EXHIBIT 26

March 27, 2018

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

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

To Whom It May Concern:

I am writing on behalf of GLBTQ Legal Advocates & Defenders (GLAD) in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. GLAD is a New England-based public interest legal organization dedicated to ending discrimination based on gender identity and expression, HIV status, and sexual orientation. Every year, thousands of people reach out to GLAD through our free and confidential legal information line, GLAD Answers, to obtain information about their legal rights or to seek assistance on legal matters. GLAD regularly hears from people who are denied critical medical services or receive substandard medical care because of their gender identity and expression, HIV status, and/or sexual orientation. Everyone has the fundamental right to receive the highest attainable health care, but the proposed regulation puts that fundamental right in jeopardy, especially for lesbian, gay, bisexual, transgender, and queer (LGBTQ) people.

The proposed regulation is overly broad and will only exacerbate the discriminatory barriers LGBTQ people face when trying to access health care services. Freedom of religion is a deeply held value in the United States of America, but sweeping exemptions that obstruct access to care are a fundamental distortion of that principle.

1. **Expanding religious refusals will exacerbate the barriers to care that LGBTQ individuals already face.**

A recent study from the Center for American Progress showed that "LGBTQ people experience discrimination in health care settings; that discrimination discourages them from seeking care; and that LGBTQ people may have trouble finding alternative services if they are turned away."[1]

[1] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2016),

LGBTQ survey respondents reported, among other things, that health care providers refused to see them because of their actual or perceived sexual orientation or gender identity; refused to recognize their family, including a child or a same-sex spouse or partner; and subjected them to harsh or abusive language, including intentional misgendering and use of wrong names of transgender patients.[2]

A recent intake GLAD received from a same-sex married couple in New Hampshire mirrors the reported experiences of survey respondents. The couple, who contacted GLAD in February of this year, reported that a religiously affiliated hospital in New Hampshire refused them joint entry into the emergency room despite being made aware that they were a married couple. Although opposite-sex spouses were seen accompanying their spouses into the emergency room for treatment, the husband of the same-sex couple was eventually ejected from the premises because of his insistence on accompanying his sick spouse into the emergency room. In addition to ejecting the husband from the hospital premises, the sick spouse seeking treatment for kidney failure was also denied treatment and was forced to seek life-saving care at a different hospital that was further away.

For transgender people, exclusion from health care settings is even more prevalent. In the Fall of 2017, GLAD was contacted by a transgender activist who battled severe depression and anxiety. When the activist sought inpatient care for mental health services at a hospital in Massachusetts, the activist was denied sleeping accommodations in a double room because of her transgender status. Instead, the activist was segregated and isolated in a single room in the psychosis ward even though the activist did not display any psychosis symptoms. While housed in the single room in the psychosis ward, the activist was threatened with physical harm by another patient. This threat of harm prevented the activist from venturing out of her room to attain appropriate and medically necessary treatment for her severe depression and anxiety. In January 2018, the activist died in her home at the age of 26, but is remembered as an activist for trans rights and mental health care reform.

These instances of discrimination, exclusion, and substandard care deter LGBTQ people from seeking basic medical services. As illustrated by the late transgender activist, avoiding or postponing health care services due to discrimination, including past experiences of discrimination or fear of future discrimination, can have deadly consequences. This is especially true for LGBTQ people of color who, according to a Lambda Legal study, are "more likely than their white counterparts to experience discrimination and substandard care" due to the combined impact of racism and anti-LGBTQ sentiments.[3] Thus, LGBTQ people of color are more likely than their white counterparts "to have concerns about their ability to obtain needed health care because of their sexual orientation, gender identity, or HIV status."[4]

The proposed regulation provides greater opportunity for LGBTQ people to be denied necessary access to health care, which not only imposes immediate life-threatening consequences, but future deadly consequences for those who fear being denied the care they need.

---

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

[2] *Id.*

[3] Lambda Legal Defense and Education Fund, Inc., *When Health Care Isn't Caring: LGBT People of Color and People of Color Living with HIV Results from Lambda Legal's Health Care Fairness Survey* (2009), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_lgbt-people-of-color.pdf.

[4] *Id.*

2. The regulation attempts to inappropriately broaden religious exemptions in a way that can lead to dangerous denials of medically necessary treatments.

The regulation purports, among other things, to clarify current "religious refusal clauses" related to abortion and sterilization in three federal statutes. Each of these statutes refers to specific, limited circumstances in which health care providers or health care entities may not be required to participate in abortion and sterilization procedures. The regulation, however, creates ambiguity about these limited circumstances and encourages an overly broad misinterpretation that goes far beyond what the statutes permit.

For example, section (d) of the Church Amendments refers to circumstances when a person may refuse to participate in any part of a health service program or research activity that "would be contrary to his religious beliefs or moral convictions." Even though longstanding legal interpretation applies this section singularly to participation in abortion and sterilization procedures, the proposed rule does not make this limitation clear. This ambiguity can encourage an overly broad interpretation of the statute that empowers a provider to refuse to provide *any* health care service or information for a religious or moral reason—potentially including not just sterilization and abortion procedures, but also Pre-Exposure Prophylaxis (PrEP), infertility care, treatments related to gender dysphoria, and even HIV treatment. Some providers may try to claim even broader refusal abilities, as a recent analysis of complaints to HHS showed that transgender patients are most often discriminated against simply for being who they are rather than for the medical care they are seeking.[5]

Doctors may be misled into believing they may refuse on religious grounds to administer an HIV test or prescribe PrEP to a gay or bisexual man, or refuse screening for a urinary tract infection for a transgender man.[6] In fact, medical staff may interpret the regulation to indicate that they can not only refuse, but decline to tell the patient where he would be able to obtain these lifesaving services or even inform patients of their treatment options. This puts the health of the patient, and potentially that of others, at risk. The regulation could lead a physician to refuse to provide fertility treatments to a same-sex couple, or a pharmacist to refuse to fill a prescription for hormone replacement therapy for a transgender customer. In addition, by unlawfully redefining the statutory term "assisting in the performance" of a procedure, the rule could encourage health care workers to obstruct or delay access to a health care service even when they have only a tangential connection to delivering that service, such as scheduling a procedure or running lab tests to monitor side-effects of a medication. The extension and broadening of this clause will impair LGBTQ patients' access to care services if interpreted—as the proposed rule improperly appears to do—to permit providers to choose patients based upon sexual orientation, gender identity, or family structure.

