Exhibit 1

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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 A Better Balance: The Work & Family Legal Center in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.

A Better Balance is a national legal advocacy organization dedicated to promoting fairness in the workplace and helping employees meet the conflicting demands of work and family through policy advocacy, outreach, and direct legal services. We are leading advocates for policies that help working families such as paid sick leave, paid family and medical leave, and policies that combat discrimination based on pregnancy and family status. We are also working to combat LGBT employment nondiscrimination through our national LGBT Work-Family project. We believe that when all working parents and caregivers have a fair shot in the workplace, our families, our communities, and our nation are healthier and stronger.

A Better Balance believes a health care provider's personal beliefs should never determine the care a patient receives. That is why we strongly oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule"), which seeks to permit discrimination in all aspects of health care.[1]

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. Such expansions exceed the Department's authority; violate the Constitution;

[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].

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undermine the ability of states to protect their citizens; undermine critical HHS programs like Title X; interfere with the provider-patient relationship; and threaten the health and well-being of people across the country and around the world.

By issuing the Proposed Rule and creating a new division within the Office of Civil Rights ("OCR")—the new "Conscience and Religious Freedom Division"—the Department seeks to inappropriately use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. For these reasons A Better Balance calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

I. The Proposed Rule Unlawfully Exceeds the Department's Authority by Impermissibly Expanding Religious Refusals to Provide Care

The Proposed Rule attempts to expand the reach not only of existing harmful refusal of care laws but also to create new refusals of care where none were intended.

A. The Proposed Rule Seeks to Allow the Refusal of any Health Service Based on Personal Belief

The Proposed Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion and transition-related care. Specifically, the Department and OCR are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[2] Read in conjunction with the rest of the Proposed Rule, it is clear this is intended to allow any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care.

B. The Proposed Rule Unlawfully Expands Already Harmful Abortion/Sterilization Refusal of Care Laws

Already existing refusal of care laws are used across the country to deny patients the care they need.[3] 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

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[2] *See id.* at 12.

[3] *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.

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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.[4] But the Proposed Rule attempts to broaden this provision to allow individuals to refuse to perform aspects of their jobs based on a mere reference to a religious or moral belief regardless of whether it relates to the specific biomedical or behavioral service or research activity they are working on.[5] Such an attempted expansion goes beyond what the statute enacted by Congress allows. Furthermore, the Proposed Rule would expansively apply other provisions of the Church Amendments to, among other things, individuals working under global health programs funded by the Department thereby allowing global health providers and entities to refuse individuals the care they need contrary to the very purpose of such programs.

Similarly, the Proposed Rule defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. For 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.[6] 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.[7]

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.[8] 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.[9] 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

[4] The Church Amendments, 42 U.S.C. § 300a-7 (2018).
[5] *See* Rule *supra* note 1, at 185.
[6] *Id.* at 180.
[7] *Id.* at 183.
[8] 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).
[9] *See* Rule *supra* note 1, at 182.

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defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert.[10]

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."[11] In particular, the Proposed Rule defines "discrimination" against a health care entity broadly to include a number of activities, including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[12] In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is vague and inappropriate. Further, it provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

II. The Proposed Rule Carries Severe Consequences for Patients and Will Exacerbate Already Existing Inequities

A. Refusals of Care Make it Difficult for Many Individuals to Access the Care They Need

LGBTQ people, women, and other vulnerable groups around the country already face enormous barriers to getting the care they need.[13] Accessing quality, culturally competent care and overcoming outright discrimination is an even greater challenge for those living in areas with already limited access to health providers. The Proposed Regulation threatens to make access even harder and, for some, nearly impossible.

Patients living in less densely populated areas already face a myriad of barriers to care including less access to health insurance coverage, lower incomes, and lower rates of paid sick leave. This is in addition to the universal costs of transportation, taking time from work, and other incidentals that go along with obtaining care in the first place. For many, the sheer distance to a

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[10] The doctrine of expression unius est exclusion alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.

[11] *See* Rule *supra* note 1, at 180.

[12] *Id.*

[13] *See, e.g.*, Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx; Sandy E. James et al., *The Report of the U.S. Transgender Survey* 93–126 (2016), www.ustranssurvey.org/report; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), http://www.lambdalegal.org/publications/when-health-care-isnt-caring; Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2016), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

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healthcare facility can be a significant barrier to getting care. For example, more than half of rural women live more than 30 minutes away from a hospital that provides basic obstetric care.[14] Patients seeking more specialized care like that required for fertility treatments, endocrinology, or HIV treatment or prevention are often hours away from the closest facility offering these services. For example, a 2015 survey of nearly 28,000 transgender adults nationwide found that respondents needed to travel much further to seek care for gender dysphoria as for other kinds of care.[15]

This means that if these patients are turned away or refused treatment, it will be much harder—and sometimes simply not possible—for them to find a viable alternative. In a recent study, nearly one in five LGBTQ people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBTQ people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.[16] For these patients, being turned away by a medical provider is not just an inconvenience: it often means being denied care entirely with nowhere else to go.

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[17] 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.[18] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[19] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[20] 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

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[14] American College of Obstetrics and Gynecologists, *Health Disparities in Rural Women* (2014), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women#17.

[15] Sandy E. James et al., *The Report of the U.S. Transgender Survey* 99 (2016), www.ustranssurvey.org/report

[16] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2016), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

[17] *See, e.g.*, *supra* note 3.

[18] *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.

[19] *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.

[20] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 29 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

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her the procedure.[21] 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.[22]

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.[23] 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.[24] In rural areas there may be no other sources of health and life preserving medical care.[25] In developing countries where many health systems are weak, health care options and supplies are often unavailable.[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 women of color in many states disproportionately receive their care at

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[21] *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.

