EXHIBIT 30

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:

On behalf of Unite for Reproductive & Gender Equity (URGE), we submit these comments to the federal Department of Health and Human Services ("Department") and its Office for Civil Rights ("OCR") in opposition to the proposed regulation entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."[1] URGE empowers young people, particularly young Lesbian, Gay, Bi-Sexual, Transgender, and Queer (LGBTQ) people of color, to make informed choices about their own health. We are deeply concerned that this regulation will harm young people, who already face social and economic barriers to healthcare.

Every day too many LGBTQ people face discrimination and other barriers to accessing lifesaving care. These barriers are especially pronounced for transgender patients. The proposed regulation will undoubtedly lead to increased discrimination and flat-out denials of care for some of the most vulnerable members of our community. We all deeply value freedom of religion, but sweeping exemptions that obstruct access to care are a fundamental distortion of that principle.

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.

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

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

For these reasons, URGE calls on the Department and OCR to withdraw the proposed rule in its entirety.

I. The Expansion of Religious Refusals Under the Proposed Rule Will Disproportionately Harm Communities Who Already Lack Access to Care

Women, individuals living with disabilities, LGBTQ persons, people living in rural communities, young people, and people of color face severe health and health care disparities, and these disparities are compounded for individuals who hold these multiple identities. For example, among adult women, 15.2% 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% of straight individuals.[2] Women of color experience health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.[3] Meanwhile, people of color in rural America are more likely to live in an area with a shortage of health professionals, with 83% of majority-Black counties and 81% of majority-Latino/a counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

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

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[2] 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.

[3] In 2014, Latinas had the highest rates of contracting cervical cancer and Black women had the highest death rates. *Cervical Cancer Rates By Rates and Ethnicity*, Ctrs. for Disease Control & Prevention, (Jun. 19, 2017), https://www.cdc.gov/cancer/cervical/statistics/race.htm.;At the end of 2014, of the total number of women diagnosed with HIV, 60 percent were Black. *HIV Among Women,* Ctrs. for Disease Control & Prevention, Nov. 17, 2017, *available at* https://www.cdc.gov/hiv/group/gender/women/index.html.

a. The Proposed Rule Will Block Access to Care for Low-income Women, Including Young People, Immigrant Women and Black Women

Broadly-defined and widely-implemented refusal clauses undermine access to basic health services for all, but can particularly harm low-income women. The burdens on low-income women can be insurmountable when women and families are uninsured,[4] underinsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services nor travel to another location. This is especially true for immigrant women. In comparison to their U.S. born peers, immigrant women are more likely to be uninsured.[5] Notably, immigrant, Latina women have far higher rates of uninsurance than Latina women born in the United States (48% versus 21%, respectively).[6]

Young people who are just beginning their independent adult lives are more likely to hold entry-level jobs with lower pay and worse benefits, resulting in higher rates of being uninsured or underinsured. Young adults (18-34) are less likely to be insured than *any* other age group.[7] These rates are even higher for young people in states without Medicaid expansion.[8] These factors severely limit access to care for young people, which will only be compounded by allowing providers to refuse care simply because of who the patient is.

According to a recent report, doctors often fail to inform Black women of the full range of reproductive health options regarding labor or delivery possibly due to stereotypes about Black women's sexuality and reproduction.[9] 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.[10]

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

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

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

[7] Casey Leins, *Latinos, Millennials Among Groups Least Likely to Have Insurance*, U.S. News and World Report (May 4, 2017), *available at* https://www.usnews.com/news/best-states/articles/2017-05-04/latinos-millennials-among-groups-least-likely-to-have-health-insurance.

[8] Id.

[9] 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.

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

b. 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. This is especially concerning for states that already severely restrict access to abortion care, including all of the states in which URGE has membership chapters.[11] The proposed regulation will create yet another barrier to health care for these young people. 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)."[12] 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.

c. 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.[13] 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.[14] 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

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[11] These states are as follows: Alabama, Georgia, Kansas, Ohio, and Texas.
[12] *See id.* at 12.
[13] *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.
[14] The Church Amendments, 42 U.S.C. § 300a-7 (2018).

are working on.[15] Such an attempted expansion goes beyond what the statute enacted by Congress allows.

