidized clinics and hospital systems. This is a costly proposition that flies in the face of the federal government's stated goal of reducing administrative burdens within the health care system.

The Proposed Rule Infringes on State and Local Governments' Ability to Enforce Their Laws and Policies and Conflicts with Patient Protections

The proposed rule may impact the ability of State and local governments to enforce the full scope of their health- and insurance-related laws and policies by conditioning the receipt of federal funding on compliance with the rule. Similarly, it may leave providers caught between conflicting mandates. The New York City Human Rights Law ("City Human Rights Law"), for example, like many state and local nondiscrimination laws, protects patients from discrimination based on sexual orientation, gender (including gender identity), marital status, and disability.

Protecting vulnerable populations from discrimination and misinformation is of paramount importance to New York City. The City Human Rights Law is one of the most comprehensive civil rights law in the nation, prohibiting discrimination in health care settings based on, among other things, a patient's race, age, citizenship status, and religion. A provider's refusal to serve a patient pursuant to the proposed rule may be a violation of state and local laws, some of which are enforced through the imposition of injunctive relief and substantial financial penalties. Violations of the City Human Rights Law, for example, can lead to the imposition of penalties of up to $250,000 per violation.

We oppose regulations that allow personal beliefs to trump science at the expense of vulnerable populations' access to health care. We oppose systems that compromise our duty to protect and improve the health of City residents. We oppose actions that sanction discrimination against patients based on who they are or what health conditions they have.

We urge HHS to rescind the proposed rule.

Sincerely,

Steven Banks
Commissioner
New York City Department of Social Services

Mary T. Bassett, MD, MPH
Commissioner
New York City Department of Health and Mental Hygiene

Mitchell Katz, MD
President and Chief Executive Officer
New York City Health and Hospitals

Carmelyn P. Malalis
Commissioner
New York City Commission on Human Rights

[i] Substance Abuse and Mental Health Services Administration. Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
[ii] Shellenberg KM, Tsui AO. Correlates of perceived and internalized stigma among abortion patients in the USA: an exploration by race and Hispanic ethnicity. *Int J Gynaecol Obstet*. 2012;118(2):60015-60010.

Exhibit 65

NEW YORK STATE
DEPARTMENT of
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

March 21, 2018

Mr. Eric Hargan
Acting Secretary
U.S. Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue SW
Washington, DC 20201
Attn: Conscience NPRM
RIN 0945-ZA03

Re: Comments on Protecting Statutory Conscience Rights in Health Care; Delegations of Authority

Dear Mr. Hargan:

The New York Department of Financial Services (NYDFS) submits the following comments on the proposed rule 45 CFR 88, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority [HHS-OCR-2018-0002] (Proposed Rule). As set forth below, the Proposed Rule impermissibly attempts to restrict womenôs access to abortion services and attempts to veil such blatant discrimination of women as conscience rights. NYSDFS urges the retraction of the Proposed Rule.

Specifically, Section 88.3(c) in the Proposed Rule unlawfully deviates from the plain language of the Weldon Amendment ï see, e.g., Pub. L. 115-31, Div. H, sec. 507(d) ï by expanding the definition of health care entities that are subject to the amendment and by incorporating a definition of the term ñdiscriminationò that far exceeds the recognized, legal meaning of that term. The Proposed Rule also attempts to interfere unlawfully with the operation of State law with respect to ensuring that women have access to medical services. NYDFS strongly supports the compelling governmental interest in providing women access to all medical services, including abortion services, to promote womenôs health and gender equality. Consistent with this compelling governmental interest, New York law requires that all health insurance plans issued in the state include coverage for medically necessary abortions. Any Department of Health and Human Services (ñHHSò) proposed rule that seeks to undermine

New Yorkôs right to promote and protect womenôs health and gender equality, violates of the Affordable Care Act (ñACAò) and bedrock constitutional principles. NYDFS strongly objects to the unconstitutional, unreasonable, and discriminatory Proposed Rule which takes a drastic step backwards and unnecessarily attempts to curtail womenôs access full to medical services.

The Proposed Rule Discriminates Against Women

The Proposed Rule discriminates against women by hindering their access to abortion and other medically necessary health care services. The U.S. Supreme Court has held that the right to terminate a pregnancy is a fundamental privacy right, protected as a liberty interest under the Fourteenth Amendment of the U.S. Constitution.[1] The number of abortion providers are already in decline,[2] and many states have enacted cumbersome barriers, forcing women to travel to obtain abortion services necessary for their health.[3] The Proposed Rule exacerbates the problem, by not only expanding the persons who may object beyond any by reasonable definition, and also increasing the categories of behavior protected under its scope. Under the Proposed Rule, employers could impose their will on their employees by forcing insurers to deny abortion coverage to women; pharmacists may not need to dispense emergency contraception; objecting health care providers could choose not to refer patients to non-objecting providers, or provide abortion funding information; and pregnant women could be denied life-saving options during an emergency. These provisions are unlawful, discriminatory, and not permissible by regulatory fiat.

The Supreme Court has ruled that an obstacle is substantial when it is created to impede rather than inform a woman of her choices.[4] By allowing plan sponsors and health care providers to obstruct the patient from being able to obtain coverage for or afford abortion services; from receiving medication that her doctor prescribed for her; by limiting medical information or options that patients have a right to know about; or by preventing women from receiving medically necessary procedures, the HHS is creating substantial obstacles and unjustifiably limiting access to the breadth of health services to which women are lawfully entitled.[5] It is neither the government nor employers that have the legal right or moral superiority over womenôs health care decisions as prescribed by their physicians.

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[1] Roe v. Wade, 410 U.S. 113, 153 (1973); see also Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833 (1992).

[2] The number of clinics providing abortions declined 6% between 2011 and 2014, and declines were steepest in the Midwest (22%) and the South (13%). Rachel K. Jones, Jenna Jerman, Abortion Incidence and Service Availability, National Center for Biotechnology Information (January 17, 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5487028/.

[3] Angie Leventis Lourgos, More Women Seem to be Crossing State Lines to have Abortions in Illinois, Chicago Tribune (February 27, 2018), http://www.chicagotribune.com/news/ct-met-abortion-numbers-illinois-20180222-story.html.

[4] ñAnd a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a womanôs choice cannot be considered a permissible means of serving its legitimate ends.ò Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833, 877 (1992).

[5] ñAll health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential

Moreover, the Proposed Rule favors the rights of a non-protected class over the rights of a protected class. HHS stated in the Proposed Rule that ñconscience objectorsò should be ñallowed a level playing field, and that their beliefs not be held to disqualify them from participation in a program or benefit.ò HHS erroneously claims that this alleged form of discrimination against conscience objectors ñparallels the type of discrimination typically prohibited with respect to other characteristics such as race, color, or national origin.ò Under the law, ñconscience objectorsò are not a protected class; therefore, they are not entitled to the same level of protection as other federally protected classes, and, such as gender and race. The Proposed Rule defines ñdiscriminateò as ñto withhold, reduce, exclude, terminate, restrict, or otherwise make unavailable or deny any benefit or privilege.ò In reducing and restricting womenôs access to abortions, by its own definition, HHS is discriminating against women. HHS compounds the problem by giving employers the new right to invade the confidentiality of womenôs health care relationship with her doctor, broadening the scope of any possible religious exemption to a ñconscience objectorò which finds no support in law or health care policy.

The Proposed Rule Is Inconsistent with the Plain Language of the Weldon Amendment

Since 2005, HHS appropriations have included a provision that restricted states and other recipients of HHS appropriations from discriminating against a ñhealth care entityò on the ground that the entity does not provide, pay for, provide coverage of, or refer for abortions. The entirety of this restriction ï commonly referred as the Weldon Amendment ï includes the following two clauses:

> (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 ñhealth care entityò 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.

See Pub. L. 115-31, Div. H, sec. 507(d).

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patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. The Limits of Conscientious Refusal in Reproductive Medicine.ò Committee on Ethics, The Limits of Conscientious Refusal in Reproductive Medicine, The American College of Obstetricians and Gynecologists, Number 385 (reaffirmed in 2016), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine.

Section 88.3(c) in the Proposed Rule, were it to be adopted (and it should not be), would unlawfully and illegally expand the restrictions in the Weldon Amendment in two material respects.

First, the definition of ñhealth care entityò used in the Proposed Rule is impermissibly broader than the definition included in the Weldon Amendment. In the Proposed Rule, the definition of ñhealth care entityò has been expanded to include ña plan sponsorò in addition to various other impermissible additions. The inclusion of ña plan sponsorò in the Proposed Ruleôs definition would mean that employers that merely purchase or sponsor a group health plan would be subject to the Weldon Amendment, an extension that violates the law. Indeed, this proposed definitional expansion is contrary to the plain language of the Weldon Amendment and its legislative history, which shows that the purpose of the Weldon Amendment was to respect the religious and moral viewpoint of those directly engaged in the delivery of health care services (i.e., doctors and hospitals). Employers or other plan sponsors are not health care entities under any stretch of the term. The proposed regulatory expansion of the Weldon Amendment to cover all employers who merely purchase or sponsor a group health insurance plan for employees is far beyond the plain language and intended scope of the amendment and would impermissibly sanction employersô intervention into private health care decisions. Given that employers (or ñplan sponsorsò) are clearly not included in the definition of ñhealth care entityò in the Weldon Amendment and cannot be characterized as a health care facility, organization or plan, the definition of ñhealth care entityò used in the Proposed Rule is contrary to law and policy. Indeed, all of the additions in the Proposed Rule to the definition of ñhealth care entityò that do not appear in the Weldon Amendment must be removed as illegal.