[22] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 27 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[23] 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.

[24] 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.

[25] 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/.

[26] *See* Nurith Aizenman, *Health Care Costs Push a Staggering Number of People into Extreme Poverty*, NPR (Dec. 14, 2017), https://www.npr.org/sections/goatsandsoda/2017/12/14/569893722/health-care-costs-push-a-staggering-number-of-people-into-extreme-poverty; *Tracking Universal Health Coverage: 2017 Global Monitoring Report*, WORLD HEALTH ORG. & THE WORLD BANK (2017), http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf.

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Catholic hospitals. In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[27] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on a wide range of hospital matters, including reproductive health care and can keep providers from offering the standard of care.[28] 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.[29] 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.[30]

In addition, in many of the countries where the Department implements global AIDS programs, many of the patients served already face numerous barriers to care, including a broad and harmful refusal provision contained within the statute governing such programs.[31]

C. *In Proposing this Rule, the Agency has Abandoned its Legal Obligations to Adequately Account for Harm to Patients*

By expanding refusals of care the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. Under Executive Order 13563, an agency may propose regulations only 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."[32] 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.[33]

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[27] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

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

[29] 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/.

[30] *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.

[31] *See The Mexico City Policy: An Explainer*, KAISER FAMILY FOUND. (June 1, 2017), https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/.

[32] 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.

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

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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.[34] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[35]

III. 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.[36] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[37] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[38] 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.[39] 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.[40] 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,

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[34] 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).

[35] 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.

[36] *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.

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

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

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

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

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including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[41]

IV. The Proposed Rule Will Carry Severe Consequences for Providers and Undermine the Provider-Patient Relationship

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care. Hospital systems across the country use religious beliefs to prevent their employees from treating patients regardless of the professional, ethical, or moral convictions of these providers.[42] The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions, including foreign and international organizations, to bind the hands of providers and attempt to limit the types of care they can provide.

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health providers and patients and ensure patient-centered decision-making.[43] Informed consent requires providers disclose relevant and medically accurate information about treatment choices and alternatives so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[44] By allowing providers, including hospital and health care institutions, to refuse to provide patients with information, the Proposed Rule makes it impossible for patients to have full information regarding treatment options. While the Department claims the Proposed Rule improves communication between patients and providers, in truth it will deter open, honest conversations that are vital to ensuring that a patient can control their medical circumstances.[45]

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral, and provision of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease,

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[41] *See id.*
[42] *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.
[43] *See* TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).
[44] *See id.*
[45] *See* Rule *supra* note 1, at 150-151.

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diabetes, epilepsy, lupus, obesity, and cancer.[46] Individuals seeking reproductive health care, regardless of their reasons for needing these services, should be treated with dignity and respect. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them.

In addition, the Proposed Rule ignores the many providers with deeply held moral convictions that affirmatively motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. Moreover, the Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[47] No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion.

V. 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.[48] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is both illogical and affirmatively harmful. For example, the notice and certification of compliance and assurance requirements do not make sense when applied to the laws the Proposed Rule seeks to enforce.[49] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

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[46] For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant. AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE § 114-15, S117 (2017), available at http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf. The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics guidelines state that the risks to the woman from persistent severe pre-eclampsia are such that delivery (abortion) is usually suggested regardless of fetal age or potential for survival. AM. ACAD. OF PEDIATRICS & AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).

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

[48] *OCR's Mission and Vision*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").

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

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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.[50] 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.[51]

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.[52] And these disparities do not occur in isolation. Black women, for example, are three to four times more likely than white women to die during or after childbirth.[53] Further, the disparity in maternal mortality is growing rather than decreasing,[54] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resulting health disparities. For example, women's pain is routinely undertreated and often dismissed.[55] And due to gender biases and disparities in

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[50] 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.

[51] *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.

[52] *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.

[53] *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.

[54] *See id.*

[55] *See, e.g.*, Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001).

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research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[56] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[57] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[58]

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.[59]

VI. The Proposed Rule Conflicts with Other Existing Federal Law

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals to care it would create.

For example, the Proposed Rule makes no mention of Title VII,[60] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[61] With respect to religion, Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[62] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public

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[56] *See, e.g.*, Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. of the Am. Heart Ass'n 1 (2015).
[57] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf. A survey examining discrimination against LGBTQ people in health care more than half of respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health care status; or health care professionals being physically rough or abusive.
[58] *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.
[59] *See supra* note 46.
[60] 42 U.S.C. § 2000e-2 (1964).
[61] *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.
[62] *See id.*

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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.[63]

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.[64] 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.

In addition, 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 to another facility.[65] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[66] 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.

VII. The Proposed Rule Will Make It Harder for States to Protect their Residents

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[63] 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.

[64] *See* Rule *supra* note 1, at 180-181.

[65] 42 U.S.C. § 1295dd(a)-(c) (2003).

[66] 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 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).

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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.[67] 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.[68]

Conclusion

The Proposed Rule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The Proposed Rule is discriminatory, violates multiple federal statutes and the Constitution, ignores congressional intent, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons A Better Balance calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

Marcella Kocolatos
Staff Attorney

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

Exhibit 2

WASHINGTON
LEGISLATIVE OFFICE

ACLU

March 27, 2018

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Office for Civil Rights
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TREASURER

Re: Proposed New 45 CFR Part 88 Regarding Refusals of Medical Care

The American Civil Liberties Union ("ACLU") submits these comments on the proposed rule published at 83 FR 3880 (January 26, 2018), RIN 0945-ZA03, with the title "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (the "Proposed Rule" or "Rule").

