EXHIBIT 44

Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
askAAMC.org

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 Anne Arundel Medical Center (AAMC) in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. AAMC is a health system based in Annapolis, Maryland. Our health system includes Maryland's third busiest hospital, five outpatient pavilions, a 40-bed substance use and mental health treatment facility, and a medical group with more than 55 locations throughout our service area. Last fiscal year (FY 2017), AAMC saw 26,300 inpatient admissions and did more than 920,000 office visits. We have more than 4,700 employees and 1,100 members of Medical Staff.

Notably, AAMC was recently recognized by the Human Rights Campaign's Healthcare Equality Index as a "2018 LGBTQ Healthcare Equality Top Performer." We are proud that AAMC fosters a culture and environment that is welcoming, fair, and open to all patients, regardless of sexual orientation or gender identity.

Providing quality, consistent patient care is a priority for AAMC. Both federal and state laws already protect individual health care employees from discrimination on the basis of their religious beliefs. These protections are meaningful and familiar to health care providers that have navigated these personnel obligations alongside our commitment to providing seamless, respectful healthcare to patients. The proposed regulation creates a complex, burdensome notice and reporting process for organizations and hospitals that is not only unnecessary, but also threatens to undermine the continuity of patient care at our facility.

These are our concerns:

1. **The proposed regulation attempts to inappropriately broaden religious exemptions in a way that would deny patients medically necessary or lifesaving care.**

Hospitals and healthcare organizations are in the business of providing healthcare services and information to our patients and communities. The broad and undefined nature of the proposed regulation prioritizes individual providers' beliefs 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 healthcare providers without standards and structures to guide the provision of necessary care to the most vulnerable populations, especially lesbian, gay, bisexual, and transgender (LGBT) people and women.

The scope of the regulation and the health care workers it applies to may make it impossible for some providers to offer certain treatments or to see certain patients. The proposed regulation purports to extend the interpretation of existing statutory exemptions far beyond the current standards. Under the proposed regulation a provider could be seen as empowered to refuse to provide any health care service or information for a religious or moral reason – capturing 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.

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

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. 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. Hospitals and health organizations are at a loss as to how to reconcile the proposed regulation and Title VII given the dearth of litigation on the subject and the lack of explanation in the proposed regulation. 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." 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." We agree with the EEOC.

3. **The proposed regulation lacks safeguards to ensure patients would receive emergency care as required by federal law (EMTALA) and ethical standards.**

The proposed regulation is dangerously silent in regards to ensuring patient wellbeing. The lack of consideration of patients' rights is evidenced by the fact that the proposed regulation 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 regulation also fails to address potential conflicts with emergency care requirements. Under the Emergency Medical Treatment and Active Labor Act (EMTALA), a hospital receiving government funds and providing emergency services is required also to provide medical screening and stabilizing treatment to a patient who has an emergency medical condition (including severe pain or labor). 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.

AAMC's EMTALA policy states, "All patients to whom this Policy applies shall receive an initial screening examination by Qualified Medical Personnel and appropriate treatment within the capabilities of Anne Arundel Medical Center without regard to age, race, color, religion, national origin, sex, sexual orientation, ability to pay, payer, physical or mental condition or handicap." Similar language exists in other AAMC policies, including our Patient Rights and discrimination policies.

Conclusion

Simply put, this proposed regulation is bad policy and will hurt our patients and communities. 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. The sweeping exemption and its undefined boundaries of the proposed regulation will have a chilling effect on the provision of life saving and medically necessary healthcare.

Sincerely,

Maulik Joshi, DrPH
Executive Vice President, Integrated Care Delivery and Chief Operating Officer
Anne Arundel Medical Center
2000 Medical Parkway
Annapolis, MD 21401

EXHIBIT 45

March 27, 2018

VIA ELECTRONIC SUBMISSION

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

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

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." We are concerned that this rule would put people with Medicare at risk of lacking access to medically necessary treatment and information they need to make educated, person-centered choices. Medicare beneficiaries, their families, and caregivers need to know their medical needs and choices will be honored within the Medicare program and the health care system as a whole.

Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

The Department of Health and Human Services ("HHS" or "the Department") has introduced this NPRM in an effort to ensure that the religious and conscience rights of medical providers and practitioners are not infringed. While Medicare Rights respects the exercise of such conscience rights, we have serious concerns with the proposed rule, including how the rule fails to balance the potential conflict between providers' conscience rights and the rights of citizens to access needed heath care without discrimination or undue barriers, the potential implications for emergency care, and the need for informed choice and transparency.

Below, please find our comments on (1) **Balancing Rights**, (2) **Emergency Care**, and (3) **Informed Choice and Transparency**.

Balancing Rights

We are very concerned that the proposal fails to address two vital things: (1) How this rule will interact with existing federal and state laws that already protect sincerely held religious beliefs; and (2) How this rule will interact with the rights of patients. These omissions make uncertainty, confusion, and disorder surrounding the rights and obligations of patients, physicians, other health care providers, and health care institutions more likely, not less.

In the preamble, the Department states that the proposed rule is an attempt to "ensure that persons or entities are not subjected to certain practices or policies that violate conscience, coerce, or discriminate, in violation of such Federal laws."[1] While protecting those who provide health care from discriminatory policies that may force them to choose between their beliefs and their continued or future employment is an important goal, the right of a provider to conscientiously object is not absolute.

Rather, the rights of providers to conscientiously object must be balanced against the rights of patients to access the care and information they need, consistent with their own sincerely held conscience and religious beliefs. Here, the rule falls far short. It appears instead to prioritize the conscience rights of organizations and personnel at the expense of the needs and rights of patients to receive care and information that is appropriate, medically necessary, freely chosen, transparent, and person centered, and to which they are entitled under federal law.[2]

Patients are the reason health care exists. Ensuring that patients have the care they need, to the extent they want such care, must be the primary goal of any health care system. The proposed rule is silent on the needs of patients, including what disclosures must be made to them, how care can be ensured, or what remedies they will have if their rights are infringed. Given the rule's silence, it is hard to know if the proposal intends religious objections to take precedence over patient needs and rights.

Additionally, the proposal does not address the limitations necessarily placed on the implementation of this rule by Title VII of the Civil Rights Act of 1964, or the careful balance that Act creates between religious rights, beliefs, and practices, and the need for employers and institutions to serve people. This failure will cause confusion for providers as practitioners, and expose them to liability and uncertainty as employers.

Title VII already requires that employers accommodate employees' religious beliefs to the extent there is no undue hardship on the employer.[3] Yet, the proposed regulations make no reference to Title VII, current Equal Employment Opportunity Commission (EEOC) guidance, or the extensive, controlling case-law interpreting these provisions and carefully balancing the rights of employers and employees under which an employer many not discriminate against an employee based on that employee's race, color, religion, sex, and national origin, but an employee must be able to perform

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[1] *NPRM* at 3880, available at: https://www.gpo.gov/fdsys/pkg/FR-2018-01-26/pdf/2018-01226.pdf
[2] 42 U.S.C. § 1395w–22
[3] 42 U.S.C. § 2000e-2.; *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

the essential functions of the job.[4] The proposed rule must ensure that the long-standing balance set in Title VII between the right of individuals to enjoy reasonable accommodation of their religious beliefs and the right of employers to conduct their businesses without undue interference is maintained.

While the proposal does identify "avoidance of undue burden on the health care industry" as a policy objective, that is limited to the newly proposed section 88.4 regarding assurance and certifications of compliance.[5] Nowhere does it discuss, even in passing, the complex issues that will arise if employees or institutions cannot meet their obligations under existing employment, anti-discrimination, or provision-of-service law because of their conscientious objections.