Second, the definition of ñdiscriminationò in the Proposed Rule is contrary to federal law. As noted above, the Weldon Amendment prevents a state from discriminating against a ñhealth care entityò on the ground that the entity does not provide, pay for, provide coverage of, or refer for abortions. Yet, Section 88.2 of the Proposed Rule would include in the definition of ñdiscriminate or discriminationò the ñenactment, application, or enforcement of laws, regulations, policies, procedures é that tends to subject individuals or entities protected under this part to any adverse effect.ò This newly-minted definition of ñdiscriminationò in the Proposed Rule attempts to prevent a state from enacting, applying or enforcing a neutral law of general applicability that would require coverage for abortion services, which is clearly contrary to federal law. Under applicable Supreme Court precedent, neutral laws of general applicability, including state laws mandating coverage of all medically necessary surgical services including abortions, by definition, are non-discriminatory:

> We have never held that an individual's religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the State is free to regulate. On the contrary, the record of more than a century of our free exercise jurisprudence contradicts that proposition. . . . Conscientious scruples have not, in the course of the long struggle for religious toleration, relieved the individual from obedience to a general law not aimed at the promotion or restriction of religious beliefs. The mere possession of religious

> convictions which contradict the relevant concerns of a political society does not relieve the citizen from the discharge of political responsibilities.

Emp't Div. v. Smith, 494 U.S. 872, 878-79, 110 S. Ct. 1595, 1600 (1990) (emphasis added; internal quotation omitted). The Court in Smith, examining conscience objections, made clear that neutral laws of general applicability do not rise to the level of discrimination. See id. at 886 n 3. The definition of ñdiscriminationò used in the Proposed Rule therefore does not accord with federal law or the U.S. Constitution.

In addition, the definition of ñdiscriminationò in the Proposed Rule does not, in fact, prohibit discrimination. Discrimination is the disparate treatment of an individual or entity. The Proposed Rule actually mandates discrimination by preventing the equal application and enforcement of neutral state laws. The definition of ñdiscriminationò in the Proposed Rule would impermissibly require a state to modify its laws to accommodate religious or moral beliefs of regulated entities. Such an accommodation would result in the disparate treatment of similarly situated individuals, and entities ï the textbook definition of discrimination. Such a requirement is far outside the boundary of a non-discrimination rule and renders the definition in the Proposed Rule contrary to law. If the rule proceeds, at a minimum, the definition of discrimination in the Proposed Rule should be revised to correct this legal deficiency.

The Proposed Rule Violates the Affordable Care Act

The Affordable Care Act (ACA) expressly authorizes a state to require coverage for medically necessary abortions in health insurance policies issued in the state. See 42 U.S.C. 18023(c)(1) (ñ[n]othing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortionsò). In other words, state laws requiring coverage for medically necessary abortion services in insurance policies are expressly permissible under the ACA. The Proposed Rule ï which unlawfully attempts to prevent the application and enforcement of abortion coverage mandates in state law ï would clearly violate the provision in the ACA by attempting to prevent New York from enforcing its abortion coverage mandates on health insurance policies issued in New York.

In 2010, when the ACA was enacted, the Weldon Amendment had already been included in HHSôs appropriation bills for five years. Had the Weldon Amendment prevented (or was intended to prevent) states from enforcing neutral laws that mandate abortion coverage, the ACA could not have included the provision quoted above as it would immediately have been rendered meaningless. Indeed, prior to the release of the Proposed Rule, neither HHS nor any arm of the federal government had ever suggested that the Weldon Amendment prevented a state from enacting, applying or enforcing a neutral law of general applicability that would require coverage for abortion services. The Proposed Ruleôs attempted expansion of the Weldon Amendment to do just that not only violates the plain language of the statute but also undermines this key provision in the ACA, and therefore lacks a legal foundation.

The Proposed Rule is an Unconstitutional Violation of the Federal Spending Clause

The Proposed Rule delegates full enforcement authority to HHSôs Office for Civil Rights (OCR) and states that if compliance is not achieved, then HHS would consider all legal options available, including ñtermination of relevant [federal] funding, in whole or in part, claw backs, referral to the Department of Justice, or other measures.ò Under settled law, for Congress to place a condition on receipt of federal funds by a State, the condition placed on the State must be unambiguous, and the amount in question cannot be so great that it can be considered coercive to the Stateôs acceptance of the condition.[6] As OCR itself noted in June 2016, it is highly questionable whether the Weldon Amendment is enforceable at all when interpreted consistent with the Proposed Rule, since the revocation of federal funds would violate the Constitutionôs prohibition on the federal government attempting to compel a State to regulate.[7] Further, the Proposed Rule does not provide a clear methodology for withholding federal funding, or any guidance on how the punitive measures would be warranted, leaving enforcement arbitrary and the Proposed Rule unenforceable. It is clear that the Proposed Rule is intended to force states to adopt a policy of regulation of their health insurance markets in a manner in line with the views of the current federal executive ñwhile the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision.ò[8] The Supreme Court has consistently held that the use of the Congressional Spending Clause power to coerce states into regulating in accordance with federal policy is an unconstitutional intrusion on the independent sovereignty of the states.[9] Therefore, even if the Proposed Rule were a permissible reading of the statutes it purports to interpretð which it is notð such a reading renders those statutes unconstitutional, and the Proposed Rule must fall with them.

The Proposed Rule Did Not Adequately Assess the Impact on Families

Under federal rulemaking rules, prior to proposing a new rule, HHS is required to determine whether a proposed policy or regulation could affect family well-being and, if affirmative, prepare an impact assessment. Yet, HHS determined that the Proposed Rule will not negatively impact family well-being. The commentary states that, ñ[i]t is unlikely that this proposed rule will negatively impact the stability of the family. . .ò The commentary further states, ñ[i]n addition, the proposed rule has no bearing on the disposable income or poverty of families and children. . .ò These statements are patently false. Interfering with a womenôs access to safe abortion services will adversely impact her health and correspondingly the well-being of her family. In addition, limiting health insurance coverage of abortion services will directly impact the disposable income of families, as women will be forced to pay for abortion services out-of-pocket, when other medical procedures are covered for men. Importantly, the

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[6] South Dakota v. Dole, 483 U.S. 203, 204 (1987).
[7] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 577-78, 132 S. Ct. 2566, 2602 (2012) (ñ[W]hen pressure turns into compulsion, the legislation runs contrary to our system of federalism. The Constitution simply does not give Congress the authority to require the States to regulate.ò quoting New York v. United States, 505 U.S. 144, 178 (1992) internal quotations omitted).
[8] New York v. United States, 505 U.S. 144, 169, 112 S. Ct. 2408, 2424 (1992).
[9] See e.g., Sebelius, 567 U.S. at 577-85.

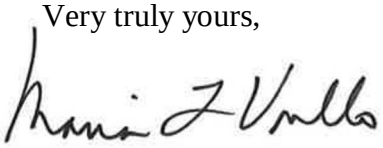
Proposed Rule would have a disparate impact on lower income women who do not have the financial means to pay for an abortion. The Proposed Rule fails for these additional reasons.

Conclusion

NYSDFS strongly urges HHS to reconsider adopting this unconstitutional, unlawful, unreasonable, discriminatory, and impermissible Proposed Rule. Women must have access to medical services to ensure their health, well-being, and gender equality. The federal government may not infringe on the independent sovereignty of the states and the states must be accorded their traditional and Congressionally recognized power over the regulation of health insurance business within their borders. The Proposed Rule unlawfully and impermissibly attempts to curtail womenôs rights and powers of the state. It should not be adopted.

We appreciate the Departmentôs consideration of these comments.

Very truly yours,



Maria T. Vullo
Superintendent of Financial Services

Exhibit 66

March 27, 2018

VIA ELECTRONIC TRANSMISSION

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

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

Dear Secretary Azar and Director Severino:

Planned Parenthood Federation of America (Planned Parenthood) and Planned Parenthood Action Fund (the Action Fund) submit these comments in response to the Protecting Statutory Conscience Rights in Health Care; Delegation of Authority, released by the Department of Health and Human Services (the Department) Office for Civil Rights (OCR) and Office of the Secretary on January 19, 2018 and published in the federal register on January 26, 2018. As a trusted women's health care provider and advocate, Planned Parenthood takes every opportunity to weigh in on policy proposals that impact the communities we serve across the country.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States. Each year, Planned Parenthood's more than 600 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted diseases (STDs), and other essential care to 2.4 million patients. We also provide abortion services and ensure that women have accurate information about all of their reproductive health care options. One in five women in the U.S. has visited a Planned Parenthood health center. The majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level (FPL).