For nearly 100 years, the ACLU has been our nation's guardian of liberty, working in courts, legislatures, and communities to defend and preserve the individual rights and liberties that the Constitution and the laws of the United States. With more than 2 million members, activists, and supporters, the ACLU is a nationwide organization that fights tirelessly in all 50 states, Puerto Rico, and Washington, D.C. for the principle that every individual's rights must be protected equally under the law, regardless of race, religion, gender, sexual orientation, gender identity or expression, disability, national origin, or record of arrest or conviction.

In Congress and in the courts, we have long supported strong protections for religious freedom. Likewise, we have participated in nearly every critical case concerning reproductive rights to reach the Supreme Court and advocated for policies that promote access to reproductive health care. The ACLU is also a leader in the fight against discrimination on behalf of those who historically have been denied their rights, including people of color, LGBT (lesbian, gay, bisexual, and transgender) people, women, and people with disabilities. Because of its profound respect for and experience defending religious liberty, reproductive rights, and principles of non-discrimination, the ACLU is particularly well positioned to comment on the Proposed Rule. We steadfastly protect the right to religious freedom. But the right to religious freedom does not include a right to harm others as this Proposed Rule contemplates. And, indeed, when the Bush Administration adopted similar rules, the ACLU challenged them in court. *See National Family Planning & Reproductive Health*

Association, Inc. v. Leavitt, *consolidated in* Case No. 3:09-cv-00054-RNC (D. Conn. 2009).[1]

The Proposed Rule grants health care providers unprecedented license to refuse to provide information and health care to patients and puts faith before patients' health. The Rule thus contravenes the core mission of the Department of Health and Human Services [the "Department"] to protect and advance the health of all. The Department's failure even to mention the impact of the rule on patients is clear evidence of its misplaced priorities. The Rule also flies in the face of the longstanding history of the Department to further our nation's health by addressing discrimination in health care, aiming instead to foster discrimination.

Tellingly, the Department justifies the Rule by citing as the "problem" cases in which patients sought remedies after being denied health care—to the detriment of their health and often for discriminatory reasons. *See* 83 FR 3888-89 & n.36. The problem, however, is not that patients want care, but that health care providers denied vital, even life-saving, medical care, discriminated, and imposed their religious doctrine to the detriment of patients' health. Tamesha Means, for example, should not have been turned away from the hospital where she sought urgent care even once, let alone three times, without even being provided with the information that her own life could be in jeopardy if she did not obtain emergency abortion care for her miscarriage.[2] Rebecca Chamorro should not have been required to undergo the additional stress, health risks, and cost of two surgical procedures, rather than a single one, when her doctor was ready, willing, and able to perform a standard postpartum tubal ligation.[3] Evan Minton's scheduled hysterectomy should not have been canceled on the eve of that procedure, despite his doctor's willingness to proceed with that routine operation, because the hospital became aware he was transgender.[4] These refusals, not the patients seeking justice, are the problem. Yet these are the types of refusals the Department seeks to make more commonplace with this Rule. 83 FR 3888-89 & n.36.

Moreover, if the Department is to adhere to its mission and to address discrimination, its focus should not be on expanding a purported right of institutions to refuse to provide care because of beliefs, but on eliminating the discrimination that continues to devastate communities in this country. 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.[5] Black women, for example, are three to four times more likely than white women to die during or after childbirth.[6] Women have long been the subject of discrimination in

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[1] That lawsuit was ultimately dismissed when the Obama Administration rescinded virtually all of the regulations. *See* 74 FR 10207, 75 FR 9968, 76 FR 9968, *infra* n.16.

[2] *See* Health Care Denied 9-10 (May 2016), *available at* https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied.

[3] *See id.* at 18.

[4] *See* Verified Complaint, *Minton v. Dignity Health*, Case No. 17-558259 (Calif. Super. Ct. April 19, 2017).

[5] *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.

[6] *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.

health care and the resulting health disparities.[7] And due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[8] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[9] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of that aspect of their identity in the year before the survey.[10] The Department should be working to end, not foster, discrimination in health care.[11]

In the comments below, the ACLU details some of the specific ways in which the Proposed Rule exceeds the Department's authority and in so doing causes significant harm to patients.[12] The non-exhaustive examples of serious flaws in the Rule include:

- The Proposed Rule utterly fails to consider the harmful impact it would have on patients' access to health care.

- The Department lacks *any* legislative rule-making authority under the Church Amendments, 42 U.S.C. § 300a-7, the Coats-Snowe Amendment, 42 U.S.C. § 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, Div. H, Tit. V, § 507(d) (collectively, the "Amendments"), the primary statutory authority for the Rule, and thus it cannot adopt these proposed force-of-law requirements to expand those Amendments.

- The Rule tries to expand the plain language Congress used in the Amendments and over a dozen other laws referenced by this rulemaking (collectively, the "Refusal Statutes"), proposing definitions that distort the ordinary meaning of words and otherwise impermissibly stretching these narrow provisions.

- The Rule's impact is not limited to individual health care providers; it attempts to greatly expand the Refusal Statutes to enable more institutions—e.g., hospitals,

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[7] *See, e.g.*, Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001).

[8] *See, e.g.*, Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. of the Am. Heart Ass'n 1 (2015).

[9] *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.

[10] *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.

[11] The Department's Office of Civil Rights ("OCR") has a long history of combating discrimination, protecting patient access to care, and eliminating 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.

[12] Although these ACLU comments primarily focus on examples of the Proposed Rule's flaws and harms with reference to the Church, Coats and Weldon Amendments, virtually all of the problems identified in this letter extend to the Rule's similar, unfounded extension of the over a dozen other provisions encompassed within the Rule.

clinics, and other corporate entities—to deny care, even in emergency situations, and even when individual providers at the institutions have no objection to providing the care.

- The Rule is entirely unnecessary as health care providers are already shielded by Title VII's religion protections, and addressed by the Refusal Statutes, and there is no evidence that existing mechanisms are insufficient to ensure compliance with those Refusal Statutes.