Similarly, the Proposed Rule defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. For example, the definition of "assist in the performance" greatly expands the types of services that can be refused to include merely "making arrangements for the procedure" no matter how tangential.[16] 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.[17]

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.[18] 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.[19] 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.[20]

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."[21] In particular, the Proposed Rule defines "discrimination" against a health care entity broadly to include a number of activities,

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[15] *See* Rule *supra* note 1, at 185.
[16] *Id.* at 180.
[17] *Id.* at 183.
[18] 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).
[19] *See* Rule *supra* note 1, at 182.
[20] The doctrine of expressio unius est exclusio alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[21] *See* Rule *supra* note 1, at 180.

including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[22] 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.

II. 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.[23] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[24] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[25] Title X is a crucial service for young women, as it is one of the only providers in the United States where they can receive confidential health care.[26] The proposed regulation is exceptionally detrimental to low-income women and women of color, who make up the majority of patients who use Title X funded clinics.[27] 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.[28] 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.[29] 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 underinsured, and

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[22] *Id.*
[23] *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.
[24] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[25] *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).
[26] Kiersten Gillette-Pierce & Jamila Taylor, *The Threat to Title X Family Planning*, Center for American Progress (Feb. 9, 2017), *available at* https://www.americanprogress.org/issues/women/reports/2017/02/09/414773/the-threat-to-title-x-family-planning/.
[27] Planned Parenthood Federation of America, *Title X: America's Family Planning Program*, *available at* https://www.plannedparenthoodaction.org/issues/health-care-equity/title-x.
[28] *See, e.g.*, Rule *supra* note 1, at 180-185.
[29] *See* NFPRHA *supra* note 34.

uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[30]

III. 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. Young people deserve health care no matter who they are or where they live. We urge you to withdraw the proposed rule.

[30] *See id.*

EXHIBIT 31

BEFORE THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

Protecting Statutory Conscience Rights in Health Care; Delegations of Authority	**Docket No. HHS-OCR-2018-0002; RIN 0945-ZA03**

Comments of Whitman-Walker Health on the Notice of Proposed Rulemaking

Whitman-Walker Clinic, Inc., dba Whitman-Walker Health (WWH or Whitman-Walker), submits these comments on the Proposed Rule published on January 26, 2018, 83 Fed. Reg. 3880. The Proposed Rule's sweeping language ventures far beyond the actual scope of the federal laws that it purports to enforce. HHS appears to be endorsing discriminatory behavior by health care workers, motivated by their personal beliefs, that would be corrosive of fundamental professional standards and would threaten our patients' welfare and Whitman-Walker's ability to fulfill our mission. We urge that the Proposed Rule be withdrawn, or at a minimum, that it be modified to make clear that no endorsement is intended of discrimination in health care against lesbian, gay, bisexual, transgender and queer persons – or any discrimination based on the race, ethnicity, gender, disability status or religion of patients.

Interest of Whitman-Walker Health

Whitman-Walker is a Federally Qualified Health Center serving the greater Washington, DC metropolitan area, with a distinctive mission. As our Mission Statement declares:

> Whitman-Walker Health offers affirming community-based health and wellness services to all with a special expertise in LGBTQ and HIV care. We empower all persons to live healthy, love openly, and achieve equality and inclusion.

Our patient population is quite diverse and reflects our commitment to be a health home for individuals and families that have experienced stigma and discrimination, and have otherwise encountered challenges in obtaining affordable, high-quality health care. In calendar year 2017, we provided health-related services to more than 20,000 unique individuals. Of our medical and

behavioral health patients, approximately 40% identified themselves as Black; approximately 40% identified themselves as White; and approximately 18% identified themselves as Hispanic. More than one-half identified their sexual orientation as gay, lesbian, bisexual or otherwise non-heterosexual. Approximately 8% identified themselves as transgender or gender-nonconforming. Our patients also are quite diverse economically; in 2017 approximately 35% of our medical and behavioral health patients reported annual income of less than the Federal Poverty Level, and another 12% reported income of 100 – 200% of the FPL.

Since the mid-1980s, Whitman-Walker's Legal Services Department has provided a wide range of civil legal assistance to our patients and to others in the community living with HIV or identifying as sexual or gender minorities. Through their work, our attorneys have broad and deep experience with HIV, sexual orientation and gender identity discrimination in health care, employment, education, housing and public services. In 2017, approximately one-half of the more than 3,000 individuals who received legal assistance, or assistance with public benefit programs, identified as gay, lesbian, bisexual or otherwise non-heterosexual, and 18% identified as transgender or gender-nonconforming.