As a health care provider, Planned Parenthood knows how important it is that people have access to quality health care and information they can trust. Already, too many people in this country are denied, often without realizing it, access to medically-appropriate information and care because of a health care provider's or employer's personal beliefs. Instead of protecting

patients' access to quality care, this rule -- if finalized -- would make it easier for health care workers to refuse care, disproportionately impacting women, LGBTQ people, people with low incomes, people from rural areas, and other people already experiencing barriers to care. Importantly, the proposed rule goes beyond the reach of the statutes the Department claims to be implementing, undermining the intent of the statutes and exceeding the authority given by Congress. Further, as outlined below, the proposed rule potentially conflicts with existing civil rights statutes and state laws, and it fails to adequately account for costs.

Indeed, this proposed rule is unprecedented in its reach and harm, seeking to allow almost any worker in a health care setting to refuse services and information to a patient because of personal beliefs, which notably would include "religious, moral, ethical, or other reasons."[1] This means that under this proposed rule, a pharmacist could refuse to fill a prescription for birth control or antidepressants, a woman could be denied life-saving treatment for cancer, or a transgender patient could be denied hormone therapy. And while the proposed rule purports to be protecting the conscience rights and "personal freedom" of health care workers "with a variety of moral, religious, and philosophical backgrounds," it selectively ignores the many workers who are prevented from following their conscience by *restrictions* on care imposed by their employers.

The Department has an obligation to follow parameters established by Congress and aim for equality in health care access across the country, including for women, LGBTQ people, and people living with HIV. To this end, the Department must withdraw this proposed rule.

I. The proposed rule would endanger patients and obstruct their access to health care.

The proposed rule reflects bad public health policy. Women -- particularly women of color and women living in rural areas -- LGBTQ people, and people living with HIV already experience barriers to care, and this proposed rule would further limit health care access and result in poor health care outcomes. The proposed rule will also interfere with the ability of patients and providers to make informed medical decisions. Notably, the proposed rule does not provide any exceptions for necessary care in the case of an emergency.

A. The proposed rule would exacerbate existing barriers to health care.

The rule would erect more barriers to reproductive health care, transition-related services, and other services, and place women, LGBTQ people, and people living with HIV at greater risk of not getting the services they need. Access to comprehensive reproductive health care, including abortion, is already limited. According to a recent report, nearly half of the women of reproductive age have to travel between 10 to 79 miles, and some women have to travel 180 miles or more, to access an abortion.[2] Importantly, the proposed rule improperly expands upon

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3923 (Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88).
[2] J. Mearak, et. al., Disparities and change over time in distance women would need to travel to have an abortion in the USA; spatial analysis, The Lancet (Nov. 2017), http://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30158-5.pdf.

existing refusal laws and policies that already harm an untold number of people, who are often denied information and care.

It is already the case that women with pregnancy complications who seek care at religiously-affiliated hospitals have been denied information or abortion care, even when that information is critical to their health. An often-cited case is that of Tamesha Means, who was rushed to Mercy Health Partners in Muskegon, Michigan after her water broke at 18 weeks of pregnancy. She was sent home twice in excruciating pain despite the fact that there was no chance that her pregnancy would survive and that continuing the pregnancy posed significant risks to her health. Due to the hospital's religious affiliation, Ms. Means was not informed that terminating her pregnancy was the safest course for her condition, and therefore her health was put at risk.[3] Another woman, Mikki Kendall, went to an emergency room after experiencing a placental abruption. Even though her pregnancy would not survive and Ms. Kendall could have died due to the amount of blood loss, the doctor on call refused to perform an abortion and refused to contact another physician to perform the procedure. Fortunately, Ms. Kendall was able to receive the care she needed after several risky and agonizing hours.[4] Unfortunately, many people are not even aware that they may be denied medically-appropriate care and information, even in emergency situations. For instance, nearly 40 percent of the people who regularly visit Catholic hospitals do not know of the religious affiliation, and even patients that are aware of the affiliation frequently do not know the hospital refuses to provide certain services.[5]

Certain communities are particularly affected by denials of care. Health care refusals disproportionately impact Black women, and the expansions outlined in this proposed rule would likewise disproportionately impact Black women. For example, according to a recent report, hospitals in neighborhoods that are predominately Black are more likely to be governed by ethical and religious directives for Catholic health care services.[6] Additionally, people living in rural areas are significantly impacted if their provider refuses to provide necessary or preventive care. Women living in in rural areas already experience provider shortages and have to travel long distances for health care, resulting in significant gaps in care and low health outcomes.[7] By making it easier for providers to refuse care, the proposed rule would further restrict these options or cut off access to care altogether, which would compromise patient health still further.

The proposed rule also threatens access to transition-related services and HIV prevention and care -- including pre-exposure prophylaxis -- disproportionately impacting LGBTQ people and

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[3] ACLU, Tamesha Means v. United States of Catholic Bishops (June 30, 2015), https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops.

[4] Mikki Kendall, Abortion Saved my Life, Salon (May 26, 2011), https://www.salon.com/2011/05/26/abortion_saved_my_life/. .

[5] *Id.*

[6] K. Shepherd, et. al., Bearing Faith: The Limits of Catholic Health Care for Women of Color, Columbia Law School (January 2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf?mc_cid=51db21f500&mc_eid=780170d2f0.

[7] The American College of Obstetricians and Gynecologists, Health Disparities in Rural Women (2014, reaffirmed 2016), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20160402T0931414521.

people living with HIV. Discrimination in health care settings already prevents LGBTQ people from accessing the care they need. For instance, nearly one-third of transgender people surveyed said a doctor or health care provider refused to treat them due to their gender identity.[8] Related, people living with HIV frequently experience stigma in the health care system.[9] The proposed rule would increase this stigma and make it more likely that these communities are denied necessary health care.

B. The proposed rule will hinder the delivery of care.

While the Department claims that the proposed rule will "facilitat[e] open communication between providers and their patients," in fact, it would do the opposite. Specifically, the proposed rule encourages medical professionals to conceal information if they believe that information might enable a patient to seek care (even elsewhere) of which they disapprove. It also inhibits communication by increasing the risk that *patients* will conceal medically relevant information, such as sexual orientation, out of fear that their provider would refuse them care.

The proposed rule itself notes that mainstream medical groups have recognized the negative effects refusing care can have on patients and that these organizations have called for patient protections when refusals may compromise health. For example, the American Congress of Obstetricians and Gynecologists (ACOG) ethics opinion states that "in an emergency in which referral is not possible or might negatively affect patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."[10] The American Medical Association's (AMA) constitution and bylaws similarly note that physicians are required to be "moral agents" and "being a conscientious medical professional may well mean at times acting in ways contrary to one's personal ideals in order to adhere to a general professional obligation to serve patients' interests first." The constitution and bylaws further state that "having discretion to follow conscience with respect to specific interventions or services does not relieve the physician of the obligation to not abandon a patient."[11] The proposed rule would exacerbate these concerns by making it harder for medical organizations and providers to preserve existing access to reproductive health care.[12]

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[8] S. Mirza & C. Rooney, Discrimination Prevents LGBTQ people from Accessing Health Care, Ctr. for Amercian Progress (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[9] CDC, HIV Among Gay and Bisexual Men, https://www.cdc.gov/hiv/group/msm/index.htm; CDC, HIV Among African-Americans, https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-aa-508.pdf.

[10] 83 Fed. Reg. at 3888; ACOG, The Limits of Conscientious Refusal in Reproductive Medicine (Nov. 2007, reaffirmed 2016), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine.

[11] American Medical Association, Physician Exercise of Conscience: Report of the Council on Ethical and Judicial Affairs, https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/i14-ceja-physician-exercise-conscience.pdf.

[12] By ignoring these harms, the Department has failed in its obligation to acknowledge and consider the impact of a proposed rule on family well-being. *See* 83 Fed. Reg. at 3919.

C. The proposed rule does not include exceptions for medical emergencies and potentially conflicts with existing federal law.