- The Rule purports to seek a "society free from discrimination," but repeatedly *invites expanded discrimination – through refusals of care* – against women, LGBT patients, and other members of historically-mistreated groups.

- Likewise, the Rule purports to advance "open and honest communication," yet it *empowers providers to withhold information* from patients about their medical condition and treatment options in contravention of legal and ethical requirements and principles of informed consent.

Because the Proposed Rule harms patient health, encourages discrimination, and exceeds the Department's rulemaking authority, it should be withdrawn. If the Department refuses to do so, it must, at a minimum, revise the Proposed Rule so that it comes into alignment with the statutory provisions it purports to implement, makes clear that it is not intended to conflict with other state and federal laws that protect patients, and mitigates the harm to patients' health and well-being.

I. The Proposed Rule Fails Even to Mention Its Impact on Patients, While Inviting More Refusals of Care That Would Fall Disproportionately on Low-Income People and Other Marginalized Groups.

The Department's mission is "to enhance and protect the health and well-being of all Americans. [It] fulfill[s] that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services."[13] The Department administers more than 100 programs, which aim to "protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves."[14]

It is thus extraordinary that this Notice of Proposed Rulemaking ("NPRM") is devoted solely to increasing the ability of health care entities and professionals to refuse to provide health care information and services to patients. Nowhere in the 50 pages that the NPRM spans in the Federal Register does it discuss the impact that refusals to provide information and denials of care have on patient health and well-being. In fact, patients are not even mentioned in the discussion of "affected persons and entities." 83 FR 3904. And in the Proposed Rule's flawed attempt at a cost-benefit analysis, the Department devotes a mere three paragraphs to the Rule's purported effects on patient-provider communication—and none at all to the direct harms suffered by those who are denied information and care. 83 FR 3916-17.

[13] *See* https://www.hhs.gov/about/index.html.
[14] *See* https://www.hhs.gov/programs/index.html.

But this failure to address the obvious consequences of giving federally-subsidized providers *carte blanche* to decide whom to treat or not treat based on religious or moral convictions—or indeed, based on any reasoning or none at all[15]—does not mean the harm does not exist. Indeed, the harms would be substantial. For example, as set forth in more detail below, the Proposed Rule:

- Appears to provide immunities for health care institutions and professionals who refuse to provide complete information to patients about their condition and treatment options;

- Would result in patients being denied, or delayed in getting, health care to the extent the Rule requires health care facilities to employ people who refuse to perform core functions of their jobs;

- Purports to create new "exemptions," that would leave patients who rely on federally-subsidized health care programs, such as Title X family planning services, unable to obtain services those programs are required by law to provide;

- Creates confusion about whether hospitals can refuse to provide, and bar its staff from providing, emergency care to pregnant women who are suffering miscarriages or otherwise need emergent abortion care; and

- Invites health care providers to discriminate against individuals based on who they are by, for example, refusing to provide otherwise available services to a patient for the sole reason that the patient is transgender.

These harms will fall most heavily on historically disadvantaged groups and those with limited economic resources. As the ACLU's own cases and requests for assistance reflect, women, LGBT individuals, and members of other groups who continue to struggle for equality are those who most often experience refusals of care. The Proposed Rule's unauthorized expansion of the Refusal Statutes will only exacerbate these disparities.

Likewise, people with low and moderate incomes will suffer most acutely under the Proposed Rule. The Refusal Statutes, and therefore the expansive Proposed Rule, are tied to federal funding. Individuals with limited income are more likely to rely on health care that is in some manner tied to federal funding and are therefore more likely to be subject to the refusals to provide care and information sanctioned by the Proposed Rule. Thus, for example, if a health care entity that, under the Proposed Rule, is now able to obtain a government contract to provide Title X family planning services despite its unwillingness to provide the required services, low-income individuals in the area are likely to have few, if any, other options for the care.

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[15] Although the NPRM highlights religious freedom and rights of conscience, a number of the Refusal Statutes – and the proposed expansions of those in the Rule – do not turn on the existence of any religious or moral justification. The Proposed Rule would empower not only those acting based on the basis of belief, but others acting, for example, out of bare animus toward a patient's desired care or any aspect of their identity.

Not only will this result in the outright denial of care to the detriment of patients' health, it will also impose serious economic consequences that the Proposed Rule fails to take into account. For example, the denial of care can result not only in greater health care costs, but also in lost wages (and in some cases loss of employment), increased transportation costs and increased child care costs. For women, immigrant patients, and rural patients, these snowballing effects can be particularly acute. Yet, remarkably, the Proposed Rule finds no effect at all on the "disposable income or poverty of families and children" from expanding denials of health care. 83 FR 3919. Contrary to the Department's conclusions, this Rule would impose new costs on and create new pressures for many families, especially those with the least economic means.

Rather than seek to expand patient protections, the Proposed Rule appears to launch a direct attack on existing federal legal protections that prevent or remedy discrimination against patients. *See, e.g., infra* Part IV. The Rule raises equal concern with regard to its intended effect on state laws that aim to enhance patient protection and address discrimination. The Preamble devotes extensive discussion to "Recently Enacted State and Local health care laws" that have triggered some litigation by "conscientious objectors," 83 FR 3888, characterizing those disputes as part of the rationale for the Rule.[16] But this rulemaking provides no clarity as to preservation of other legal protections and repeatedly evidences an intent to cut back on, for example, important equality safeguards for patients. At the very least, this will create severe confusion, creating competing and contradictory requirements, and in so doing put critical federal funding for vital care at risk. At worst, it targets vulnerable patients for increased refusals of care and the harms described above.