We are particularly concerned that the proposed rule will be used to refuse medically necessary care to transgender patients. We are concerned that the rule's sweeping terms and HHS's troubling discussions of a case involving a transgender patient will encourage the mistaken belief that treatments that have an incidental impact on fertility, such as some procedures used to treat gender dysphoria, are sterilization procedures. Treatments for serious medical conditions may have the incidental effect of causing or contributing to infertility: for example, a hysterectomy to treat gender dysphoria, chemotherapy to treat

---

[5] https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/

[6] https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/

cancer, and a wide range of medications can have the incidental effect of temporarily or permanently causing infertility. The primary purpose of such procedures, however, is not to sterilize, but to treat an unrelated medical condition. If religious or moral exemptions related to sterilization are misinterpreted to include treatments that have simply an incidental effect on fertility—as the vague and sweeping language of this rule encourages—it can lead to refusals that go even further beyond what federal law allows and unlawfully encourages individuals and institutions to refuse a dangerously broad range of medically needed treatments.

3. The proposed rule tramples on states' and local governments' efforts to protect patients' health and safety, including their nondiscrimination laws.

The Department claims that its unwarranted new interpretations of federal law supersede laws passed by state and local governments to ensure patients' access to health care. By claiming to allow individuals and institutions to refuse care to patients based on the providers' religious or moral beliefs in such a sweeping way, the proposed rule creates conflicts with hundreds of state and local nondiscrimination laws around the country that apply to health care. It therefore is disingenuous for the Department to claim that the proposed rule "does not impose substantial direct effects on States," "does not alter or have any substantial direct effects on the relationship between the Federal government and the States," and "does not implicate" federalism concerns under Executive Order 13132.

4. The regulation lacks safeguards to protect patients from harmful refusals of care.

The proposed regulation is dangerously silent in regards to the needs of patients and the impact that expanding religious refusals can have on their health. The proposed regulation includes no limitations to its sweeping exemptions that would protect patients' rights under the law and ensures that they receive medically warranted treatment. Any extension of religious accommodation should always be accompanied by equally extensive protections for patients to ensure that their medical needs remain paramount, and that they are able to receive both accurate information and quality health services.

Indeed, the Establishment Clause of the First Amendment requires the government to adequately account for burdens a religious accommodation may impose on others, including patients, and prohibits granting accommodations when they would materially harm any third party. As detailed at length above, the proposed regulation would cause significant harm by interfering with patients' access to healthcare and thus, conflicts with this constitutional bar.

The expanded religious exemptions in the proposed regulations also conflict with many patient protections in federal laws like the Affordable Care Act and the Emergency Medical Treatment and Active Labor Act. While protections under these laws are subject to religious exemptions provided under federal statute, they are not subject to exemptions whose scope goes beyond federal law—including many of the exemptions expanded in this rule. Additionally, the proposed regulation's approach to religious exemptions—which appears to allow for no limitations even when those exemptions unjustifiably harm patients or employers—conflict with the well-established standard under other federal laws, like Title VII of the Civil Rights Act. Title VII ensures that employers can consider the effect that providing a religious accommodation would have on coworkers, customers, and patients, as well as factors like public safety, public health, and other legal obligations. A standard that appears to allow for none of these considerations, and instead appears to require broad, automatic exemptions, would create confusion and undermine the federal government's ability to properly enforce federal laws.

5. The Department's rushed rulemaking process failed to follow required procedures.

The Department rushed to publish this rule without first publishing any notice regarding in its Unified Regulatory Agenda, as is normally required. The failure to follow proper procedure reflects an inadequate consideration of the rule's impact on patients' health.

The timing of the proposed rule also illustrates a lack of sufficient consideration. The proposed rule was published just two months after the close of a public comment period for a Request for Information closely related to this rule. The 12,000-plus public comments were not all posted until mid-December, a month before this proposed rule was released. Nearly all of the comments submitted at that time related to the subjects covered by the proposed rule—namely, the refusal of care by federally funded health care institutions or their employees on the basis of personal beliefs. This short period of time calls into question the comprehensiveness of the review of the Request for Information and whether the proposed rule was developed in an arbitrary and capricious manner.

Conclusion

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

Sincerely,

Allison Wright, Esq.
GLBTQ Legal Advocates & Defenders
617-426-1350 x. 6961
awright@glad.org

EXHIBIT 27

north carolina
JUSTICE CENTER

March 27, 2018

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

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

To Whom It May Concern:

I am writing on behalf of the North Carolina Justice Center in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1]

The North Carolina Justice Center advocates for the social, political, economic, and healthful well-being of all North Carolinians. Our mission is to eliminate poverty by ensuring that every household has access to the resources, services and fair treatment it needs to enjoy economic security and participate equally in the opportunities available in the state. A project of the NC Justice Center, the Health Advocacy Project works to ensure that all North Carolinians, especially underserved populations, including racial and ethnic minorities and rural communities, have meaningful access to high quality, affordable, equitable, and comprehensive health care so that children, adults, and families have better health outcomes and live productive lives. In addition, each of the undersigned organizations joining to support these comments also advocates for policies that would improve access to health care for North Carolinians.

This proposed regulation would exacerbate the challenges that many patients -- especially women, LGBTQ people, people of color, immigrants and low-income people -- already face in getting the health care they need in a timely manner and at an affordable cost. The rule would expose vulnerable patients to increased discrimination and denials of medically-indicated care by broadening religious health care provider exemptions beyond the existing limited circumstances allowed by law. Moreover, while protecting health providers who deny care, the rule would provide *no protections for patients who are being denied care – even in emergencies*. As drafted, the rule would not even require that patients be informed of all their potential treatment options and referred to alternative providers of needed care.

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

Indeed, this proposal runs in the opposite direction of everything the American health system is striving to achieve in the pursuit of "patient-centered care." We urge the administration to put patients first, and withdraw the proposed regulation because of the serious problems enumerated below.

1. The rule improperly seeks to expand on existing religious refusal exemptions to potentially allow denial of any health care service based on a provider's personal beliefs or religious doctrine.