The proposed rule could endanger women's lives because it fails to make sure that the protections of the Emergency Medical Treatment and Active Labor Act (EMTALA) apply and take precedence when a patient is facing a medical emergency. EMTALA requires virtually every hospital to provide an examination or treatment to individuals that come into the emergency room, including care for persons in active labor, and the hospital must provide an appropriate transfer if the hospital cannot stabilize the patient.[13] The proposed rule does not address EMTALA and the potential legal conflict between that Act and the proposed rule. In particular, it is unclear if the Department or a state or local government would be considered to have engaged in prohibited "discrimination" if it penalized a hospital for failing to comply with EMTALA when a pregnant woman needs an abortion in an emergency situation.[14] There is no dispute that some pregnant women develop serious medical complications for which the standard treatment is pregnancy termination.[15] The proposed rule's silence on medical emergencies could create confusion among health care institutions or even allow them to refuse to comply with existing federal requirements to treat patients with medical emergencies and thereby endanger women's lives.[16]

II. The proposed rule exceeds the authority granted under the underlying statutes.

While purporting to interpret long-standing statutes, the Department is expanding the requirements of the statutes beyond what Congress intended. The Department claims that it is seeking to clarify the scope and application of existing laws, but this rule would in fact drastically alter, not clarify, existing requirements. The Department both creates expansive definitions that did not exist before and reinterprets the provisions of the underlying laws in harmful ways.

A. The proposed rule expands the definition of various terms beyond their well-settled meanings and beyond congressional intent.

The proposed rule expands the definitions of well-settled terms used in the relevant refusal laws far beyond their commonly understood meanings, defining terms so broadly as to encompass a

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[13] 42 U.S.C. § 1395dd.

[14] The government can clearly take such action under Title VII. *See* Shelton v. Univ. of Med. & Dentistry of N.J. 223 F.3d 220, 228 (3d Cir. 2000).

[15] See *e.g.*, *Planned Parenthood v. Casey*, 505 U.S. 833, 880 (1992) ("[It is undisputed that under some circumstances each of these conditions [preeclampsia, inevitable abortion, and premature rupture of membrane] could lead to an illness with substantial and irreversible consequences.").

[16] Federal abortion policy generally has recognized the need to protect women's lives. *See e.g.*, 18 U.S.C. § 1531(a) (prohibiting abortion procedure except where "necessary to save the life of a mother"); 10 U.S.C. § 1093 (banning almost all abortion services at U.S. military medical facilities, and prohibiting Department of Defense funds, which includes health insurance payments under Civilian Health and Medical Program for the Uniformed Services, from being used to perform abortions, "except where the life of the mother would be endangered if the fetus were carried to term"); Consolidated Appropriations Act, 2017, Pub. L. No. 115-131, Title V §§ 507 131 Stat. 135 (2017) (prohibiting that funds appropriated under the Act be used to pay for an abortion except where, among other narrow exceptions, "where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed").

ridiculously wide array of activities that go well beyond congressional intent. As an initial matter, although the Department purports to be bringing the refusal laws in line with other civil rights laws, the rule proposes to define "discrimination" contrary to how it is has been long understood in those laws. Under the Department's proposed rule, "discrimination" is more broadly defined to include a large number of activities, including denying a grant, employment, benefit or other privilege, as well an unspecified catch-all phrase "any activity reasonably regarded as discrimination." It also includes any laws or policies that would have the effect of defeating or substantially impairing accomplishment of a "health program or activity." The term, "health program or activity" is then defined to include, among other things, "health studies, or any other services related to health or wellness whether directly, through payments, grants contracts, or other instruments, through insurance, or otherwise."[17] The inclusion of any impairment of a "health program or activity," as defined, only adds to an unreasonably expansive definition of "discrimination" that could be applied to anything with a tangential connection to health or wellness. As set forth below, the rule's all-encompassing definition of "discrimination" fails to account for established anti-discrimination law that reflect a balancing of interests -- protecting against religious discrimination but recognizing it is not discriminatory to require an employee to perform functions that are essential to the position for which she applied and was hired.

The proposed rule also improperly stretches the definition of "refer" to include providing "any information … by any method … that could provide any assistance in a person obtaining, assisting, training in, funding, financing, or performing a particular health care service, activity or procedure."[18] This means that any health care entity, including both individuals and institutions, could refuse to provide any information that could help an individual to get the care they need, including even to provide patients with a standard pamphlet. The objecting entity would be able to refuse to provide that information even if they believe that a particular health care service is only the "possible outcome of the referral."[19] This definition would allow health care providers to deny patients full, accurate, and comprehensive information on health care options that allow people to make their own health care decisions.

The proposed rule also defines "assist in the performance of" far more broadly than its common meaning, to include participating in any program or activity with "an articulable connection" to a procedure, health service, health program, or research activity. The proposed rule specifically notes that this includes *but is not limited to* counseling, referral, training, and other arrangements.[20] Even though the Department claims to acknowledge "the rights in the statutes are not unlimited," this definition could in effect create an unlimited right to refuse services. For example, it is unclear if an employee whose task it is to mop the floors at a hospital that provides abortion would be considered to "assist in the performance" of the abortion under this proposed rule. A definition this limitless provides no functional guidance to health care providers as to what they can ask of their employees, and the refusals permitted by health care providers and non-medical staff.

The proposed rule also broadens the health care workers that can claim "discrimination," potentially allowing a range of health care workers not directly involved in delivering care to

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[17] 83 Fed. Reg. at 3924.
[18] Referral is defined far more narrowly elsewhere in federal law. *See, e.g.*, 42 U.S.C. § 1395nn(h)(5); 42 C.F.R. § 411.351.
[19] 83 Fed. Reg. at 3924.
[20] 83 Fed. Reg. at 3923.

refuse to perform their duties at a health care facility. Specifically, the proposed rule seeks to expand the definition of "health care entity," "individual," and "workforce" to include a broad range of workers and organizations, including volunteers, trainees, and contractors.[21] The proposed rule notes that the workers included in the definitions are illustrative and not exhaustive, potentially creating the opportunity for non-medical personnel, such as receptionists or facilities staff, to refuse to perform job tasks. In particular, the notion that an individual who agrees to volunteer to perform a service for an entity has the right to then refuse to perform that service, but presumably without losing his or her status as "volunteer," is absurd. This nonsensical interpretation of the statutes exceed the Department's regulatory authority. In short, if this provision is finalized, a wide range of workers may be able to deny access to care - even if the worker's job is only tangentially related to that care.

The proposed rule also seeks to expand the health care providers and institutions that are subject to the rule's burdensome requirements. The proposed rule's broad definition of "entity" to include individuals as well as corporations, would greatly expand the individuals and institutions subject to the underlying laws' requirements.[22]

In general, the proposed rule's unreasonably expansive definitions could inhibit health care providers and institutions from offering a broad range of health care services to patients, and would ultimately limit patients' access to care. This is particularly so because in addition to expanding the terms used in the refusal laws beyond any possible meaning Congress intended, the Department has also expanded the substance of the refusal laws beyond their statutory text, as is discussed below. Thus, rather than clarify statutes that are as much as forty-years old, the proposed rule has stretched the meaning of key terms. This will lead to illogical, unworkable, and unlawful results.

B. The Department broadly interprets the Church Amendments in violation of the statute.

The Department is exceeding its statutory authority by interpreting the Church Amendments far beyond what Congress intended. Each provision of the Church Amendments was enacted at a different point in time to address specific concerns. The first two provisions of the Church Amendments were enacted in 1973 during the public debate following the *Roe v. Wade* decision, and they clarify that receipt of certain federal funds does not require a health care entity to perform abortions or sterilizations or make its facilities available for abortions or sterlizations.[23] These provisions of the Church Amendments, codified at 42 U.S.C. § 300a-7(b) and (c)(1), permit individuals to refuse to perform or assist in the performance of a sterilization or abortion in certain federally funded programs if it is contrary to their religious or moral beliefs. Sections (d) and (e) of the Amendments were passed as a part of the National Research Act, which aimed at funding biomedical and behavioral research, and ensuring that research projects involving human subjects were performed in an ethical manner. [24] The Department's purported

[21] 83 Fed. Reg. at 3923–3924.
[22] 83 Fed. Reg. at 3924.
[23] The implicated funds are the Public Health Service Act [42 U.S.C. § 201 *et seq*.], the Community Mental Health Centers Act [42 U.S.C. § 2689 *et seq*.], and the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C. § 6000 *et seq*.].
[24] See 119 Cong. Rec. 2917 (1973).

interpretation of these provisions goes far beyond both the statutory text and Congressional intent in at least two ways.

First, section (b) of the Church Amendments states that courts, public officials, and public authorities are not authorized to require the performance of abortions or sterilizations, *based on the receipt of* any grant, contract, loan, or loan guarantee under the Public Health Service Act (PHSA), the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act. The proposed rule goes beyond the text of the statute and interprets it to prohibit public authorities from *requiring any individual or institution* to perform these services if they receive a grant, contract, loan or loan guarantee under the PHSA. Therefore, while the Church Amendments only make it clear that public authorities are not allowed to require the performance or assistance in the performance of abortion or sterilization based on the receipt of certain federal funding, the proposed rule imposes a blanket prohibition on any requirements related to individuals or institutions performing or assisting in the performance of abortion and sterilization if the institution or individual receives the specified funding. Combined with the expanded definition of "assist in the performance" that impacts sections (b)(1) and (b)(2)(B), the proposed rule allows for denials of services related to abortion and sterilization by both individual providers and those ancillary to the provision of health care. It could also prevent states and the federal government from requiring a hospital to provide an abortion, even if a patient's health or life is threatened.