As would be expected given our very diverse community, Whitman-Walker's patient population and legal clients also subscribe to a wide range of religious faiths.

Consistent with our commitment to welcoming and nondiscriminatory health care, our growing work force is very diverse. We currently have almost 270 employees at five sites in Washington, DC. More than 55% of our employees identify as people of color, and more than 55% are women. Although we of course do not require employees to identity their sexual orientation or gender identity, substantial numbers of our staff are sexual and gender minorities.

And while we do not collect data on employee religious beliefs or practices, our work force includes a wide range of religious beliefs and practices, as well as a wide range of non-religious beliefs and philosophies.

The diversity of our patient population, legal clients and work force all reflect our commitment to inclusive, welcoming and nondiscriminatory health care of the highest quality, with a special focus on persons who fear, or who have experienced, the lack of such care elsewhere. The Proposed Rule's sweeping language and lack of specificity are of great concern; they appear to endorse discriminatory behavior, motivated by personal beliefs, that would be corrosive of fundamental professional standards and would threaten our patients' health and welfare and Whitman-Walker's mission.

The Proposed Rule's Sweeping, Overbroad Language Threatens Great Harm to Our National Health Care System, and Particularly to Mission-Driven Health Systems Such as Whitman-Walker, and to LGBTQ Individuals and Families and Others Particularly at Risk of Discrimination

The Proposed Rule announces the intention of HHS' Office for Civil Rights to vigorously enforce a number of federal statutes that protect conscience rights under limited circumstances. Most of these statutes delineate the rights of health care providers, in certain circumstances, to decline to perform specific procedures without retaliation: abortion; procedures intended to result in sterilization; and medical interventions intended to end a patient's life. Several of the statutes pertain to the right of certain religious institutions to provide religiously-oriented, non-medical health care to their members. Other statutes delineate the right of certain health plans to participate in Medicaid or Medicare while declining to cover certain services, provided adequate notice is provided to their members. Other statutes address the right of *patients* (not providers) or the parents of minors to decline certain health-related screenings, vaccinations or treatments.

The Proposed Rule, however, contains broad language that appears to sweep far beyond these limited circumstances, and implies that persons working in a health care field have a general right to decline to provide care for any reason, moral or religious, or for no articulable reason at all. *See, e.g.,* proposed Section 88.1 (Purpose) and Appendix A (mandatory notice to employees) to 45 C.F.R., 83 Fed. Reg. at 3931, declaring a broad, undefined right to accommodation for any religious or moral belief. *See also* 83 Fed. Reg. at 3881, 3887-89, 3903, which discusses at length the "problem" of health care workers being legally or professionally compelled to meet patient needs regardless of their personal beliefs. Moreover, HHS' public pronouncements about the new Conscience and Religious Freedom Division within OCR, and encouraging health care workers to file complaints, send a message that health care workers' personal beliefs prevail over their duties to patients. *E.g.*, https://www.hhs.gov/about/news/2018/01/18/hhs-ocr-announces-new-conscience-and-religious-freedom-division.html (January 18, 2018 press release); https://www.hhs.gov/conscience/conscience-protections/index.html ("Conscience Protections for Health Care Providers") The statutes in question do not support these declarations of a general health care provider "right" to deny needed care.

The potentially harmful reach of the Proposed Rule is exacerbated by an overbroad, legally unsupported interpretation of what constitutes "assisting in the performance" of an objected-to medical procedure. The proposed definition – "to participate in any program or activity with an articulable connection to a procedure, health service, health program, or research activity .... [i]nclud[ing] but ... not limited to counseling, referral, training, and other arrangements for the procedure, health service, health program, or research activity" (Section

88.2, 83 Fed. Reg. at 3923) – is so broad that it might authorize an individual in any health care-related job to decline to provide information or any assistance whatever to someone seeking care to which they may object. The problem is compounded by the broad definition of a protected refusal to provide a "referral" as "includ[ing] the provision of any information … by any method … pertaining to a health care service, activity, or procedure … that could provide any assistance in a person obtaining … a particular health care service …." Section 88.2, 83 Fed. Reg. at 3924.