Because it is contrary to the very mission of the Department, attempts to license widespread denials of care and harm to patients, and fosters discrimination, the Proposed Rule should be withdrawn.

II. The Department Lacks the Authority to Promulgate the Proposed Rule.

Not only does the Rule undermine patient's health, it is unauthorized. For example, the Department does not possess *any* legislative rulemaking powers under the Church, Coats-Snowe or Weldon Amendments – the Amendments that form the bases for the bulk of the Rule – and thus it lacks the authority to promulgate this Rule with respect to those statutes.

"It is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority delegated by Congress." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). With this Proposed Rule, the Department clearly seeks to adopt legislative rules that will impose force-of-law, substantive requirements and compliance procedures that must be followed by covered entities. But there is no authority delegated by Church, Coats-Snowe or Weldon to undertake such rulemaking. Indeed, in prior litigation, the Department itself emphasized that "[i]n the first place, it is not clear that the Weldon Amendment can be said to delegate regulatory authority to the Executive Branch at all." Br. of

[16] *See also* 83 FR 3889 (seeking to "clarify" that conscience protections "supersede conflicting provisions of State law"; pointing to state requirements, for example, that insurers include abortion coverage in health plans as illustrations of "the need for greater clarity concerning the scope and operation" of federal rights of refusal).

Defs. at 35, *National Family Planning and Reproductive Health Association v. Gonzales*, 391 F. Supp. 2d 200 (D.D.C. 2005), *available at* 2004 WL 3633834; *see also* 76 FR 9971, 9975 (discussing that the Amendments do not provide for promulgation of regulations).

None of the Amendments includes, or references, *any* explicit delegation of regulatory authority. *Compare, e.g.*, 42 U.S.C. § 2000d-1 (expressly directing all relevant federal agencies to issue "rules, regulations, or orders of general applicability" to achieve the objectives of Title VI). Nor is there any implicit delegation of legislative rulemaking authority for these provisions. As underscored by the decades that Church, Coats-Snowe and Weldon have applied without any legislative rulemaking supplementing their content, those enactments do not give the Department the power to issue force-of-law rules under them, as the Department is now – expansively – trying to do.[17] For this reason alone, the Department cannot properly proceed to adopt the Proposed Rule or any similar variation of it.

III. The Rule Proposes Numerous Expansive Definitions That Defy the Meaning of the Statutory Terms and Would Fuel Confusion, Misinformation, and Denials of Care.

Even if the Department had the necessary rulemaking authority (which it does not), the Proposed Rule's broad definition of certain terms and expansions of the Refusal Statutes' reach would far exceed any conceivable authority. An agency cannot use rulemaking to extend the scope of a statute. *See City of Arlington, Tex. v. F.C.C.*, 569 U.S. 290, 297 (2013) (agency must stay within the bounds of the statute under which it acts). Yet that is what this Rule does, through numerous proposed "definitions," including, among others, those proposed for "assist in the performance," "referral or refer for," and "discrimination."

Indeed, it is telling that the Rule's Preamble devotes four pages in the Federal Register to trying to justify its over-reaching definitions, but does not attempt to describe the Rule's proposed substantive requirements at all. Instead, the Preamble claims that the substantive requirements are simply "taken from the relevant statutory language." 83 FD 3895. But that assertion is belied by, *inter alia*, the Department's proposed expansion and re-writing of those statutes through impermissible re-definition of numerous statutory terms and other sleights of hand. Any rule-making of this kind needs to attempt to explain not only the definitions of words, but how those definitions and the Rule's substantive requirements come together to regulate conduct, which the Department utterly fails to do.

For example, the Department proposes to define "assist in the performance" of an abortion or sterilization to include not only assistance *in the performance* of those actual procedures—the ordinary meaning of the phrase—but also participation in any other activity

[17] Although the Bush Administration promulgated similar rules in December 2008, those rules did not take full effect before their reconsideration and rescission commenced. The eventual replacement regulation, which became final in 2011 and remains in force today, consists of just two provisions describing solely that OCR is designated to receive complaints under the Amendments. The Department promulgated that rule under 5 U.S.C. § 301, the Department's "housekeeping" authority for adopting regulations limited to the conduct of its own affairs. Section 301 does not authorize the promulgation of substantive regulatory requirements like those in the Proposed Rule. *See* 76 FR 9975-76. Moreover, that we here highlight the lack of regulatory rule-making authority under Section 301 and under the Amendments should not be read to imply that any such authority exists under the other Refusal Statutes referenced in this NPRM; the Proposed Rule does not specify *any* authority for legislative rulemaking.

with "an articulable connection to a procedure[.]" 83 FR 8892, 3923. Through this expanded definition, the Department explicitly aims to include activities beyond "direct involvement with a procedure" and to provide "broad protection"—despite the statutory references limited to "assist[ance] in the performance of" an abortion or sterilization procedure itself. *Id.*; *cf. e.g.,* 42 U.S.C. § 300a-7(c)(1).

This would mean, for example, that simply admitting patients to a health care facility, filing their charts, transporting them from one part of the facility to another, or even taking their temperature could conceivably be considered "assist[ing] in the performance" of an abortion or sterilization, as any of those activities could have an "articulable connection" to the procedure. As described more fully below, *see infra* Part VI, the Proposed Rule would even sanction the withholding of basic information about abortion or sterilization on the grounds that "assist[ing] in the performance" of a procedure "includes but is not limited to counseling, referral, training, and other arrangements for the procedure." 83 FD 3892, 3923.

But the term "assist in the performance" does not have the virtually limitless meaning the Department proposes ascribing to it. The Department has no basis for declaring that Congress meant anything beyond actually "assist[ing] in the performance of" the specified procedure—given that it used that phrase, 42 U.S.C. § 300a-7(c)(1). There is no basis for the Department to interpret that term to mean any activity with any connection that can merely be articulated, regardless of how attenuated the claimed connection, how distant in time, or how non-procedure-specific the activity.