Second, the proposed rule interprets section (d) of the Church Amendments in a way that goes well beyond the statute and that has the potential to allow any individual employed at a vast number of health care institutions to refuse to provide care that is central to the institution. Importantly, this provision was intended to apply only to individuals who work for entities that receive grants or contracts for biomedical or behavioral research. The proposed rule incorrectly claims that paragraph (d) of the Church Amendments is not based on receiving specified funding through a specific appropriation, instrument, or authorizing statute, but applies to "[a]ny entity that carries out any part of a health service program or research activity funded in whole or in part under a program administered by" the Department.[25]

The expansive definitions of "entity," "health service program" and "assist in the performance" only serve to exacerbate this unlawful expansion. As noted, "entity" is defined broadly in the proposed rule to include a "'person', as defined in 1 U.S.C. 1 or a State, political subdivision of any State, instrumentality of any State or political subdivision thereof, or any public agency, public institution, public organization, or other public entity in any State or political subdivision of any state." "Health service program" is discussed by the Department in the proposed rule as not only including programs where the Department provides care or health services directly, but programs administered by the Secretary that provide health services through grants, cooperative agreements or otherwise; programs where the Department reimburses another entity to provide care; and "health insurance programs where Federal funds are used to provide access to health coverage (e.g. CHIP, Medicaid, Medicare Advantage)." It also may include components of State or local governments.[26]

Thus, under the proposed rule, virtually any individual could refuse to provide any type of health care or any job task that has a minimal connection to the provision of health care. This provision

[25] 83 Fed. Reg. at 3925.
[26] 83 Fed. Reg. at 3894.

would not only allow individuals to refuse to provide any type of care that they object to, but could also prevent states from protecting patients by requiring the provision of health care or fulfillment of other job duties by individuals in a medical facility. This could include, for instance, enforcing a state law that requires individual pharmacists to fill all the prescriptions they receive.

Nothing in the legislative history of section (d) of the Church Amendments suggests that this provision was meant to restrict the actions of this broad range of health care related individuals and organizations, nor that it was meant to apply to these individuals and institutions in the context of such a broad range of health-related programs.[27] The Department has clearly exceeded its statutory authority by attempting to create a catch-all provision that would allow almost any health care provider in the country to refuse to provide services based on a 40-year old law that was targeted to the receipt of specific, and limited, federal funds.

C. The Department's interpretation of the Weldon Amendment is not consistent with the plain language of the statute.

The Department has proposed a similarly broad -- and impermissible -- expansion of the Weldon Amendment. That amendment was added to the appropriations bill for the Departments of Labor, Health and Human Services, and Education in 2004 and each subsequent appropriations bill. It prohibits funds appropriated by those three agencies to be provided to a federal agency or program, or to a state or local government, if such agency, program, or government requires any institutional or individual health care entity to provide, pay for, provide coverage of, or refer for abortions.[28] While the text of the statute is limited to state and local governments and federal agencies or programs, the rule would apply the Weldon Amendment to "any entity that receives funds through a program administered by the Secretary or under an appropriations act [HHS]."[29] This interpretation of the Weldon Amendment would impermissibly turn private entities into "federal agencies or programs" by virtue of their receipt of HHS funding.

In addition to conflicting with the plain meaning of the statute, the Department's broad interpretation is also contrary to the legislative history of the Weldon Amendment. During final floor debates on the appropriations bill that included the first Weldon Amendment, one of its supporters explained: "The addition of conscience protection to the Hyde amendment remedies current gaps in Federal law and promotes the right of conscientious objection by forbidding federally funded government bodies to coerce the consciences of health care providers."[30] In other words, the Weldon Amendment's reference to "federal agency or program" was intended as a restriction on government bodies only, not on private entities that receive federal funds.

Indeed, the Department of Justice (DOJ) has taken the formal position that the receipt of federal funds does not mean that an organization is a federal agency or program. In litigation, the DOJ stated: the term "federal agency or program" does not automatically include private, individual family planning clinics that receive federal funds; the Weldon Amendment does not clearly

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[27] Indeed, section (d) of the Church Amendments does not by its terms impose any restrictions on health care providers. Rather, it is framed as an exemption to individuals from certain federal requirements that are contrary to their religious or moral beliefs. 42 U.S.C. § 300a-7(d).

[28] Weldon Amendment, Consolidated Appropriations Act 2017, Pub. L. 115-31, Div. H, Tit. V, Sec. 507(d).

[29] 83 Fed. Reg. at 3925.

[30] 150 Cong. Rec. H10095 (daily ed. Nov. 20, 2004) (statement of Rep. Smith) (emphasis added).

provide that an individual Title X clinic would constitute a "federal agency or program" covered by the statute, and "no agency responsible for the implementation or enforcement of the statute has adopted a reading to that effect."[31] If Congress intended for the Weldon Amendment to apply to virtually every private hospital, pharmacy, and outpatient care center in the country, and hundreds of thousands of private doctors and other health care practitioners, it surely would have said so more directly, either at the time the Weldon Amendment was enacted or in the 14 years that the amendment has been interpreted otherwise.

The unreasonably broad definitions of "discrimination" and "health care entity" also act to greatly expand the reach of the Weldon Amendment. By defining discrimination to include any adverse actions without any balancing of the interests of employers or patients, this provision could be used to attempt to strike down neutral state laws that protect access to health care. The term, "health care entity" is already defined in the Weldon Amendment, so a proposal to add certain entities via regulation clearly exceeds the authority of the Department. For example, the inclusion of "a plan sponsor, issuer, or third party administrator" expands the reach of the provision by allowing employers that provide health insurance (even if they have no connections to health care) to become "health care entities" for purposes of this protection from "discrimination."

Finally, the legislative history cited above makes it clear that the Weldon Amendment was intended to be limited to objections based on conscience, but under the proposed rule, the Department would allow refusal for *any* reason, including, for example, a financial one. All of these expansions are contrary to law and, more importantly, work to deny women access to information about and access to lawful medical services.

D. The Department similarly expands the applicability of the Coats Amendment.

The proposed rule's broad definitions of "health care entity," "refer," and "discrimination" would also expand the applicability of the Coats Amendment beyond its statutory language and intent. The Coats Amendment was adopted in 1996 in response to a new standard adopted by the Accrediting Council for Graduate Medical Education, requiring all obstetrics and gynecology residency programs to provide induced abortion training.[32] Senator Coats offered the amendment to "prevent any government, Federal or State, from discriminating against hospitals or residents that do not perform, train, or make arrangements for abortions."[33]

The amendment prohibits the federal government, or any state or local government that receives federal financial assistance, from discriminating against medical residency programs or individuals enrolled in those programs based on a refusal to undergo, require, or provide abortion training.[34] Under the Coats Amendment, the term "health care entity" is limited to "an individual physician, a postgraduate physician training program, and a participant in a program

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[31] Brief of Respondent, *NFPRHA v. Gonzales*, 391 F.Supp.2d 200 (D.D.C. 2004) (No. 04-2148).

[32] *See* 142 Cong. Rec. 5159 (March 19, 1996) (Senator Frist stating that "this amendment arose out of a controversy over accrediting standards for obstetrical and gynecological programs").

[33] 142 Cong. Rec. 4926 (March 14, 1996). *See also* 142 Cong. Rec. 5158 (March 19, 1996) (Senator Coats stating he offered the language in the bill because "it is [not] right that the Federal Government could discriminate against hospitals or ob/gyn residents simply because they choose, on a voluntary basis, not to perform abortions or receive abortion training, for whatever reason.").

[34] *See* 42 U.S.C. § 238n.

of training in the health professions."[35] However, the proposed rule's definition of health care entity would prohibit "discrimination" not just against those specified in the Coats Amendment, but also against other health care professionals, health care personnel, an applicant for training or study in the health professions, a hospital, a laboratory, an entity engaging in biomedical or behavioral research, a health insurance plan, a provider-sponsored organization, a health maintenance organization, a plan sponsor, issuer, third-party administrator, or any other kind of health care organization, facility or plan. Similar to the proposed rule's changes to the Weldon Amendment, the Department has taken a narrow statute that was enacted to address a specific concern and used the proposed rule to promote broader discrimination in health care.

III. The proposed rule would undermine health care access in programs that Congress intended to expand care for women with low incomes and their families.

The proposed rule would impact health care programs, both domestically and internationally, that are intended to expand access and quality of care for women, people with low incomes, people living with HIV, and others. The expanded scope of the rule would reach both the Title X Family Planning Program (Title X) and the President's Emergency Plan for AIDS Relief (PEPFAR).

A. The Department's proposal would reduce access to vital services through Title X and other programs by allowing objectors to ignore their general requirements contrary to the intent of these programs.

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 funds are generally conditioned. We find this 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 people with low-incomes. 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 objective of expanding access to reproductive health care to underserved communities.