A sweeping interpretation of "conscience protection" rights for persons working in health care could have far-reaching consequences. Does HHS intend to countenance, for instance:

- Refusal to provide assistance to a same-sex couple with a sick child because of an objection to same-sex parenting?
- Refusal to even provide information to an individual questioning their gender identity on their possible options, or places where they might get the information or support they need?
- Refusal to provide help to a sick woman or man who is, or is thought to be Muslim because of a health care worker's aversion to Islam?
- Refusal to provide assistance to an individual struggling with an opioid addiction because of a conviction that the addiction is the result of sin or the patient's moral failings?
- Refusal to help an individual diagnosed with HIV or Hepatitis C because of moral or religious disapproval of the way that the individual acquired (or is assumed to have acquired) the infection – namely, sex or injection drug use?

The dangers to LGBTQ persons needing health care are particularly grave. Many studies and medical authorities have documented the persistence of biases – explicit or implicit – against LGBTQ persons among many health care workers at every level – from physicians, nurses and other licensed providers to front-desk staff. LGBTQ persons continue to encounter stigma and discrimination in virtually every health care setting, including hospitals, outpatient clinics,

private doctors' offices, rehabilitation centers, and nursing homes. Transgender and gender-nonconforming persons are particularly at risk of substandard care or outright refusals of care. In this regard, it is particularly disturbing that the Proposed Rule offers, as an example of the "ills" it seeks to address, a lawsuit against a surgeon and hospital for refusing to perform a hysterectomy on a transgender man because of the patient's transgender status. 83 Fed. Reg. at 3888 n.36, 3889, c*iting Minton* v. *Dignity Health,* No. 17–558259 (Calif. Super. Ct. Apr. 19, 2017). Statutes that provide limited protection for health care providers who object to performing sterilization procedures on religious or moral grounds provide no justification for denying a medically indicated treatment of any kind – surgical, hormonal or other – to a transgender person. Suggesting otherwise is to encourage the gender identity discrimination that already is too prevalent.

Messaging that health care workers are legally entitled to refuse or restrict care, based on their personal religious or moral beliefs, flies in the face of the standards and ethics of every health care profession, and would sow confusion and undermine the entire health care system. Health care is a fundamentally patient-oriented endeavor. With limited exceptions explicitly recognized in the statues referenced in the Proposed Rule, the personal beliefs of health care workers are irrelevant to the performance of their jobs. A broad notion of a right to avoid "complicity" in medical procedures, lifestyles, or actions of other people with which one might personally disagree, which disregards the harm that might result to others, is legally, morally and politically unsupportable, particularly in a society like ours which encompasses, and encourages, a diversity of religious beliefs, cultures and philosophies. In health care, a sweeping right to "avoid complicity" is fundamentally corrosive. Encouraging employees of hospitals, health

systems, clinics, nursing homes and physician offices to express and act on their individual beliefs, in our religiously and morally diverse nation, would invite chaos, consume health care institutions with litigation, and result in denial of adequate care to uncounted numbers of people – particularly racial and ethnic minorities and LGBTQ people. No hospital, clinic or other health care entity or office could function in such an environment.

The impact of a broad, legally unsupported expansion of health care worker refusal rights on Whitman-Walker and our patients would be particularly drastic. Providing welcoming, high-quality care to the LGBTQ community and to persons affected by HIV is at the core of our mission. These are communities which are in particular need of affirming, culturally competent care because of the widespread stigma and discrimination they have experienced and continue to experience. We strive to message to all our staff that one's personal religious and moral views are irrelevant to our mission and to patient needs. It would be very difficult if not impossible for us to accommodate individual health care staff who might object to, e.g., transgender care, or counseling and assisting pregnant clients with their pregnancy termination options, or harm-reduction care for substance abusers, or care for lesbian, gay or bisexual patients – without fundamentally compromising our mission and the quality of patient care. Many of our LGBTQ patients and patients with HIV have experienced substantial stigma and discrimination and are very sensitive to being welcomed or not welcomed in a health care setting. If they encounter discrimination at WWH from any staff person at any point, our reputation as a safe and welcoming place would be undermined. There are multiple "patient touches" in our system as in any health care system: from the staff person answering the phone or sitting at the front desk to

the physician to the pharmacy worker. Each of those touches can promote or undermine patient health – can convey respect and affirmation or disrespect and rejection.