Likewise, the Proposed Rule's definition of "referral or refer for" impermissibly goes beyond the statutory language and congressional intent. The Rule declares that "referral or refer for" means "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, assisting, … financing, or performing" it, where the entity (including a person) doing so "sincerely understands" the service, activity, or procedure to be a "possible outcome[.]" 83 FR 3894, 3924 (emphasis added). This expansive definition could have dire consequences for patients. For example, a hospital that prohibits its doctors from even discussing abortion as a treatment option for certain serious medical conditions could attempt to claim that the Rule protects this withholding of critical information because the hospital "sincerely understands" the provision of this information to the patient may assist the patient in obtaining an abortion.[18]

But by providing a green light for the refusal to provide information that patients need to make informed decisions about their medical care, the Proposed Rule not only violates basic medical ethics, but also far exceeds congressional intent. A referral, as used in common parlance and the underlying statutes, has a far more limited meaning than providing *any* information that *could* provide *any assistance whatsoever* to a person who may ultimately decide to obtain, assist, finance, or perform a given procedure sometime in the future. The meaning of "referral or refer for" in the health care context is to *direct* a patient elsewhere for care. *See* Merriam-Webster, https://www.merriam-webster.com/dictionary/referral ("referral" is "the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive

[18] As explained in Part VI(B), *infra*, the Proposed Rule's overbroad interpretation of the phrase "make arrangements for," 83 FR 3895, compounds the problems with the unjustified definition of referral.

treatment"); Medicare.gov, *Glossary: Referral*, https://www.medicare.gov/glossary/r.html (defining referral as "[a] written order from your primary care doctor for you to see a specialist or get certain medical services"); HealthCare.gov, *Glossary: Referral*, https://www.healthcare.gov/glossary/referral/ (same); Ctrs. for Medicare & Medicaid Services Website, *Glossary: Referral*, https://www.cms.gov/apps/glossary/default.asp?Letter=R&Language ("Generally, a referral is defined as an actual document obtained from a provider in order for the beneficiary to receive additional services."); *id.* (a referral is a "written OK from your primary care doctor for you to see a specialist or get certain services").

In addition, the Proposed Rule's definition appears to include a subjective element not present in any of the referenced statutes or in the ordinary meaning of "referral": Under the Rule, an entity's "sincere understanding" determines whether or not a referral has occurred. 83 FR 3924; *see also* 83 FR 3894 n.46 (claiming that a "referral constitutes moral cooperation with a conscientiously objected activity"). The Proposed Rule states that it is attempting to provide "broad protection for entities unwilling to be complicit in" certain services, 83 FR 3895, but transforming "refer for" into a much looser, subjective notion of being "complicit in" is a significant departure from the actual statutory language of the Refusal Statutes and plainly exceeds the Department's authority.

These expansive definitions are all the more troubling to the extent the Proposed Rule's definition of "discrimination" purports to provide unlimited immunity for institutions or employees who refuse to perform essential care. The Rule apparently attempts to provide unlimited immunity for institutions that receive some federal funds to deny abortion care, to block coverage for such care, or to stop patients' access to information, no matter what the patients' circumstances or the mandates of state or federal law. Likewise, the definition appears aimed at providing immunity for employees who refuse to perform central parts of their job, regardless of the impact on the ability of a health care entity to provide appropriate care to its patients. This expansion of "discrimination" would apparently treat virtually any adverse action—including government enforcement of a patient non-discrimination or access-to-care law—against a health care facility or individual as *per se* discrimination. Indeed, the definition of discrimination appears designed to provide a tool to stop enforcement of state laws providing more protection of patients, particularly those seeking abortion care. But "discrimination" does not mean any negative action, and instead requires an assessment of context and justification, with the claimant showing unequal treatment on prohibited grounds under the operative circumstances. [19] *See infra* Parts IV-V.

While this comment letter does not attempt to detail all of the unfounded definitional expansions included in the Proposed Rule, other examples abound. *See e.g.*, 83 FR 3893

[19] The Rule should not be expanded even further by an unfounded "disparate impact" concept that has no place in implementing these narrowly-targeted Refusal Statutes. While the Proposed Rule does not explain its proffered "disparate impact" concept, such a concept might empower the Department, for example, to forbid *any* enforcement of a general state government policy that is contrary to a particular institution's religious dictates, or of a neutral employment rule that is contrary to some employees' beliefs (rather than accepting that an employer's obligations are at most reasonable accommodation of particular employees, if possible without undue hardship, *see infra* Part IV).

(proposing to define "health care entity" to include those employers and others who sponsor health plans but "are *not* primarily in the business of health care") (emphasis added), 3894 (proposing to define "workforce" to include volunteers and contractors, despite those individuals' independence from any corporate or public entities employing workers), 3894 (erroneously expanding definition of "health service program"), 3923-24.[20] The Department has no authority to expand the Refusal Statutes in this way, and these irrational definitions that are contrary to both the Refusal Statutes and congressional intent should be explicitly rejected.

IV. The Proposed Rule Threatens to Upend the Appropriate Balance Struck by Long-Standing Federal Laws.

A. The Proposed Rule Ignores the Careful Balance Title VII Strikes Between Protecting Employees' Religious Beliefs and Ensuring Patients Can Obtain the Health Care They Need.

The Proposed Rule is not only unauthorized and harmful to patients, it is also unnecessary as federal law already amply protects individuals' religious freedom—freedom the ACLU has fought to protect throughout its nearly 100-year history.