As Title VII provides protection for individual beliefs while still ensuring employers can operate their businesses as they see fit, so too do other existing federal and state civil rights laws balance the religious and other rights of providers with the very real need to protect patients against discrimination—including the adverse consequences of health care refusals—based on a variety of characteristics, such as race, gender, sexual orientation, immigration status, disability, and HIV status.[6]

For example, the Medicare program places conditions of participation on providers and institutions, including requiring Medicare Advantage organizations to provide access to all of the benefits of the Medicare fee-for-service program[7] and holding hospitals to "Conditions of Participation" to ensure that patients' rights are respected and that they received medically appropriate care.[8] Troublingly, the proposed rule does not explore the interaction between its mandate and these kinds of existing protections.

Additionally, the proposed rule does not define "discrimination." This lack of clarity regarding what constitutes discrimination may undermine non-discrimination laws. Because of the potential harm to individuals if religious refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.[9] Instead, courts have held that the government has a compelling interest in ending discrimination and that anti-

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[4] *NPRM* at 3880.
[5] *NPRM* at 3897.
[6] See, e.g. Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,194 (Sept. 8, 2015) (codified at 45 C.F.R. pt. 2).
[7] 42 U.S.C. § 1395w–22
[8] 42 CFR 482.13 (b) (2) (The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. . . .
(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives)
[9] See e.g., *Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government's interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that "the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family"); *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race," and are narrowly tailored to meet that "critical goal."[10] The uncertainty regarding how the proposed rule will interact with non-discrimination laws is extremely concerning.

Illustrating how organizations or personnel will be able to abide by each of these laws and regulations as well as this proposal is an absolutely vital step in rulemaking—but this proposed rule fails to make these interactions clear. As a result, its expansive definitions and seemingly broad application leaves open the question of whether health care personnel or institutions could potentially refuse to provide some or all services to entire categories of patients.

Emergency Care

In addition to the need for more specificity regarding the general balance between individual conscience rights and patient needs, there is the issue of emergency care, which is expressly addressed in the Social Security Act.[11] Federal and state laws reflect the long-standing obligation of health care institutions to provide assessment and care in an emergency. The Emergency Medical Treatment and Labor Act (EMTALA), for example, requires hospitals to stabilize patients who come to the emergency room in medical emergencies.[12] Any final rule should clarify the interplay of conscience rights with physicians' and hospitals' legal obligations under EMTALA.

It is concerning, then, that the proposed rule does not just avoid discussion of these legal obligations; it appears to suggest there should be no obligation to provide care in an emergency situation. In the preamble, the Department gives several reasons for this proposed rule, the first being that "allegations and evidence of discrimination and coercion have existed since 2008 and increased over time."[13]

To support this claim, the Department states that the previous rule was promulgated to address "an environment of discrimination toward, and attempted coercion of, those who object to certain health care procedures based on religious or moral convictions" and that rescinding the guidance has allowed this discriminatory environment to prosper.[14] As evidence of this growing trend, the Department cites regulatory comments, lawsuits, news reports, and polling data.

In this discussion, the Department also points to the American Congress of Obstetricians and Gynecologists (ACOG) 2016 reaffirmation of an ethics document as confirmation of the aforementioned "environment of discrimination" toward health care providers.[15] The referenced

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[10] *Burwell v. Hobby Lobby Stores, Inc*., 134 S. Ct. 2751, slip op. at 46 (2014).
[11] Centers for Medicare & Medicaid Services, *Emergency Medical Treatment & Labor Act,* available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/
[12] 42 U.S. Code § 1395dd
[13] *NPRM* at 3887.
[14] *Ibid.*
[15] *Ibid.*

ACOG guidance—"The Limits of Conscientious Refusal in Reproductive Medicine"[16]—was originally issued in 2007 and, according to the Department "at least, in part, prompted the 2008 rule."[17]

While reproductive medicine is fertile ground for those seeking conscience exceptions and therefore may have a reasonable place in this policy making discussion, the Department does not to cite a reproductive health-related section of ACOG's ethics document as an example of provider coercion. Rather, HHS focuses on the following provision, in which ACOG addresses a provider's obligation to treat a patient in an emergency situation:

"[i]n an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."[18]