Moreover, in our diverse workforce, encouraging individual employees to think that their personal beliefs can prevail over their duties to patients – and to their fellow employees – would introduce confusion and discord into our staff as well pose barriers to patient care. The harm to our operations, finances and employee morale would be particularly complicated because we, like many health care entities, have a quasi-unionized workforce. Attempts to accommodate, for instance, one employee's unwillingness to work with transgender patients, or patients perceived to be gay, or Muslim patients, or persons with opioid addiction, would impose burdens on other staff, and likely would result in grievances filed by other employees. We would incur substantial financial costs and drains on staff time that would substantially challenge our ability to care for a growing patient load. There would also be increased pressure to ascertain whether job applicants will be unwilling to perform essential job functions, which seems likely to undermine our philosophy, which is to foster a diverse workforce.

In addition, there is every reason to believe that the Proposed Rule, and HHS' overly broad messaging of its legal authority, would result in increased discrimination against LGBTQ people and people with HIV at other health care centers and providers, outside Whitman-Walker. Biased attitudes towards LGBTQ people are still widespread but have tended to be more restrained or repressed due to changing social norms in some places. HHS messaging about the conscience rights of health care workers, particularly if not narrowly confined to specific procedures identified in the authorizing statutes, threatens to stimulate a sharp increase in those attitudes, which will have significant negative impacts on individual and public health. Fear of

discrimination among LGBTQ people would also increase. Whitman-Walker's health care providers – particularly our counselors, psychiatrists and other behavioral health staff – have many patients who have experienced traumatic stigma and discrimination – based on sexual orientation, gender identity, HIV status, race/ethnicity, and/or other factors. The creation of the new OCR Conscience and Religious Freedom Division, and HHS messaging to date, is causing increased fear and anxiety among our patients and in the LGBTQ community generally.

Escalating health care discrimination, and escalating fear of such discrimination, would result in increased demand for Whitman-Walker's services. Such increased demand would present considerable financial challenges. Many of our services to current patients lose money, due to third-party reimbursement rates and indirect cost reimbursement rates in contracts and grants which are substantially less than our cost of service. Substantially increased demand for our services, driven by increased discrimination and fear of discrimination outside Whitman-Walker, would exacerbate that pressure.

Conclusion

For the above reasons, Whitman-Walker Health requests that the Proposed Rule be withdrawn. At a minimum, HHS should substantially modify the Rule to make clear that it does not permit discrimination in health care against lesbian, gay, bisexual, transgender and queer persons – or any discrimination based on the race, ethnicity, gender, disability status or religion of any patient.

Respectfully Submitted,

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March 27, 2018

EXHIBIT 32

March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
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Washington, D.C. 20201

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

To Whom it May Concern:

We are writing on behalf of Raising Women's Voices for the Health Care We Need (Raising Women's Voices) in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1]

Raising Women's Voices is a national initiative with 30 regional coordinator organizations in 29 states working to ensure that the health care needs of women and our families are addressed in federal and state health policies. We have a special mission of engaging women who are not often invited into health policy discussions: women of color, low-income women, immigrant women, young women, women with disabilities, and members of the LGBTQ community.

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 we believe the American health system must do to achieve "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. Providers could conceivably be motivated by the proposed rule to object to administering vaccinations or refuse to prescribe or dispense Pre-exposure Profylaxis (PrEP) medication to help gay men reduce the risk of HIV transmission through unprotected sex.

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."

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

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

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

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

An expansive interpretation of "assist in the performance of" thus *could conceivably allow an ambulance driver to refuse to transport a patient to the hospital for care he/she finds objectionable*. It could mean a hospital admissions clerk could refuse to check a patient in for treatment the clerk finds objectionable or a technician could refuse to prepare surgical instruments for use in a service.

On an institutional level, the right to refuse to "assist in the performance of" a service could mean *a* religiously-affiliated hospital or clinic could deny care, and *then also refuse to provide a patient with a referral or transfer to a willing provider* of the needed service. Indeed, the proposed rule's definition of "referral" goes beyond any common understanding of the term, allowing refusals to provide *any information,* including location of an alternative provider, that could help people get care they need.[6]

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."[7]

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[8] -- have gone to hospital emergency departments and been denied prompt, medically-indicated care because of institutional religious restrictions.[9] This lack of protections for patients is especially problematic in regions of the country, such as rural areas, where there may be no other nearby hospital to which a patient could easily go without assistance and careful medical monitoring enroute.[10]

The proposed rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person

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[6] *See* Rule *supra* note 1, at 183.