Several of the Department's proposed provisions and definitions appear to exempt recipients of federal funds from following the rules that govern federal programs if they have an objection to doing so. As discussed above, the proposed rule's expansion of the Weldon Amendment turns private entities into "federal agencies or programs" and then bars them (as well as the Department) from "discriminating" against a "health care entity" based on its refusal to provide "referrals" for abortion.[36] "Discrimination" includes, among other things, denying federal awards or sub-awards to objectors.[37] Similarly, the proposed rule provides that the Department cannot require recipients of grants provided under the Public Health Service Act to "assist in the performance of an abortion."[38] Such "assistance" includes an unreasonably broad range of conduct, including "counseling, referral, training, and other arrangements." Also, the proposed rule provides that entities receiving Public Health Service Act grants cannot be required to

[35] 42 USC § 238n(c)(2).
[36] 83 Fed. Reg. at 3925.
[37] 83 Fed. Reg. at 3923–3924.
[38] 83 Fed. Reg. at 3925.

provide personnel for "the performance or assistance in the performance of any . . . abortion;" the overbroad definition of "assistance" again applies here.[39]

Federal agencies routinely provide financial assistance to eligible entities in the form of grants, contracts, or other agreements in exchange for the performance of a prescribed set of services or activities. The Department's approach would seem to give objectors a virtually unlimited right to ignore these generally applicable requirements and may even force the Department to fund entities that refuse to advance the fundamental goals of the programs in which they seek to participate. Nowhere in the proposed rule does the Department acknowledge that its exemptions in these areas would allow conduct that conflicts with pre-existing legal requirements. Nor does it consider how overriding these rules could undermine important health care objectives that are central to the effective administration of federally supported health programs.

The proposed rule's defects come into clear focus in the context of Title X, the nation's program for birth control and reproductive health. Title X of the Public Health Service Act empowers the Department to make grants to public and not-for-profit entities for the purpose of providing confidential family planning and related preventive services.[40] Title X gives priority to services for people with low incomes and, depending on their income and insurance status, patients may be eligible for free or discounted Title X services.[41] In 2016, Title X-funded providers served over 4 million people.[42] This total includes a disproportionate share of individuals from groups that face longstanding racial and ethnic inequities; for example, 32 percent of Title X patients identified as Hispanic or Latino, and 21 percent identified as Black in 2016.[43] Title X-funded projects offer a range of reproductive health care and information, including counseling and services related to a broad range of contraceptive methods, HIV/STI services, cancer screenings, and other care.

The Department's proposal appears to sanction conduct that would interfere with Title X's legal requirements. For example, although Title X funds are barred from going toward abortion, the program's regulations expressly require providers to offer non-directive options counseling to patients, including abortion counseling and referrals upon request.[44] Even before its codification in regulation, longstanding Departmental interpretations held that non-directive options counseling was a basic and necessary Title X service.[45] The centrality of non-directive options counseling in Title X is reinforced every year through legislative mandates in annual appropriations measures.[46] These prescriptions reflect well-settled principles of medical ethics: patients are entitled to prompt, accurate, and complete information to enable them to make informed decisions about their health. And, especially when an entity does not offer a desired

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[39] 83 Fed. Reg. at 3925.
[40] 42 U.S.C. §§ 300 - 300a-8.
[41] 42 U.S.C. § 300a–4(c).
[42] Christina Fowler, et al., RTI International, *Family Planning Annual Report: 2016 national summary* (2017), available at https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.
[43] *Id*.
[44] 42 U.S.C. § 300a-6 (prohibiting funding for abortion); 42 C.F.R. § 59.5(a)(5) (requiring non-directive options counseling and referral).
[45] *See* Comptroller General of the United States, "Restrictions on Abortion and Lobbying Activities In Family Planning Programs Need Clarification" (Sept. 1982), available at http://www.gao.gov/assets/140/138760.pdf.
[46] *See, e.g.*, Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, 131 Stat 135 (2017).

service such as abortion, health professionals have a responsibility to provide the information and referrals needed to ensure that such services are provided to patients in a timely and competent manner. Yet, under the proposal, entities that object to "assist[ing] in the performance of abortion" could claim a right to refuse to offer non-directive options counseling and referrals to Title X patients.

On top of interfering with counseling and referrals under Title X, the proposed rule could also override other program requirements. For instance, Title X requires projects to provide medical services, including "a broad range of acceptable and effective medically approved family planning methods."[47] This unquestionably includes long-acting reversible contraceptive methods such as intrauterine devices (IUDs). The central place of IUDs, which are exceptionally effective, in the family planning repertoire is cemented by the Centers for Disease Control and Prevention's (CDC) Quality Family Planning recommendations. These recommendations provide, for example, that "[c]ontraceptive services should include consideration of a full range of FDA-approved contraceptive methods," and a "broad range of methods, including long-acting reversible contraception (i.e., intrauterine devices [IUDs] and implants), should be discussed with all women and adolescents."[48] Despite these national clinical standards of care, some individuals are opposed to contraception or certain forms of contraception, and under the proposed impermissible expansion of Church (d) discussed above, any individual working for an entity participating in Title X could claim a right to refuse to provide information or services related to contraception for Title X patients.

If allowed by the Department, such exemptions not only would overtake pre-existing legal rules, but could also thwart the critical health care objectives that federal programs are meant to advance. For example, Congress's purpose in passing Title X was, in part, "to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services," and "to enable public and nonprofit private entities to plan and develop comprehensive programs of family planning services."[49] Permitting health care entities to withhold vital counseling, referrals, and services is hardly conducive to the "comprehensive" approach that was contemplated by Congress. In practical terms, such policies could cut off access to basic, preventive health care and information for the low-income and uninsured people who turn to Title X-funded providers.

Since the inception of these important public health programs, entities that do not want to provide the required services are free to decline to participate. All recipients of federal funds, however, should be bound by the same, general requirements and serve the same priorities in order to serve program beneficiaries and faithfully adhere to Congress's aims.

B. The proposed rule would severely undermine the purpose and effectiveness of U.S. funded health programs around the world.

The Department's global health programs include those focused on combating HIV/AIDS and malaria, improving maternal and child health, and enhancing global health security. In addition

[47] 42 C.F.R. § 59.5(a)(1).
[48] Centers for Disease Control and Prevention, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, 7, 8, (2014), available at https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.
[49] Act of Dec. 24, 1970, Pub. L. No. 91-572, § 2, 84 Stat. 1504 (1970).

to funds directly appropriated to the Department for global health, considerable funding is transferred to the Department by the State Department and USAID to administer global AIDS programs under PEPFAR.

We strongly oppose the statutory prohibition on the use of foreign aid funding for abortion as a method of family planning, known as the Helms Amendment, both as it is written and the broader manner in which it is applied, and the broad and harmful refusal provision contained within the statute governing PEPFAR, which are both cited in the proposed regulation.[50] The Helms Amendment effectively coerces women into continuing unwanted pregnancies because the health care they are able to access is provided with U.S. funding. The outcome of this harmful policy is increased unwanted pregnancies and maternal morbidity and mortality.

PEPFAR's statutory refusal provision, which applies only to organizations, already puts beneficiaries at risk and undermines the overall program. For example, this restriction allows PEPFAR-participating organizations to refuse to provide condoms (or any other service to which they object) or even information about condoms to people served by the program -- despite the fact that the purpose of the program is to combat HIV/AIDS and condom provision is proven to be an essential component of effective HIV prevention programs. Organizations may even refuse to coordinate their activities or have any other relationship with programs that provide the services or information to which they object, creating a serious barrier to ensuring that the full range of HIV prevention, care, and treatment activities are available in any one community or to any individual client.

The proposed rule would go even further than the statutory refusal provision and under the guise of paragraph (d) of the Church Amendments allow any individual working under global health funds from the Department (whether the funds are from direct appropriations or transferred from another agency and then administered by the Department) to refuse to perform or assist in any part of a health service program. As explained above, this expansion of Church (d) is contrary to Congress' intent in enacting this provision. The result is to magnify the harm of PEPFAR's refusal provision by appearing to allow individuals to refuse to treat any patient if doing so would violate his or religious beliefs or moral convictions, without concern for the needs of the patient and regardless of what type of health service the patient needs -- whether it be contraception, a blood transfusion, a vaccination, condoms to prevent HIV transmission, sexually transmitted infection screenings and treatment, or even information about health care options. The proposed rule would impact a limitless array of health services.

Moreover, individuals could potentially use this broad interpretation of section (d) of the Church Amendments to pick and choose which patients to assist, making LGBTQ individuals, adolescent girls and young women, and other marginalized populations particularly vulnerable to discrimination in the provision of services. This is particularly egregious in the context of HIV/AIDS programs where these communities face elevated risk in many parts of the world. In developing countries where health systems are especially weak, there is a shortage of available health care options and supplies, and individuals often travel long distances to obtain the services that they need; it is particularly critical that individual health care providers do not deny patients the information and services that they need. Such action undermines the purpose of the programs and the rights of those they intend to serve.