Existing refusal of care laws (such as for abortion and sterilization services) are already being used across the country to deny patients the care they need.[2] The proposed rule attempts to expand on these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. Specifically, the Department and its Office for Civil Rights (OCR) are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[3]

This expansive interpretation could lead to provider denials based on personal beliefs that are biased and discriminatory, such as objections to providing care to people who are transgender or in same-sex relationships. We are aware of cases in which this type of unjust denial of care has occurred, such as a California physician's denial of donor insemination to a lesbian couple, even though the doctor routinely provided the same service to heterosexual couples. [4]

We are also concerned about potential enabling of care denials by providers based on their non-scientific personal beliefs about other types of health services. For example, certain religiously-affiliated hospitals and individual clinicians have refused to provide rape victims with emergency contraception to prevent pregnancy[5] based on the belief that it can cause an abortion, even though there is no scientific evidence that this is the case.

2. The rule would protect refusals by anyone who would be "assisting in the performance of" a health care service to which they object, not just clinicians.

The rule seeks to protect refusals by any "member of the workforce" of a health care institution whose actions have an "articulable connection to a procedure, health services or health service program, or research activity." The rule includes examples such as "counseling, referral, training and other arrangements for the procedure, health service or research activity."

An expansive interpretation of "assist in the performance of" thus *could conceivably allow an ambulance driver to refuse to transport a patient to the hospital for care he/she finds objectionable*. It

---

[2] *See, e.g.*, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Uttley, L., et al, *Miscarriage of Medicine,* MergerWatch and the ACLU (2013), https://www.aclu.org/report/miscarriage-medicine.

[3] *See* Rule *supra* note 1, at 12.

[4] Hardaway, Lisa, *Settlement Reached in Case of Lambda Legal Lesbian Client Denied Infertility Treatment by Christian Fundamentalist Doctors,* Lambda Legal, September 29, 2009, accessed at https://www.lambdalegal.org/news/ca_20090929_settlement-reached.

[5] Erdely, Sabrina, *Doctors' beliefs can hinder patient care*, SELF magazine, June 22, 2007, accessed at http://www.nbcnews.com/id/19190916/print/1/displaymode/1098/

could mean a hospital admissions clerk could refuse to check a patient in for treatment the clerk finds objectionable or a technician could refuse to prepare surgical instruments for use in a service.

On an institutional level, the right to refuse to "assist in the performance of" a service could mean *a* religiously-affiliated hospital or clinic could deny care, and *then also refuse to provide a patient with a referral or transfer to a willing provider* of the needed service.

The proposed rule thus could be read as allowing health providers to refuse to inform patients of all potential treatment options. A 2010 publication of the National Health Law Program, "Health Care Refusals: Undermining Quality of Care for Women," noted that "refusal clauses and institutional restrictions can operate to deprive patients of the complete and accurate information necessary to give informed consent."[6]

3. The rule does not address how a patient's needs would be met in an emergency situation.

There have been reported instances in which pregnant women suffering medical emergencies – including premature rupture of membranes (PPROM) and ectopic pregnancies[7] -- have gone to hospital emergency departments and been denied prompt, medically-indicated care because of institutional religious restrictions.[8] The proposed rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[9] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[10] Because the proposed rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

4. **Health care institutions would be required to notify employees that they have the right to refuse to provide care, *but would not be required to notify patients about the types of care they will not be able to receive at that hospital, pharmacy, clinic or doctor's office*.**

---

[6] The NHeLP publication noted (at page 21) that the Ethical and Religious Directives for Catholic Healthcare Services, which govern care at Catholic hospitals, limit the information a patient can be given about treatment alternatives to those considered "morally legitimate" within Catholic religious teachings. (Directive No. 26).

[7] Foster, AM, and Smith, DA, *Do religious restrictions influence ectopic pregnancy management? A national qualitative study*, Jacob Institute for Women's Health, Women's Health Issues, 2011 Mar-Apri; 21(2): 104-9, accessed at https://www.ncbi.nlm.nih.gov/pubmed/21353977

[8] Stein, Rob, *Religious hospitals' restrictions sparking conflicts, scrutiny,* The Washington Post, January 3, 2011, accessed at https://www.washingtonpost.com/health-environment-science/religious-hospitals-restrictions-sparking-conflicts-scrutiny/2011/01/03/ABVVxmD_story.html?utm_term=.cc34abcbb928

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

[10] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); *In re Baby K*, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, *93 Fair Empl. Prac. Cas.* (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).

The rule sets forth extensive requirements for health care institutions, such as hospitals, to notify employees about their refusal rights, including how to file a discrimination complaint with OCR. The rule requires posting of such notices on the employer's website and in prescribed physical locations within the employer's building. The rule also sets forth the expectation that OCR would investigate or do compliance reviews of whether health care institutions are following the posting rule.[11]

By contrast, the rule contains no requirement that patients be notified of institutional restrictions on provision of certain types of care. Such notification is essential because research has found that patients often are unaware of service restrictions at religiously-sponsored health care institutions. [12]

5. The rule conflicts with other existing federal laws, including the Title VII framework for accommodation of employee's religious beliefs.

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals of care it would create. For example, the proposed rule makes no mention of Title VII,[13] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[14] Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[15] The proposed rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both.

5. There is no provision protecting the rights of health care providers with religious or moral convictions to *provide* (not deny) services their patients need.

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care and end-of-life care. The rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[16]

Doctors are, in effect, forced to abandon their patients when they are prevented by health care institutions from providing a service they believe is medically-indicated. This was the case for a doctor in Sierra Vista, Arizona, who was prevented from ending a patient's wanted, but doomed, pregnancy after

---

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

[12] *See*, for example, Freedman, Lori R., Luciana E. Hebert, Molly F. Battistelli, and Debra B. Stulberg, *Religious hospital policies on reproductive care: what do patients want to know?* American Journal of Obstetrics & Gynecology 218, no. 2 (2018): 251-e1, accessed here: http://www.ajog.org/article/S0002-9378(17)32444-4/fulltext; also Guiahi, Maryam, Jeanelle Sheeder, and Stephanie Teal, *Are women aware of religious restrictions on reproductive health at Catholic hospitals? A survey of women's expectations and preferences for family planning care*, Contraception and Stulberg, D., et all, accessed here: http://www.contraceptionjournal.org/article/S0010-7824(14)00358-8/fulltext; *Do women know when their hospital is Catholic and how this affects their care? Restrictions in Catholic Hospitals (PARRCH) national survey*, Contraception, Volume 96, Issue 4, 268-269,accessed here: http://www.contraceptionjournal.org/article/S0010-7824(17)30235-4/fulltext; a

[13] 42 U.S.C. § 2000e-2 (1964).