[7] 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).

[8] 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

[9] 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

[10] For example, a 2016 study found there were 46 Catholic-affiliated hospitals that were the federally-designated "sole community providers" of hospital care for their geographic regions. Women needing reproductive health services that are prohibited by Catholic health restrictions would have no other easily accessible choice of hospital care. Uttley, L., and Khaikin, C., *Growth of Catholic Hospitals and Health Systems,* MergerWatch, 2016, accessed at www.MergerWatch.org

to another facility.[11] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[12] Because the proposed rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

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

The rule sets forth extensive requirements for health care institutions, such as hospitals, to notify employees about their refusal rights, including how to file a discrimination complaint with OCR. The rule requires posting of such notices on the employer's website and in prescribed physical locations within the employer's building. The rule also sets forth the expectation that OCR would investigate or do compliance reviews of whether health care institutions are following the posting rule.[13]

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. [14]

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,[15] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[16] 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.[17] For decades, Title VII has

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[11] 42 U.S.C. § 1295dd(a)-(c) (2003).

[12] 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).

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

[14] *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

[15] 42 U.S.C. § 2000e-2 (1964).

[16] *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.

[17] *See id.*

established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The proposed rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both. Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[18]

Furthermore, the language in the proposed rule would seem to put health care entities in the position of being forced to hire people who intend to refuse to perform essential elements of a position, even though Title VII would not require such an "accommodation." For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling, even though the employer would not be required to do so under Title VII.[19] 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.

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

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care and end-of-life care. The rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[20]

Doctors are, in effect, forced to abandon their patients when they are prevented by health care institutions from providing a service they believe is medically-indicated. This was the case for a doctor in Sierra Vista, Arizona, who was prevented from ending a patient's wanted, but doomed, pregnancy after she suffered premature rupture of membranes. The patient had to be sent to the nearest non-objecting hospital, which was 80 miles away, far from her family and friends. The physician described the experience as "a very gut wrenching thing to put the staff through and the patient, obviously."[21]

7. The proposed rule carries severe consequences for patients and would exacerbate existing inequities.

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

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[18] Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.
[19] *See* Rule *supra* note 1, at 180-181.
[20] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).
[21] Uttley, L, et all, *Miscarriage of Medicine,* MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.

Across the country, refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[22] 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.[23] Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.[24] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[25] 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.[26] 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.[27]

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.[28] 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.[29] In rural areas there may be no other sources of health and life preserving medical care.[30] When these individuals encounter refusals of care, they may have nowhere else to go.

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

[23] *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.

[24] *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.

[25] *See* Kira Shepherd, et al., *supra* note 23, at 29..

[26] *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.

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

[28] 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.

[29] 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.

[30] 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/.

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.[31] 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.[32] 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.[33] 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.[34]

We concur with the comments submitted by the National Health Law Program (NHeLP) that the regulations fail to consider the impact of refusals on persons suffering from substance use disorders. Rather than promoting the evidence-based standard of care, the rule could allow practitioners to refuse to provide, or even recommend, Medication Assisted Treatment (MAT) and other evidence-based interventions due simply to a personal objection.

Stigma associated with drug use stands in the way of saving lives.[35] America's prevailing cultural consciousness -- after decades of treating the disease of addiction as largely a criminal justice and not the public health issue it is -- generally perceives drug use as a moral failing and drug users as less deserving of care. For example, a needle exchange program designed to protect injection drug users from contracting blood borne illnesses such as HIV, Hepatitis C, and bacterial endocarditis was shut down in October 2017 by the Lawrence County, Indiana County Commission due to their moral objection to drug use, despite overwhelming evidence that these programs are effective at reducing harm and do not increase drug use.[36] One commissioner even quoted the Bible as he voted to shut it down. Use of MAT to reverse overdose has been decried as "enabling these people" to go on to overdose again.[37]