[50] 83 Fed. Reg. at 3926–3927.

Furthermore, the proposed rule does not refer or defer to any but a small set of federal provisions governing U.S. foreign policy and foreign assistance, or to the agencies entrusted to set this policy. This could create confusion or even conflict with existing laws and policies, which may differ, for example, across PEPFAR implementing agencies and departments.

Finally, we are deeply concerned that the proposed rule defines recipient and subrecipient as including foreign and international organizations, including agencies of the United Nations. There are likely unique and severe compliance and certification burdens on international recipients and subrecipients, including, but not limited to with regard to translation and conflict with local law and policy. The proposed rule may directly conflict with the laws and policies of other countries where global health programs operate, putting those implementing the global health programs in an untenable position. For example, some countries may require health care providers to provide necessary care in emergency situations or information or referral for all legal health services - requirements that would be in direct conflict with this proposed regulation. The application of these requirements to UN agencies, such as the World Health Organization (WHO) with whom the Department works on issues like measles and polio, may be wholly unworkable given their missions and structures and could completely jeopardize the ability of these agencies to partner with the Department.

V. The proposed rule would cause chaos and confusion as it is inconsistent with federal and state laws designed to prohibit discrimination and increase people's access to care.

The Department claims that it is creating a regulatory scheme that is "comparable to the regulatory schemes implementing other civil rights laws." First, the proposal does not warrant the broad enforcement authority delegated to the newly created division within OCR. The proposed rule and underlying statutes are not civil rights laws, and the proposed rule seeks to grant OCR the authority to take enforcement actions. Further, the proposed rule is not consistent with civil rights laws as it fails to provide covered entities due process protections afforded under Title VI of the Civil Rights Act (Title VI). Finally, the proposed rule would create confusion as to the interaction with existing federal and state laws. In particular, the proposed rule does not explain how it interacts with Title VII of the Civil Rights Act (Title VII) and it undermines states' ability to require care.

A. The proposed rule provides expanded enforcement authority to OCR, while at the same time lacking necessary due process protections, such as those provided by Title VI.

While the proposed rule purports to model itself after "the general principles . . . enshrined in Title VI of the Civil Rights Act (Title VI)," it includes draconian enforcement provisions that are wildly out of sync with those in Title VI. Title VI requires a four step process before a federal agency may deny or terminate a recipient's federal funds: 1) the recipient must be notified that it has been found not in compliance with the statutes and that it can voluntarily comply; 2) the recipient must be afforded an opportunity for a hearing on the record and the agency must make an express finding of failure to comply; 3) the Secretary or head of the agency must approve the decision to suspend or terminate funds; and 4) the Secretary of the agency must file a report with the House and Senate legislative committees with jurisdiction over the applicable programs that explains the grounds for the agency's decision, and the agency may not terminate funds

until 30 days after the report is filed.[51] The proposed rule affords no such procedural due process for those accused, investigated, or those found in violation of the underlying requirements. In particular, if the proposed rule were to become law as is, then a recipient could have its financial assistance withheld in whole or in part, have its case referred to DOJ, or face a range of other unspecified actions – all without the opportunity to explain or defend its actions.

Additionally, Title VI clearly requires that an agency must engage in a concerted effort to obtain voluntary compliance *before* it may begin enforcement proceedings against an entity found to be in violation.[52] Specifically, federal law states that "effective enforcement of Title VI requires that agencies take prompt action to achieve voluntary compliance in all instances in which noncompliance is found."[53] The proposed rule loosely states that "OCR will inform relevant parties and the matter will be resolved informally wherever possible," and notes that while attempting to obtain this informal compliance, OCR can simultaneous engage in a range of enforcement actions.[54] This is not consistent with Title VI as it does not require the Department to attempt to achieve voluntary compliance from an entity *before* enforcement actions are taken.

Further, no guidance is given about the actions that would trigger each enforcement mechanism. For instance, would failure to meet the rule's requirement to post a notice result in millions of dollars of funds being withheld? Can failure to certify intention to comply with the rule result in a referral to DOJ? This proposed rule seems to allow OCR unlimited discretion to choose its enforcement mechanism -- including withdrawal of all federal funding and/or a referral to DOJ within any assurance that the Department's actions are proportionate to the violation. The Supreme Court has found government overreach when Congress authorized the Department to utilize federal financial assistance to control recipients' actions. Specifically, in *National Federation of Independent Business v. Sebelius*, the Supreme Court held that Congress exceeded its authority when it authorized the Department to withhold federal financial assistance from a state's Medicaid program if the state failed to expand the program's eligibility.[55] The Court explained if the Department withheld all federal funding from a state for failing to comply with conditions attached to the funding, then States would not have a "genuine choice whether to accept the offer" for funding.[56] Such financial inducement was found to be akin to a "gun to the head."[57] Therefore, the Department does not have unbridled authority to withhold federal financial assistance, and the Department's actions must be proportionate to the violation.

The enforcement actions contemplated under the proposed rule resulting from a formal or informal complaint are all the more problematic given that the entity may ultimately not be found in violation of the proposed rule's requirements. Covered entities subject to a "compliance review or investigation" must inform any Department funding component of such review, investigation, or complaint, and for five years, the entity must disclose on applications for new or renewed federal financial assistance or Department funding that it has been the subject of a

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[51] 42 U.S.C. § 2000d-1.

[52] 42 U.S.C. § 2000d-1.

[53] 28 C.F.R. § 42.411(a).

[54] 83 Fed. Reg. at 3930.

[55] National Federation of Independent Business v. Sebelius, 567 U.S. 519, 588 (2012).

[56] *Id.* at 584.

[57] *Id.* at 582.

review, investigation, or complaint.[58] This disclosure must be done even if the compliance reviews or investigations are found frivolous or do not lead to a finding of violation. The Department can conduct compliance reviews "whether or not a formal complaint has been filed." The Department is also "explicitly authorized to investigate 'whistleblower' complaints, or complaints made on behalf of others, whether or not the particular complainant is a person or entity protected by" the refusal laws.

The Department's sweeping enforcement authority, coupled with the lack of specific guidance to covered entities about what the proposed rule would require, places an unwarranted burden upon covered entities. The proposed rule is not consistent with Title VI - in particular, the rule does not offer due process and affords the Department complete discretion to impose penalties disproportionate to actions or alleged actions.

B. The proposed rule upsets the balance for religious objection long enshrined in law by Title VII.

For more than 50 years, Title VII has provided protections against religious discrimination.[59] In defining "discrimination" in a way that can be understood as both different from and far broader than it has long been understood, the Department has both exceeded its authority and caused confusion. In particular, the proposed rule does not clearly state that "discrimination" has the same limits as it does in the context of religious discrimination under Title VII and in particular that the "reasonable accommodation/undue hardship" framework for assessing if there has been "discrimination" also applies under the proposed rule. On its face, it is unclear if the proposed rule adopts Title VII's reasonable accommodation/undue hardship standard, or rather, creates a *per se* rule that allows employees' beliefs to take precedence over the needs and interests of health care providers and their patients under any circumstance.

Under Title VII and the case law interpreting it: [A]n employer, once on notice, [must] reasonably accommodate an employee whose sincerely held religious belief, practice or observance conflicts with a work requirement, *unless providing the accommodation would create an undue hardship, . . . [meaning] that the proposed accommodation in a particular case poses a "more than de minimis" cost or burden.*[60] Court cases that have addressed the issue of religious refusal have found that there are limits to what employers must do to accommodate refusals, and specifically that it is legal and appropriate for employers to prioritize maintaining patient access to care.[61] Additionally, years of case law interpreting religious accommodation

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[58] 83 Fed. Reg. at 3929–3930.

[59] 42 U.S.C. § 2000e(j).

[60] U.S. Equal Employment Opportunities Comm'n, Section 12: Religious Discrimination, Compliance Manual 46 (2008), *available at* http://eeoc.gov/policy/docs/religion.html [hereinafter EEOC Compliance Manual] (emphasis added).

[61] *See*, *e.g.*, *Walden v. Centers for Disease Control & Prevention*, 669 F.3d 1277 (11th Cir. 2012) (The plaintiff was employed as a counselor through CDC's employment assistance program, but refused to counsel people in same-sex relationships. After she was laid off, the court held that CDC "reasonably accommodated Ms. Walden when it encouraged her to obtain new employment with the company and offered her assistance in obtaining a new position"); *Bruff v. N. Miss. Health Servs.*, 244 F.3d 495, 501 (5th Cir. 2001) (the accommodation requested by plaintiff—a counselor who refused to counsel individuals on certain topics that conflicted with her religious beliefs—constituted an undue hardship

provisions of Title VII has made clear that an accommodation should not place an unfair load on co-workers.[62] Finally, case law has made it clear that "Title VII does not require an employer to reasonably accommodate an employee's religious beliefs if such accommodation would violate a federal statute."[63] The proposed rule fails to give any consideration to this binding precedent or suggest why "discrimination" should be given any different meaning in the context of the refusal laws.