For example, for more than four decades, Title VII has required employers to make reasonable accommodations for current and prospective employers' religious beliefs so long as doing so does not pose an "undue hardship" to the employer. 42 U.S.C. §§ 2000e(j), 2000e-2(a).[21] An "undue hardship" occurs under Title VII when the accommodation poses a "more than *de minimis* cost" or burden on the employer's business. *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 84 (1977); EEOC Guidelines, 29 C.F.R. § 1605.2(e)(1). Thus, Title VII—while protecting employees' freedom of religion—establishes an essential balance. It recognizes that an employer cannot subject an employee to less favorable treatment solely because of that employee's religion and that generally an employer must accommodate an employee's religious practices. However, it does not require accommodation when the employee objects to performing core job functions, particularly to the extent those objections harm patients, depart from standards of care, or otherwise constitute an undue hardship. *Id.*; *see also Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703 (1985). This careful balance between the needs of employees, patients, and employers is critical to ensuring that health care employers are able to provide quality health care.

Despite this long-standing balance, nowhere does the Proposed Rule mention these basic legal standards or the need to ensure patient needs are met. Instead, by presenting a seemingly unqualified definition of what constitutes "discrimination," 83 FR 3923-24, the Department

[20] Moreover, the Proposed Rule not only re-defines words and phrases from the Refusal Statutes, but also adds words. For example, Section 1303 of the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 18023(b)(1)(A)(i), refers to "abortion services"; the Proposed Rule expands that to "abortion or abortion-related services," without defining what that added term – found nowhere in the statute – purports to cover. 83 FR 3926; *see also, e.g.,* 83 FR 3924 (defining "health program or activity" without any apparent use of phrase in a Refusal Statute though it is used to protect patients in Section 1557 of the ACA).

[21] For purposes of Title VII, religion includes not only theistic beliefs, but also non-theistic "moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." Equal Employment Opportunity Commission ("EEOC") Guidelines, 29 C.F.R. §1605.1.

appears to attempt to provide complete immunity for religious refusals in the workplace, no matter how significantly those refusals undermine patient care, informed consent, or the essential work of health care institutions. Indeed, the Rule is explicit in seeking an unlimited ability to "be[] free not to act contrary to one's beliefs," regardless of the harm it causes others. 83 FR 3892. This definition thus raises real concerns that the Proposed Rule could be invoked by employees or job applicants who refuse to perform core elements of the job. For example, job applicants may attempt to claim that a family planning provider is required to hire them as pregnancy options counselors even though they refuse to provide any information about the option of abortion and even where the provision of such information is required by the provider's federal funding.

However, neither the Refusals Statutes, nor any other federal law, permits such an unprecedented re-definition of "discrimination." When Congress prohibited discrimination in certain Refusal Statutes, it did not *sub silentio* create an absolute right to a job even if the employee refuses to perform essential job functions, as that has never been the meaning, legal or otherwise, of "discrimination." *See, e.g., McDonnell Douglas Corp. v. Green*, 411 U.S. 793, 802 (1973) (employment discrimination claim requires proof that employee was qualified for the position, and employer may articulate a legitimate, non-discriminatory job-related reason to defeat such a claim). Such an unfounded definitional shift for "discrimination" improperly expands narrow congressional enactments and attempts to reinterpret federal laws, all long construed to be harmonious, to instead be conflicting and contradictory. It turns the Department's mission on its head. If the Department does not withdraw the entire Rule, it should explicitly limit its reach and attempt to clarify how Title VII's balance can continue to have full force and effect in the workplace.

B. Rather than Ensuring Patients Can Get Care in an Emergency, the Proposed Rule Describes the Obligation to Provide Critical Care as Part of the "Problem."

The Proposed Rule puts patients at risk by ignoring the federal Emergency Medical Treatment and Labor Act ("EMTALA") and hospitals' obligations to care for patients in an emergency. As Congress has recognized, a refusal to treat patients facing an emergency puts their health and, in some cases, their lives at serious risk. Through EMTALA, Congress has required hospitals with an emergency room to provide stabilizing treatment to any individual experiencing an emergency medical condition or to provide a medically beneficial transfer. 42 U.S.C. § 1395dd(a)-(c).

The Refusal Statutes do not override the requirements of EMTALA or similar state laws that require health care providers to provide abortion care to a patient facing an emergency. *See, e.g., California v. U.S.*, Civ. No. 05-00328, 2008 WL 744840, at *4 (N.D. Cal. March 18, 2008) (rejecting notion "[t]hat enforcing [a state law requiring emergency departments to provide emergency care] or the EMTALA to require medical treatment for emergency medical conditions would be considered 'discrimination' under the Weldon Amendment"). Indeed, after a challenge to the Weldon Amendment was filed on the ground that it could inhibit the enforcement of statutes requiring hospitals to provide emergency abortion care, Representative

Weldon emphasized that his amendment did not disturb EMTALA's requirement that critical-care facilities provide appropriate treatment to women in need of emergency abortions.[22]

It is particularly troubling, therefore, to have the Department include the long-standing legal and ethical obligation to provide emergency care to patients in the Rule's Preamble as *justification* for expanding the Refusal Statutes – in other words, as justification to *relieve* hospitals or hospital personnel of any obligation, for example, to perform an emergency abortion when a patient is in the midst of a miscarriage, or even to "refer" a patient whose health is deteriorating for an emergency abortion. 83 FR 3888, 3894. But the ethical imperative is the opposite: "In 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." 83 FR 3888 (quoting American Congress of Obstetricians and Gynecologists ("ACOG") ethics opinion and describing it as part of the problem the Proposed rule is meant to address).