By citing this ACOG recommendation as a reason for the proposed rule, the Department is suggesting that it disagrees with this specific provision, and that providing medically indicated and requested care in an emergency runs counter to the purpose of the rule. We are extremely concerned about the impact such an approach to care provision would have on patients in emergent situations. For example, could the proposed rule allow institutional health care providers, such as hospital emergency rooms, to refuse to provide emergency care? If so, this puts patients who need emergency medical care at grave risk and would run afoul of EMTALA's requirements to, at a minimum, stabilize patients who come to the emergency room in medical emergencies.[19]

The lack of clarity in the proposed rule will cause confusion and put the health and lives of patients at risk. A provider's right to refuse access to health care must not come at the expense of a patient's right to needed care.

Informed Choice and Transparency

We are also concerned that the under the rule, covered entities would be free not only to refuse to perform any given health care service, but also to deny patients access to information about or referrals for such services, by defining "referral" in a staggeringly broad way.[20] Specifically, under the proposed rule, an objecting provider could refuse to provide a patient with any information distributed by any method, regarding any service, procedure, or activity when the provider "sincerely understands the particular health care service, activity, or procedure [to which he or she objects] to be a purpose or possible outcome of the referral."[21] This would seemingly allow providers to refuse to give patients any information that they could then use to access care. In addition, the Department states that the underlying statute of the proposed rule permits entities to deny help to anyone who is likely to make a referral for an abortion or "for other kinds of

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[16] ACOG Committee Opinion, *The Limits of Conscientious Refusal in Reproductive Medicine*, available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine
[17] *NPRM* at 3388, Footnote 37.
[18] *NPRM* at 3388.
[19] 42 U.S. Code § 1395dd
[20] *NPRM* at 3894.
[21] *NPRM* at 3895.

services."[22] The breadth and vagueness of this definition could lead providers to refrain from providing information vital to patients out of anxiety and confusion of what the proposed rule permits, or requires, them to do.

The proposed regulation would allow a provider to refuse to counsel patients for services or provide medical information and options for any medical treatment without a mechanism to ensure patients get the information they need to make informed health care decisions. Cutting patients off from critical information without a disclosure that the information, services, or referral may be incomplete may not be the intent of the rule, but there is no requirement in the text that objectors be transparent about their refusals.

The expansion of refusals as proposed under this rule will exacerbate disparities and undermine the ability of 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.

The NPRM establishes that transparency and openness are valuable, and we agree that "poor communication negatively affects continuity of care and undermines the patient's health goals."[23] In addition to such practical concerns, ethical and legal standards also require that professionals ensure patients have the information they need to provide informed consent to care. However, the rule does not appear to require any disclosure on the part of objecting providers or institutions. Indeed, one case highlighted in the NPRM revolved around a hospital's lack of transparency about provider unwillingness to assist a patient through California's Aid-in-Dying rule.[24] As it stands, the proposed regulation threatens to fundamentally undermine the relationship between providers and patients, who will have no way of knowing which services, information, or referrals they may have been denied.

By contrast, Medicare rules require that Medicare Advantage organizations that object to paying for particular referrals or counseling must notify both the Centers for Medicare & Medicaid Services and any current or prospective enrollees of their refusal, with advance notice for current enrollees.[25] Such notice allows patients and their families to determine for themselves if the provider or institution offer sufficient services to meet the patient's wants and needs. Any finalized rule should use such notice requirements as a model and must be explicit in requiring that such notice be given, in writing, and in advance whenever possible, to ensure patients and families have the information they need to make informed, person-centered choices.

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[22] *Ibid.*
[23] *NPRM* at 3917.
[24] *NPRM* at 3889.
[25] The Centers for Medicare & Medicaid Services, *Managed Care Manual,* Chapter 6, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c06.pdf.