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

[15] *See id.*

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

she suffered premature rupture of membranes. The patient had to be sent to the nearest non-objecting hospital, which was 80 miles away, far from her family and friends. The physician described the experience as "a very gut wrenching thing to put the staff through and the patient, obviously."[17]

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

a. Refusals of care make it difficult for many individuals to access the care they need

Across the country, refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[18] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[19] Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.[20] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[21] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[22] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[23]

b. Refusals of care are especially dangerous for those already facing barriers to care

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[24] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[25] In rural

---

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

[18] *See, e.g.*, *supra* note 2.

[19] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[20] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

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

[22] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.

[23] *See* Kira Shepherd, et al., *supra* note 19, at 27.

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

[25] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health &

areas there may be no other sources of health and life preserving medical care.[26] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that In 19 states, women of color are more likely than white women to give birth in Catholic hospitals.[27] Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provide guidance on a wide range of hospital matters, including reproductive health care, and can keep providers from offering the standard of care.[28] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[29]

7. The Department is abdicating its responsibility to patients

If finalized, the proposed rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities

The proposed rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. For example, Black women are three to four times more likely than white women to die during or after childbirth.[30] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[31] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[32] OCR must work to address these disparities, yet the proposed rule is antithetical to OCR's mission.

8. The proposed rule will make it harder for states to protect their residents

The proposed rule will have a chilling effect on the enforcement and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. Moreover, the proposed rule invites states to further expand refusals of care by making clear that this expansive rule is a floor, and not a ceiling, for religious exemption laws.[33]

Ctr. For Reproductive Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: the Fight for Women's Reproductive Health in the Rio Grande Valley* 1, 7 (2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf.

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

[27] *See* Kira Shepherd, et al., *supra* note 19, at 12.

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

[29] *See, e.g.*, *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

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

[31] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf.

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

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

Conclusion

The proposed pule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The proposed rule is discriminatory, violates multiple federal statutes and the Constitution, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons, the North Carolina Justice Center calls on the Department to withdraw the proposed rule in its entirety.

Thank you for this opportunity to comment. If you have any questions, please contact Brendan Riley at Brendan@ncjustice.org.

North Carolina Justice Center

EXHIBIT 28

March 27, 2018

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

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

To Whom It May Concern:

On behalf of the Human Rights Campaign's more than three million members and supporters nationwide, I write in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. As the nation's largest organization working on behalf of lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, we are deeply troubled by the likely impact of the proposed regulation on LGBTQ people—who already face significant barriers to accessing quality healthcare. The proposed regulation sets forth a problematic standard that prioritizes individual providers' beliefs ahead of patient health and well-being. As proposed, this regulation adopts an overly expansive interpretation of existing conscience protections that will undoubtedly empower healthcare providers to deny life-saving care to some of the most vulnerable patients.

The Proposed Regulation is Overly Broad and Fails to Address the Impact on Vulnerable Health Minorities, Including LGBTQ People.

Discrimination against LGBTQ People is Real and Causes Irreparable Harm.

LGBTQ patients face an increased risk of discrimination at the hands of healthcare providers. Numerous surveys, studies, and reports have documented the widespread extent of the discrimination faced by LGBT individuals and their families in the health care system. One

nationwide study found that 56 percent of lesbian, gay, and bisexual (LGB) respondents and 70 percent of transgender respondents reported experiencing discrimination by health care providers, including providers being physically rough or abusive, using harsh or abusive language, or refusing to touch them.[1] In the same study, 8 percent of LGB respondents and 27 percent of transgender respondents reported being refused necessary medical care outright.[2] Similarly, the 2015 National Transgender Discrimination Survey found that 33 percent of respondents had negative experiences when seeing a health care provider in the past year.[3] The survey also found that respondents were three times more likely to have to travel more than 50 miles for transgender-related care than for routine care.[4]

Beyond each of these numbers is an individual story – and too often a nightmare. The Human Rights Campaign gathered over 13,000 individual comments and stories in response to the Department's request for public comment regarding the proposed regulation implementing Section 1557 of the Affordable Care Act. Thousands of our members shared personal, heartbreaking stories of discrimination and denial when seeking healthcare. Our members recounted incidents of hostility including homophobic statements, intrusive and unnecessary questioning, and unwarranted physical removal of a same-sex partner from a doctor's visit. One of the most common stories of hostility and harassment reported by our members in their public comments included unwanted proselytizing by hospital or clinic staff. Unwanted proselytizing is a distinct form of bullying. It undermines patient care and can prevent individuals from seeking much needed care in the future.

Amongst the thousands of stories we received, many members shared stories of outright denial of care. For example, a nurse assigned to care for an elderly gay man in an assisted living facility refused to bath him or provide the necessary day-to-day care that he needed and deserved simply because he was gay. We have also received calls from individuals who have been denied access to treatment because they are in a same-sex couple. In one particular instance two nurses serving in the military and stationed in Missouri had been denied fertility treatment by every local clinic and by the military hospital because of their sexual orientation. The couple was forced to drive five hours round trip to a clinic in another city to receive treatment. This denial of care was not only a threat to their dignity, but required a costly and time-consuming alternative.