In this frame of mind, only total abstinence is seen as successful treatment for substance use disorders, usually as a result of a 12-step or faith-based program, even though evidence for 12-step

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[31] *See* Kira Shepherd, et al., *supra* note 23, at 12.
[32] *See id.* at 10-13.
[33] 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/.
[34] *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.
[35] Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL'Y 49, 56 (2010); German Lopez, *There's a highly successful treatment for opioid addiction. But stigma is holding it back.*, https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone.
[36] German Lopez, *An Indiana county just halted a lifesaving needle exchange program, citing the Bible,* VOX, Oct. 20, 2017, https://www.vox.com/policy-and-politics/2017/10/20/16507902/indiana-lawrence-county-needle-exchange.
[37] Tim Craig & Nicole Lewis, *As opioid overdoses exact a higher price, communities ponder who should be saved*, WASH. POST, Jul. 15, 2017, https://www.washingtonpost.com/world/as-opioid-overdoses-exact-a-higher-price-communities-ponder-who-should-be-saved/2017/07/15/1ea91890-67f3-11e7-8eb5-cbccc2e7bfbf_story.html?utm_term=.4184c42f806c.

programs is weak. The White House's own opioid commission found that "negative attitudes regarding MAT appeared to be related to negative judgments about drug users in general and heroin users in particular."[38]

People with substance use disorders already suffer due to stigma and have a difficult time finding appropriate care. This rule, which allows misinformation and personal feelings to get in the way of science and lifesaving treatment, would not help achieve the goals of the administration; it could instead trigger countless numbers of deaths.

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. 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."[39] The proposed rule plainly fails on both counts. Although the proposed rule attempts to quantify the costs of compliance, it 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.[40]

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.[41] Because the proposed rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[42]

8. 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

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

[39] *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.

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

[41] 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).

[42] 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.

[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

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]

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 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] Black women are three to four times more likely than white women to die during or after childbirth.[48] According to a recent report, doctors often fail to inform Black women of the full range of reproductive health options regarding labor or delivery, possibly due to stereotypes about Black women's sexuality and reproduction.[49] Young Black women said they felt they were shamed by

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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.

[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] 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*

providers when seeking sexual health information and contraceptive care, due to their age and in some instances, sexual orientation.[50]

Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[51] 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.[52]

As NHelP's comments note, many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously-affiliated providers. Historically, people with disabilities who rely on these services have sometimes faced discrimination, exclusion, and a loss of autonomy due to provider objections. Group homes have, for example, refused to allow residents with intellectual disabilities who were married to live together in the group home.[53] Individuals with HIV – a recognized disability under the ADA – have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. One man with HIV was refused care by six nursing homes before his family was finally forced to relocate him to a nursing home 80 miles away.[54] Given these and other experiences, the extremely broad proposed language at 45 C.F.R. § 88.3(a)(2)(vi) that would allow any individual or entity with an "articulable connection" to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a moral or religious objection is extremely alarming and could seriously compromise the health, autonomy and well-being of people with disabilities.

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

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

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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.

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

[51] *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.

[52] *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.

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

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

[55] *See supra* note 42.

The proposed rule will have a chilling effect on the enforcement of and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. The preamble of the proposed rule discusses at length state laws that the Department finds objectionable, such as state laws that require anti-abortion counseling centers to provide information about where reproductive health care services can be obtained or whether facilities have licensed medical staff, as well as state laws that require health insurance plans to cover abortion.[56] 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.[57]

10. 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.[58] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[59] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[60] 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.[61] The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the sub-recipients 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.[62] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[63]

Conclusion

The proposed rule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The proposed rule is discriminatory, violates multiple federal statutes and the

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[56] *See, e.g.*, Rule, *Supra* note 1, at 3888-89.
[57] *See id.*
[58] *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.
[59] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[60] *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).
[61] *See, e.g.*, Rule *supra* note 1, at 180-185.
[62] *See* NFPRHA *supra* note 34.
[63] *See id.*

Constitution, ignores congressional intent, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons, Raising Women's Voices calls on the Department to withdraw the proposed rule in its entirety.

If you have any questions regarding these comments, please contact Lois Uttley, co-founder of Raising Women's Voices and Women's Health Program Director for Community Catalyst, at luttley@communitycatalyst.org.

Respectfully submitted,

Raising Women's Voices for the Health Care We Need