Conclusion

The center of all health care decision making must be the person receiving care. The patient, in the medical context, is supposed to be the focus, in close partnership with their families if they choose and always with practitioners in order to "ensure that decisions respect patients' wants, needs and preferences and solicit patients' input on the education and support they need to make decisions and participate in their own care."[26]

No system that ignores or overrides the person's wants, needs, or preferences, or that fails to provide necessary information, can ever be person centered. While person centeredness is an aspirational goal for the health care system, it must be at the forefront in our thinking, not shunted aside when there are other considerations on the table.

The proposed rule does not appear to take the person at the heart of health care—the patient—into account at all when discussing the rights of providers and other entities. No regulatory action in health care can succeed unless it accounts for the fundamental purpose of health care—patient well-being.

Coupled with this rule's silence about its interaction with various statutes, this omission would create chaos and confusion if this rule were finalized as-is. We urge that HHS abandon this approach and instead explore ways to bring this rule into harmony with existing law, to find a balance in the rights of patients and practitioners, to protect the health, well-being, and access to care of all patients, and to promote person-centered practices that must be at the heart of our health care system.

Thank you for the opportunity to provide comment.

For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

[26] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

EXHIBIT 46

March 27, 2018
U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

To Whom It May Concern:

I am writing on behalf of the Oregon Foundation for Reproductive Health in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1] The Oregon Foundation for Reproductive Health (OFRH) is a non-profit advocacy organization located in Portland, that provides a channel for Oregon women's voices from all over the state to be heard, particularly those historically under-served. We believe that all people should have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction for themselves and their families without fear of discrimination, exclusion, or harm. We will work to break down barriers to health care so that all people have the opportunity to thrive. Our mission is to improve access to comprehensive reproductive health care, such as preventing unintended pregnancy and planning healthy families, and we are committed to advancing reproductive rights and advocating for reproductive health equity in all Oregon communities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

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

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

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

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

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

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

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

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. The

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[11] The notice requirement is spelled out in section 88.5 of the proposed rule.
[12] *See*, for example, Freedman, Lori R., Luciana E. Hebert, Molly F. Battistelli, and Debra B. Stulberg, *Religious hospital policies on reproductive care: what do patients want to know?* American Journal of Obstetrics & Gynecology 218, no. 2 (2018): 251-e1, accessed here: http://www.ajog.org/article/S0002-9378(17)32444-4/fulltext; also Guiahi, Maryam, Jeanelle Sheeder, and Stephanie Teal, *Are women aware of religious restrictions on reproductive health at Catholic hospitals? A survey of women's expectations and preferences for family planning care*, Contraception and Stulberg, D., et all, accessed here: http://www.contraceptionjournal.org/article/S0010-7824(14)00358-8/fulltext; *Do women know when their hospital is Catholic and how this affects their care? Restrictions in Catholic Hospitals (PARRCH) national survey*, Contraception, Volume 96, Issue 4, 268-269,accessed here: http://www.contraceptionjournal.org/article/S0010-7824(17)30235-4/fulltext; a
[13] 42 U.S.C. § 2000e-2 (1964).
[14] *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.
[15] *See id.*

rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[16]

Doctors are, in effect, forced to abandon their patients when they are prevented by health care institutions from providing a service they believe is medically-indicated. This was the case for a doctor in Sierra Vista, Arizona, who was prevented from ending a patient's wanted, but doomed, pregnancy after she suffered premature rupture of membranes. The patient had to be sent to the nearest non-objecting hospital, which was 80 miles away, far from her family and friends. The physician described the experience as "a very gut wrenching thing to put the staff through and the patient, obviously."[17]

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

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

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

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

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another

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[16] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).
[17] Uttley, L, et all, *Miscarriage of Medicine,* MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.
[18] *See, e.g.*, *supra* note 2.
[19] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[20] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[21] *See* Kira Shepherd, et al., *supra* note 19, at 29.
[22] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.
[23] *See* Kira Shepherd, et al., *supra* note 19, at 27.

location, refusals bar access to necessary care.[24] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[25] In rural areas there may be no other sources of health and life preserving medical care.[26] When these individuals encounter refusals of care, they may have nowhere else to go.

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

7. The Department is abdicating its responsibility to patients

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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