HHS has Consistently Found LGBTQ People to be Vulnerable to Discrimination

For almost a decade HHS has consistently considered LGBTQ people to be a health disparity population for purposes of HHS-funded programs and services. Healthy People 2020 provides

[1] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People*
[2] *Id.*
[3] S.E. James, C. Brown, & I. Wilson, *2015 U.S. Transgender Survey*, 97 (National Center for Transgender Equality 2017).
[4] *Id.* at 98.

that, "Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[5] The Healthy People report provides science-based national objectives designed to improve the health of every American.[6] One of the five core missions detailed by the initiative is to identify critical research areas and data collection needs and opportunities.[7] Healthy People 2020 specifically provides that recognizing the impact of social determinants on health – which include factors like sexual orientation and gender identity – is essential to improving the health and well-being of the nation.[8]

The National Institutes of Health has also formally designated sexual and gender minorities as a health disparity population for purposes of NIH research.[9] The term "sexual and gender minorities" includes lesbian, gay, bisexual, transgender, and queer people.[10] This designation recognizes the devastating health disparities facing LGBTQ people across the nation and the need for a concerted federal research response. In announcing this designation NIH provided that, "mounting evidence indicates that SGM populations have less access to health care and higher burdens of certain diseases, such as depression, cancer, and HIV/AIDS."[11]

The proposed rule is silent as to how hospitals should navigate the impact of the proposed "protections" on patient care, including the anticipated increase in discriminatory denials. The absence of any protections for vulnerable populations, including those who are LGBTQ, is a marked departure from longstanding HHS policies regarding patient care and access.

LGBTQ People will be Disparately Impacted by the Proposed Regulation's Expansive Interpretation of Conscience Laws

The regulation purports, among other things, to clarify current "religious refusal clauses" related to abortion and sterilization in three federal statutes. Each of these statutes refers to specific, limited circumstances in which health care providers or health care entities may not be required to participate in abortion and sterilization procedures. The regulation, however, creates ambiguity about these limited circumstances and encourages an overly broad interpretation that

[5] Healthy People 2020, *Disparities*, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities (last visited Mar. 26, 2017).
[6] Healthy People 2020, *About Healthy People*, https://www.healthypeople.gov/2020/About-Healthy-People (last visited Mar. 26, 2017).
[7] *Id.*
[8] *Disparities*, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities (last visited Mar. 26, 2017).
[9] Eliseo J. Pérez-Stable, M.D., *Director's Message: Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes*, National Institute on Minority Health and Health Disparities (Oct. 6, 2016) https://www.nimhd.nih.gov/about/directors-corner/message.html.
[10] *Id.*
[11] *Id.*

goes far beyond what longstanding legal tradition and public policy understanding have understood the statutes permit.

For example, section (d) of the Church Amendments refers to circumstances when a person may refuse to participate in any part of a health service program or research activity that "would be contrary to his religious beliefs or moral convictions."[12] Even though longstanding legal interpretation has applied this section singularly to participation in abortion and sterilization procedures, the proposed rule does not make this limitation clear. This ambiguity can encourage an overly broad interpretation of the statute that empowers a provider to refuse to provide *any* health care service or information for a religious or moral reason—potentially including not just sterilization and abortion procedures, but also Pre-Exposure Prophylaxis (PrEP), infertility care, treatments related to gender dysphoria, and even HIV treatment. Some providers may try to claim even broader refusal abilities, as a recent analysis of complaints to HHS showed that transgender patients are most often discriminated against simply for being who they are rather than for the medical care they are seeking.[13]

Doctors may be misled into believing they may refuse to administer an HIV test or prescribe PrEP to a gay or bisexual man, or refuse screening for a urinary tract infection for a transgender man.[14] In fact, medical staff may interpret the regulation to indicate that they can not only refuse, but decline to tell the patient where he would be able to obtain these lifesaving services or even inform patients of their treatment options. This puts the health of the patient, and potentially that of others, at risk. The regulation could lead a physician to refuse to provide fertility treatments to a same-sex couple, or a pharmacist to refuse to fill a prescription for hormone replacement therapy for a transgender customer. In addition, by unlawfully redefining the statutory term "assisting in the performance" of a procedure, the rule could encourage health care workers to obstruct or delay access to a health care service even when they have only a tangential connection to delivering that service, such as scheduling a procedure or running lab tests to monitor side-effects of a medication. The extension and broadening of this clause will impair LGBTQ patients' access to care services if interpreted—as the proposed rule improperly appears to do—to permit providers to choose patients based upon sexual orientation, gender identity, or family structure.

We are particularly concerned that the proposed rule will be used to refuse medically necessary care to transgender patients. We are concerned that the rule's sweeping terms and HHS's troubling discussions of a case involving a transgender patient will encourage the mistaken belief that treatments that have an incidental impact on fertility, such as some procedures used to treat

[12] 42 U.S. Code § 300a–7(d).
[13] Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (Mar. 7, 2018) https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.
[14] *Id.*

gender dysphoria, are sterilization procedures. Treatments for serious medical conditions may have the incidental effect of causing or contributing to infertility: for example, a hysterectomy to treat gender dysphoria, chemotherapy to treat cancer, and a wide range of medications can have the incidental effect of temporarily or permanently causing infertility. The primary purpose of such procedures, however, is not to sterilize, but to treat an unrelated medical condition. If religious or moral exemptions related to sterilization are misinterpreted to include treatments that have simply an incidental effect on fertility—as the vague and sweeping language of this rule encourages—it can lead to refusals that go even further beyond what federal law allows and unlawfully encourages individuals and institutions to refuse a dangerously broad range of medically needed treatments.

The Regulation Lacks Safeguards to Protect Patients from Harmful Refusals of Care.

The proposed regulation is dangerously silent in regards to the needs of patients and the impact that expanding religious refusals can have on their health. The proposed regulation includes no limitations to its sweeping exemptions that would protect patients' rights under the law and ensure that they receive medically warranted treatment. Any extension of religious accommodation should always be accompanied by equally extensive protections for patients to ensure that their medical needs remain paramount, and that they are able to receive both accurate information and quality health services.

The expanded religious exemptions in the proposed regulations also conflict with many patient protections in federal laws like the Affordable Care Act and the Emergency Medical Treatment and Active Labor Act. While protections under these laws are subject to religious exemptions provided under federal statute, they are not subject to exemptions whose scope goes beyond federal law—including many of the exemptions expanded in this rule. Additionally, the proposed regulation's approach to religious exemptions—which appears to allow for no limitations even when those exemptions unjustifiably harm patients or employers—conflict with the well-established standard under other federal laws, like Title VII of the Civil Rights Act.

The Proposed Regulation Will Undermine Hospital and Provider Autonomy as Centers of Care and as Private Employers.