By requiring a balancing of interests between the employee, the employer, and the employer's clients, Title VII ensures that accommodating the religious beliefs of an employee in the health care field does not harm patients by denying them health care and/or health care information. Title VII also avoids placing employers in the untenable position of having employees on staff who will not fulfill core job functions. The Department has ignored that balancing, undermining its stated goal to "ensure knowledge, compliance, and enforcement of the Federal health care conscience and associated antidiscrimination laws."[64] In so doing, the Department should bear in mind that a decision not to incorporate the Title VII reasonable accommodation/undue hardship balancing would lead to absurd and disastrous results. For example, a health care provider could be forced to hire employees who refuse to be involved in medical services that form the core of the medical care it offers. The Department should also bear in mind Executive Order 13563's injunction, which as the Department notes requires it to "avoid creating redundant, inconsistent, or overlapping requirements applicable to already highly-regulated industries and sectors."

The ability of health care employers to continue providing medically appropriate services and information would be significantly compromised if they are forced to operate under a rule which could be understood to compel them to hire, retain, and/or not transfer employees who refuse to provide medically necessary health services and information to patients -- or face a possible penalty of loss of all federal funding.

C. The proposed rule limits states' authority to increase health care access for their citizens.

This rule would undermine states' ability to protect and expand health care access. States have an important role to play when addressing the harm from denials of health care. State laws that require institutions to provide information, referrals, prescriptions, or care in the event of a life or health risk are vital safeguards for individuals who might be impacted by religious refusals. The expansion of the Weldon and Church Amendments through new definitions and a

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because it would have required her co-workers to assume her counseling duties whenever she refused to do so, resulting in a disproportionate workload on co-workers); *see also Haliye v. Celestica Corp.*, 717 F. Supp. 2d 873, 880 (D. Minn. 2010) ("when an employee has a religious objection to performing one or more of her job duties, the employer may have to offer very little in the way of an accommodation—perhaps nothing more than a limited opportunity to apply for another position within the organization") (citing Bruff).

[62] *See, e.g., Tagore v. United States*, 735 F.3d 324, 330 (5th Cir. 2013) ("more than de minimis adjustments could require coworkers unfairly to perform extra work to accommodate the plaintiff"); *Harrell v. Donahue*, 638 F.3d 975, 980 (8th Cir. 2011) ("an accommodation creates an undue hardship if it causes more than a de minimis impact on co-workers").

[63] *Yeager v. First Energy Generation Corp.*, 777 F.3d 362, 363 (6th Cir. 2015).

[64] 83 Fed. Reg. at 3887.

reinterpretation of existing law could render useless any existing or future state laws that protect patients and consumers.

The Department makes it clear that there are certain types of state laws that they seek to eliminate by reinterpreting the federal refusal laws. For example, the Department clearly wants to undermine state laws that require coverage of abortion. To do so, the Department not only reverses their position on the application of the Weldon amendment, but actually changes the existing (and statutory) definition of "health care entity" so as to include plan sponsors and third party administrators. This will mean more individuals are covered under the statute. The Department has previously rejected this interpretation noting "by its plain terms, the Weldon Amendment's protections extend only to health care entities and not individuals who are patients of, or institutions, or individuals that are insured by such entities."[65]

The Department also highlights state laws that require crisis pregnancy centers to provide information or referrals, as well as state laws and previous lawsuits that seek to require the provision of health care by an institution when a patient's health or life is at risk. The Department clearly wishes to contort the federal refusal laws to address state laws that it finds objectionable. If Congress had wanted to prohibit federal, state, and local governments from ever requiring health care entities to provide, pay for, cover, or refer for abortions, it could easily have done so. The Department now reinterprets these laws to attempt to limit the reach of state laws that protect patients from harmful denials of health care, including laws that simply require referrals to another provider.

The proposed rule invites those who oppose access to reproductive health to make OCR complaints by allowing any individual to file a complaint, whether or not they are the subject of any potential violation. This may have a chilling effect on states' willingness to enforce their own laws. The uncertainty regarding whether enforcement of state laws is "discrimination," especially as to health care entities that refuse to provide medical services or insurance coverage for reasons other than moral or religious reasons, would inhibit states' ability to increase access and provide for the well-being of their citizens. The negative effects of such confusion and uncertainty in our public health care system would certainly fall disproportionately on the millions of people in this country who already experiences barriers to health care access and worse health outcomes, including but not limited to women, LGBTQ people, and people living with HIV.

VI. The proposed rule fails to properly account for the enormous costs it would impose on providers, patients, and the public.

The Department purports to have conducted an economic analysis for the proposed rule, as required by Executive Order 12866 as well as the Regulatory Flexibility Act, but that analysis is deficient in at least two respects.[66] First, and critically, the Department's analysis ignores entirely the cost to patients of reduced access to health care, fewer health care options, less

[65] Letter from Jocelyn Samuels, Director, Office for Civil Rights to Catherine Short, Life Legal Defense Foundation et. al. re: OCR Transaction Numbers: 14-193604, 15-193782, & 15-195665 (June 21, 2016), http://www.adfmedia.org/files/CDMHCInvestigationClosureLetter.pdf.

[66] That Act requires an analysis of a rule's effects on small businesses, including non-profits. The proposed rule's analysis at 83 Fed. Reg. 3918 is inadequate because as explained below it radically underestimates costs. And while the proposed rule notes that some entities are exempted from some requirements based on cost concerns, it fails to explain why those exemptions (which at any rate would not mitigate the costs described below) were so limited.

comprehensive medical information, impeded ability for patients to make their own health care choices, and interference with provider-patient relationships.[67] Also contrary to Executive Order 12866, it fails to account for how these costs are distributed, e.g. whether they will fall disproportionately on women, rural residents, individuals with low incomes, people of color, LGBTQ people, and people living with HIV. It fails to account for the public health costs associated with reduced patient access to medical information, contraception, abortion, and other reproductive health care, or delays in accessing care due to refusals. Thus, it clearly fails multiple requirements under Executive Order 12866, including the requirement that the Department analyze "any adverse effects on the efficient functioning of the economy, private markets (including productivity, employment, and competitiveness), health, safety, and the natural environment), together with, to the extent feasible, a quantification of those costs."

Second, the Department's estimate of costs that the rule imposes on health care providers is far too low. Given the new burdensome notice and attestation policies, it is unrealistic to think that health care providers -- who as of 2015, employed more than 12 million employees -- would be able to adjust all of their policies, train all of their hiring managers, and ensure and document compliance with the proposed rules, for less than $1000 the first year and less than $900 in subsequent years.[68] Moreover, the Department's cost analysis ignores entirely the enormous cost imposed on health care providers if they were required to employ people unwilling to fulfill job functions necessary to deliver care.

Therefore, the Department's estimate that the proposed rule would cost over $812 million dollars within the first five years is inadequate.[69] But even if it would *only* cost the amount estimated by the Department (which it would not), that sum could be far better used to *provide* health care to individuals and correct inequities in the health care system. While the Department claims the rule is required to "vindicate" the religious or moral conscience of health care providers, significant portions of the proposed rule have nothing to do with the Department's purported motivation. Rather, certain sections give license to HMOs, health insurance plans, or any other kind of health care organization to refuse to pay for, or provide coverage of necessary abortion services for any reason—even financial.[70] These provisions do not protect anyone's conscience, they simply undercut providers' ability to deliver care and consumers' ability to obtain and pay for medical services. The limited resources of the Department and health care providers should be better spent.

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We strongly urge the Department to withdraw this rule. In 2011, the Department withdrew a

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[67] The Department claims that the rule provides non-quantifiable benefits, such as more diverse and inclusive workforce, improved provider patient relationships; and equity, fairness, and non-discrimination. This proposed rule would in fact lead to the exact opposite of these intended benefits. While the Department claims to be protecting the psychological, emotional, and financial well-being of health care workers who refuse to provide care, the proposed rule does not mention the psychological, emotional, or financial harms to patients of well-being associated with being denied access to care.

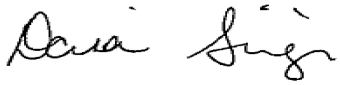
[68] Kaiser Family Foundation, State Facts: Total Health Care Employment (May 2015), https://www.kff.org/other/state-indicator/total-health-care-employment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[69] The economic analysis estimates the cost at $312 million dollars in year one alone and over $125 million annually in years two through five. And those estimates are based on "uncertain" assumptions that the costs would decrease after five years. 83 Fed. Reg. at 3902.

[70] 83 Fed. Reg. at 3925.

similar rule that was enacted in 2008 noting that the 2008 rule attempting to clarify existing laws had "instead led to greater confusion." This rule has the potential to cause even more confusion and, more egregiously, to reduce access to critical health care even more severely than the 2008 rule. It would jeopardize many people's health and lives. Planned Parenthood strongly urges the Department to follow the law and withdraw this dangerous rule.

Respectfully,



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