Over the past decade, many hospitals and health systems have followed the recommendations of major accrediting bodies including the Joint Commission and have taken significant steps to ensure that LGBTQ patients receive consistent, quality, culturally competent care. Hospitals and health systems have trained staff, developed nondiscrimination patient and personnel policies, and have made other structural changes to ensure that facilities are welcoming. However, the proposed regulation could cause these hospitals and organizations to feel restricted in their ability to create inclusive and welcoming environments for both their staff, as well as their patients. The proposed regulation may empower staff to deny to provide services beyond the scope of existing law. Many hospitals facing the threat of a costly federal complaint and

investigation process may acquiesce to even unnecessary denials in order to avoid an investigation regardless of the merit of the complaint.

The proposed regulation also interferes with hospital and health systems' personnel decisions. Title VII requires employers to reasonably accommodate the sincerely-held religious beliefs, observances, and practices of its applicants and employees, when requested, unless the accommodation would impose an undue hardship on business operations.[15] This is defined as more than a de minimis cost. The proposed regulation fails to mention Title VII and the balancing of employee rights and provider hardships. The Equal Employment Opportunity Commission (EEOC) addressed this problematic intersection in its public comment in response to the 2008 regulation that had the substantively identical legal problem, noting that "Introducing another standard under the Provider Conscience Regulation for some workplace discrimination and accommodation complaints would disrupt this judicially-approved balance and raise challenging questions about the proper scope of workplace accommodation for religious, moral or ethical beliefs."[16] In this public comment the EEOC concluded that, "Title VII should continue to provide the legal standards for deciding all workplace religious accommodation complaints. HHS's mandate to protect the conscience rights of health care professionals could be met through coordination between EEOC and HHS's Office for Civil Rights, which have had a process for coordinating religious discrimination complaints under Title VII for over 25 years."[17]

Conditions for Federal Healthcare Funding Must be Grounded in Promoting Health Outcomes

"Enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services."[18] This is the mission statement that HHS asserts drives its programs, policies, and in turn this regulation. Conditions of receipt of funding for participation in HHS programs are routinely patient centered. The Conditions of Participation (CoPs) that guide the Medicare and Medicaid programs directly address patient care including infection control, nurse-bed ratios, and staffing requirements. Grant programs operated through HHS condition funding on beneficiary well-being and service delivery. For example, organizations receiving funding to serve runaway and homeless youth must certify that they are appropriately training staff to best meet the needs of youth. Domestic violence shelters receiving HHS grants must take steps to keep their delivery of services confidential to protect survivors. Patients and

[15] Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e.
[16] Letter in response to request for public comment from Reed L. Russell, Legal Counsel, EEOC, to Brenda Destro, Department of Health and Human Services (Sept. 24, 2008) https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.
[17] *Id.*
[18] Department of Health and Human Services, *Mission Statement*, https://www.hhs.gov/about/strategic-plan/introduction/index.html (last visited Mar. 26, 2017).

beneficiaries are at the center of these conditions. Holding organizations and hospitals accountable for delivering quality, accessible services and care is essential.

The proposed regulation offers no quantifiable description of a direct patient benefit. In fact, of the 216 page proposed rule, HHS dedicates a mere three paragraphs to what it describes as "ancillary" benefits to patients.[19] Webster's Dictionary defines "ancillary" as "subordinate," or "placed in or occupying a lower class, rank, or position: inferior."[20] We believe this description to be troublingly accurate. One of these inferior patient benefits includes the ability to seek health care providers who share a patient's deepest held beliefs—asserting that this will strengthen the doctor-patient relationship. The proposed regulation provides that "open communication in the doctor-patient relationship will foster better over-all care for patients. . . Facilitating open communication between providers and their patients also helps to eliminate barriers to care, particularly for minorities."[21] We could not agree more. However, as proposed the regulation does nothing to improve communication between patients and doctors, and will in fact dramatically undermine the relationship for any patient wary of discrimination. While the insertion of a physician's personal religious belief within the healthcare relationship might be welcome by some, it will come at a devastating cost to a myriad of vulnerable and traditionally underserved communities.

Studies already show that fear of discrimination causes LGBTQ people to delay or wholly avoid necessary care – even in an emergency. The proposed regulation requires that entire facilities be put on notice that a range of health care workers can deny care based on their own moral or religious beliefs. As a result, the proposed regulation also puts many patients on notice that if they are honest and open about critical clinical factors including their medical history, behavior, and even marital status and family structure that they can be turned away from care. For communities with long histories of discrimination, like the LGBTQ community, the proposed regulation's so-called "protections" will do nothing to promote open doctor-patient relationships. Instead, they provide a concrete, federally sanctioned requirement that may necessitate that they hide their own identities to get critical care.

The proposed regulation boldly asserts that it will "generate benefits by securing a public good—a society free from discrimination, which permits more personal freedom and removes unfairness."[22] The Human Rights Campaign and our members work every day to create such a society. This is why we must oppose this regulation in its entirety.

---

[19] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. 18, 3916 (proposed Jan. 26, 2018).
[20] *Ancillary*, Merriam-Webster.com. Accessed March 26, 2018. https://www.merriam-webster.com/dictionary/ancillary.
[21] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3917.
[22] *Id.* at 3916.

EXHIBIT 29

March 27, 2018

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

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

To Whom It May Concern:

I am writing on behalf of Boston Medical Center (BMC), a private, not-for-profit, 487-bed, academic medical center located in Boston, Massachusetts, in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26, 2018. BMC is the primary teaching affiliate for Boston University's School of Medicine. It is the busiest trauma and emergency services center and the largest safety net hospital in New England. BMC is dedicated to providing accessible health care to everyone. 57% of its patients are from under-served populations and 32% of patients do not speak English as a primary language. Seeing more than one million patient visits a year in over 70 medical specialties and subspecialties, BMC physicians are leaders in their fields with the most advanced medical technology at their fingertips and working alongside a highly-skilled nursing and professional staff. BMC's mission is to provide exceptional care, without exception to all patients. BMC's staff is committed to providing quality care to every patient and family member with respect, warmth and compassion.

Providing quality, consistent patient care is a priority at our hospital. Through its commitment to serve everyone, BMC offers numerous outreach programs and services. BMC offers Interpreter Services in over 250 Languages, 24 hours a day. We are proud of the diversity of our patients and employees and hold strong in our belief that many faces create our greatness. BMC has a long history of caring for lesbian, gay, bi-sexual, transgender and gender queer (gender non-conforming) (LGBTQ) patients. In 2016 BMC proudly established its Center for Transgender Medicine and Surgery (CTMS), which is the first medical center in New England to provide a comprehensive transgender health care program and is a leader nationally in the delivery of transgender medical care. BMC recognizes that the transgender patient population has been severely marginalized because of discrimination and bias, which

has resulted in significant health disparities for this group. The 2015 U.S. Transgender Survey Report, prepared by the National Center for Transgender Equality, found that one-third of the survey respondents reported having at least one negative health care related experience because of being transgender and nearly one-fourth, of the almost 28,000 respondents, did not seek health care due to a fear of mistreatment by health care providers because of being transgender. As a result of the historical harm and mistreatment faced by transgender people, many health care institutions throughout the United States are providing more targeted health care services for transgender and LGBQ patients and thereby working towards decreasing the health care disparities for LGBTQ patients that are still pervasive throughout the United States.

The Department of Health and Human Services' Proposed Rule "Protecting Statutory Conscience Rights in Health Care", as currently drafted, has the potential to significantly detract from the progress made and increase the health disparities faced by the LGBTQ patient population. First, the proposed rule, under the notion of religious protection, overreaches with an embedded catch-all provision that essentially states that no entity shall discriminate against a physician or other health care personnel for refusing to perform "**any lawful health service"** on grounds that "it is contrary to [the health care provider's] religious beliefs or moral convictions." (Proposed Rule §88.3(a)(2)(v)). **This provision is too broad.** Second, both federal and state laws already protect individual health care employees from discrimination on the basis of their religious beliefs. For example, to be in compliance with the existing federal and Massachusetts laws, BMC has a policy, as do many other hospitals, that establishes a procedure to excuse an employee from participating in a patient's care or treatment when the prescribed care or treatment conflicts with the employee's values, ethics, or religious beliefs. The existing protections are meaningful and familiar to health care providers who have navigated these personal obligations alongside their commitment to providing seamless, respectful health care to patients. There is no need to augment the existing protections. Third, HHS' proposed regulation creates a complex, burdensome notice and reporting process for organizations and hospitals that is not only unnecessary and threatens to undermine the continuity of patient care, but also results in significant additional costs at a time when we as a society are trying to bring down the cost of health care in the United States. Finally, the proposed rule does not address what should happen in emergency departments or emergent care situations in which a patient's life is in danger. There are specific requirements under the federal Emergency Medical and Labor Treatment Act (EMTALA) that prohibit hospitals with emergency departments from refusing to treat people based on their insurance status or ability to pay. EMTALA requires hospitals to provide "an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available in emergency departments, to determine whether or not an emergency medical condition exists." (42 C.F.R. 489.24(a)(1)(i)). The proposed rule is silent on how EMTALA's requirements can be reconciled with its catch-all provision. **For these reasons and as further explained below, we urge the Department to withdraw the proposed rule.**

BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

The primary teaching affiliate of the Boston University School of Medicine.

1. **The proposed rule attempts to inappropriately broaden religious exemptions in a way that would deny patients medically necessary care and could lead to discrimination against entire patient groups.**

Hospitals and health care organizations are in the business of providing health care services and information to patients and communities. The broad and undefined nature of the proposed rule gives individual providers' beliefs priority over life-saving patient care and threatens to prevent the provision of services to patients in need. The lack of definition, structure, and guidelines will leave health care providers without standards and structures to guide the provision of necessary care to the most vulnerable populations, including LGBTQ people.

The broad scope of the proposed rule's catch-all provision and the health care workers it applies to will make it possible for some providers to deny certain treatments or to decline to see certain patients. The proposed rule contemplates extending the interpretation of existing statutory exemptions, for procedures such as abortion and sterilization, far beyond the current standards. Forty-five states, including Massachusetts, have state laws that protect health care providers who object to participating in abortion procedures and several states also include protections for providers who do not want to participate in sterilization procedures.[1] Massachusetts General Law Ch. 112 §12I provides a protocol through which a health care provider shall not be discriminated against for not participating in a patient's care or treatment related to abortion and sterilization. These type of state laws and the existing federal laws (Church Amendment, Coats-Snowe Amendment and the Weldon Amendment) already provide health care provider protection. Hospital policies throughout the country should reflect compliance with their state and federal laws. For example, BMC has a policy that delineates a protocol so that an employee "shall not be required to participate in tubal ligations, vasectomies, abortions, or any other procedures that conflict with his/her ethical principles unless the patient's life is in immediate danger." The BMC policy is tailored to address specific procedures that may be contrary to a provider's religious beliefs or ethical principles, it also makes a reference to "any other procedure" that may conflict with a provider's ethical principle and outlines a specific method (in writing) by which a provider can request to be relieved from certain patient care duties, while taking patient safety into consideration. The existing protections are sound and protect the religious beliefs and moral convictions of BMC's health care providers, as well as ensure that necessary patient care is provided.

[1] "*Refusing to Provide Health Services*" Published on *Guttmacher Institute* (https://www.guttmacher.org.) March 1, 2018. See https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services

Roger Sevirino, Director of HHS' Office of Civil Rights stated in an interview that "The way these conscience claims work is that providers do not deny service to patients because of identities. What happens is providers choose not to provide or engage in certain procedures at all."[2] The problem with this approach is that the scope of what procedures are covered by the proposed rule are not clear. The proposed rule certainly emphasizes abortion, sterilization and assisted suicide, but Section 88.3 (a)(2)(v) is a catch-all provision that essentially empowers any physician or other health care personnel "to refuse to perform or assist in the performance of such service or activity on the grounds that doing so would be contrary to his or her religious beliefs or moral convictions, or because of his or her religious beliefs or moral convictions."

Under HHS' proposed rule a provider could be seen as empowered to refuse to provide **any** health care service or information for a religious or moral reason – extending beyond abortion and sterilization procedures, to other types of procedures in general and other areas of health care services, such as the provision of Pre-Exposure Prophylaxis (PrEP), infertility care, hormone therapy and other non-surgical gender transition-related services, and possibly even HIV treatment under the auspices of "any" service. The language of the proposed rule extends beyond specific procedures to health care services in general. This is problematic because, as drafted, the catch-all provision could also be viewed as protecting a health care provider who refuses to treat a transgender person for a condition that is completely unrelated to a gender transition procedure, such as providing treatment for a broken leg, cancer care, the flu or appendicitis, if the health care provider asserts that caring for a transgender person is contrary to his/her moral conviction. The language of this proposed rule potentially authorizes discrimination by health care providers towards an entire patient group regardless of the procedure, treatment or service that is needed.

2. The proposed rule conflicts with Title VII and fails to inform hospitals of the boundaries of the rule when the exemption may cause an undue hardship on the hospital.

Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e) already requires employers to reasonably accommodate the sincerely-held religious beliefs, observances, and practices of its applicants and employees, when requested, unless the accommodation would impose an undue hardship on business operations, which is defined as more than a *de minimis* cost. The proposed regulation fails to mention Title VII and the balancing of employee rights and provider hardships. BMC and other hospitals and health organizations are at a loss as to how to reconcile the proposed rule and Title VII given the dearth of litigation on the subject and the lack of explanation in the proposed rule.

[2] "*New Trump Initiatives: A win for anti-abortion activists, protections for "conscience" objections*" By Jessica Ravitz, CNN, January 19, 2018.

The Equal Employment Opportunity Commission (EEOC) addressed this problematic intersection in its public comment in response to the 2008 Federal Health Care Conscience Rule that had the substantively identical legal problem, noting that: "Introducing another standard under the Provider Conscience Regulation for some workplace discrimination and accommodation complaints would disrupt this judicially-approved balance and raise challenging questions about the proper scope of workplace accommodation for religious, moral or ethical beliefs." In this public comment the EEOC concluded that, "Title VII should continue to provide the legal standards for deciding all workplace religious accommodation complaints. HHS's mandate to protect the conscience rights of health care professionals could be met through coordination between EEOC and HHS's Office for Civil Rights, which have had a process for coordinating religious discrimination complaints under Title VII for over 25 years." On this point, Boston Medical Center agrees with the EEOC.

3. The proposed rule creates additional and unnecessary cost for hospitals.

The proposed rule requires each hospital to make routine assurances, certifications and employee and public notifications related to compliance with its requirements. The Proposed Rule's Notice Requirement, § 88.5, requires that notices concerning the Federal Health Care Conscience and Associated Anti-Discrimination Protections be placed on hospital websites, posted in prominent and conspicuous physical locations in every department where notices to the public and notices to their workforce are customarily posted. This section also makes reference to including the notification in personnel manuals, employment applications and student handbooks. The costs associated with these requirements are unnecessary because most hospitals, including BMC, already have policies and references in employee manuals that respect religious freedoms and offer relief to employees from patient care duties that conflict with an individual's religious beliefs or ethical principles.

Furthermore, according to the proposed rule's preamble (Table 4: Summary of Costs) the estimated financial burden for the proposed rule will be $312.3 million in the first year and $125.5 million, annual recurring costs, during years two to five. The total estimated burden for compliance with this proposed rule, over its first five years, is $814.3 million dollars; over three-quarters of a billion dollars. This is an exorbitant amount of money for the facilities within the health care industry to spend at a time when there are calls to action and efforts being made to bring down the cost of health care throughout the United States. The return on investment will not justify the estimated burden, especially since there are already protections in place at the federal and state level related to conscience objections to participating in procedures such as abortion, sterilization and assisted suicide.

4. **The proposed rule lacks safeguards to ensure patients would receive emergency care as required by federal law and ethical standards.**

The proposed rule is dangerously silent in regards to ensuring patient wellbeing. The lack of consideration of patients' rights is evidenced by the fact that the proposed rule contains no provision to ensure that patients receive legally available, medically warranted treatment. Any extension of religious accommodation should always be accompanied by equally extensive protections for patients to ensure that their medical needs remain paramount, and that they are able to receive both accurate information and quality health services.

The proposed rule also fails to address potential conflicts with emergency care requirements. Under the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 U.S.C. § 1395dd), a hospital receiving government funds and providing emergency services is required to provide medical screening and stabilizing treatment to a patient who has an emergency medical condition (including severe pain or labor) (42 U.S.C. § 1395dd(a) and (b)). However, the proposed regulation contains a blanket right of refusal for physicians, with no discussion of their duties under EMTALA or how conflicts should be resolved. In fact, the proposed rule's preamble specifically identifies as problematic the 2016 American Congress of Obstetricians and Gynecologists reaffirmation of its ethics opinion that providers have an obligation to provide care regardless of the provider's personal moral objections if a referral is not possible or would negatively impact the patient's health. This reaffirmation is a tenet of providing necessary care for all who are in need. The requirements of EMTALA must be reconciled with the elements of the proposed rule, since EMTALA contains significant civil penalties (up to $50,000 for each violation) to prevent hospitals and physicians from disregarding their duties in treating all patients in similar manner (42 U.S.C. § 1395dd(d)(1)).

Conclusion

BMC is committed to providing exceptional care, without exception to everyone in our community. Hospitals and health systems exist to treat patients and provide them with access to the information they need for treatment. Entities that serve patients must be committed to respecting both the values of health care workers and the patients and the communities they serve in a way that allows for the delivery of care. BMC respects the dignity and rights of its diverse employees and patients. Our vision is to meet the health needs of the people of Boston and beyond by providing high quality comprehensive care to all, particularly mindful of the needs of vulnerable populations. HHS's proposed rule would stymie our ability to do this. The sweeping catch-all provision and the undefined boundaries of this proposed rule will have a chilling effect on the provision of life saving and medically necessary health care, result in significant unnecessary costs and contradict existing federal and state laws. BMC strongly urges the Department to withdraw the proposed rule. Alternatively, the rule should be re-proposed and (1) narrowed in scope to, at a minimum, remove the broad and vague catch-all language found in §88.3, (2) be drafted in a way that it does not contradict or is silent towards existing federal

BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

The primary teaching affiliate of the Boston University School of Medicine.

laws, such as Title VII and EMTALA and (3) should not include an expensive and burdensome notification and certification protocol.

If you would like additional information, please contact Melissa Shannon, Vice-President of Government Affairs at (617) 638-6732 or melissa.shannon@bmc.org or Wendoly Ortiz Langlois, Associate General Counsel at (617) 638-7901 or wendoly.langlois@bmc.org.

Sincerely,

Kate Walsh

Kate Walsh
President and Chief Executive Officer
Boston Medical Center