Tragically, such concerns are far from hypothetical. As noted above, Tamesha Means was turned away from critical care three times, exposing her to serious risk and putting her life in jeopardy, and in the midst of being discharged the third time, was finally helped only when she started to deliver. Another miscarrying patient collapsed at home and almost bled to death after being turned away three different times from the only hospital in her community which refused to provide her the emergency abortion she needed.[23] Refusals such as these disproportionately affect women of color who are more likely than other women to receive their care at Catholic hospitals, which follow directives that can keep providers from following standards of care and governing law.[24]

The Proposed Rule suggests that hospitals that fail to provide patients like these with appropriate emergency care should be given a free pass. Any such license to refuse patients emergency treatment, including emergency abortions, however, would not only violate EMTALA, but also the legal, professional, and ethical principles governing access to health care in this country. For that reason, if not withdrawn in its entirety, the Proposed Rule should, as one of many necessary limitations, clarify that it does not disturb health care providers' obligations to provide appropriate care in an emergency.

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[22] *See* 151 Cong. Rec. H176-02 (Jan. 25, 2005) (statement of Rep. Weldon) ("The Hyde-Weldon Amendment is simple. It prevents federal funding when courts and other government agencies force or require physicians, clinics, and hospitals and health insurers to participate in *elective* abortions.") (emphasis added); *id.* (Weldon Amendment "ensures that in situations where a mother's life is in danger a health care provider must act to protect a mother's life"); *id.* (discussing that the Weldon Amendment does not affect a health care facility's obligations under EMTALA). Nor were the other Refusal Statutes intended to affect the provision of emergency care. *See*, e.g., 142 Cong. Rec. S2268-01, S2269 (March 19, 1996) (statement of Senator Coats in support of his Amendment) ("a resident needs not to have [previously] performed an abortion … to have mastered the procedure to protect the health of the mother if necessary"); *id.* at S2270 (statement of Senator Coats) ("[T]he similarities between the procedure which [residents] are trained for, which is the D&C procedure, and the procedures for performing an abortion are essentially the same and, therefore, [residents] have the expertise necessary, as learned in those training procedures, should the occasion occur and an emergency occur to perform an abortion.").

[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] *Id.* at 12 (2018).

C. The Proposed Rule Fosters Discrimination.

The Proposed Rule also puts patients at risk by ignoring the federal Patient Protection and Affordable Care Act ("ACA"), which explicitly confers on patients the right to receive nondiscriminatory health care in any health program or activity that receives federal funding. 42 U.S.C. § 18116. Incorporating the prohibited grounds for discrimination described in other federal civil rights laws, the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. *Id.* at § 18116(a).

The Refusal Statutes must be read to coexist with the nondiscrimination requirements of the ACA and similar state nondiscrimination laws. If a nondiscrimination requirement has any meaning in the healthcare context, it must mean that patients cannot be refused care simply because of their race, color, national origin, sex, age, or disability. And as courts have recognized, the prohibition on sex discrimination under the federal civil rights statutes should be interpreted to prohibit discrimination against transgender people. *See Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1049-50 (7th Cir. 2017) (discrimination against transgender students violates Title IX, which is the basis for the ACA's prohibition on sex discrimination); *see also EEOC v. R.G. & G.R. Funeral Homes, Inc.*, __ F.3d __, 2018 WL 1177669 at *5-12 (6th Cir. Mar. 7, 2018) (Title VII); *Glenn v. Brumby*, 663 F.3d 1312, 1316-19 (11th Cir. 2011) (Title VII); *Rosa v. Park W. Bank & Tr. Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187, 1201-03 (9th Cir. 2000) (Gender Motivated Violence Act).

Notwithstanding these protections, as well as explicit statutory protections from discrimination based on gender identity and sexual orientation in many states, the Proposed Rule invites providers to discriminate against LGBT patients, particularly transgender people. The Department includes as a *justification* for expanding the Refusals Statutes a California lawsuit—*Minton v. Dignity Health*—in which a transgender patient is suing under the state nondiscrimination law, alleging that he was denied care a religiously-affiliated hospital routinely provided to other patients, simply because he is transgender. 83 FR 3888-89 & n.36. The Proposed Rule thus suggests that discrimination against a patient simply because he is transgender is permissible—in violation not only of California's nondiscrimination law, but also of the ACA. For that reason, if not withdrawn in its entirety, the Proposed Rule should, as one of many necessary limitations, clarify that it does not disturb health care providers' obligations to provide nondiscriminatory care.

D. The Proposed Rule Creates Confusion That Threatens to Deprive Title X Clients of Services That the Underlying Statutes and Regulations Require.

Finally, the Proposed Rule threatens to undermine the Title X program, which for more than four decades has provided a safety net upon which millions of low-income, under-insured, and uninsured individuals rely each year for family planning essential to their health and the promise of equality. For example, Congress requires that all pregnancy counseling within the Title X program be neutral and "nondirective." *See, e.g.*, Pub. L. No. 115-31 at 521. The Department's own regulations also require that pregnant women receive "neutral, factual

information" and "referral[s] upon request" for prenatal care and delivery, adoption, and/or abortion. 42 C.F.R. § 59.5(a)(5). Yet the Proposed Rule's unauthorized expansion of the Weldon Amendment, *see infra* Part V(C), creates confusion about whether health care entities that refuse to provide non-directive options counseling (which includes discussion of abortion) and abortion referrals may seek to claim an exemption from these requirements and therefore a right to participate in the Title X program despite their refusal to provide the services to which Title X clients are entitled. The Department cannot promulgate a rule that conflicts with federal law in this manner and if it is not withdrawn, the Department should make explicit that it does not provide an exemption to the Title X requirements.

* * *

None of the Refusal Statutes was intended or designed to disrupt the balance between existing federal laws—such as Title VII, EMTALA, Title X and also later-in-time statutes, such as Section 1557 of the ACA—or to create categorical and limitless rights to refuse to provide basic health care, referrals, and even information. Thus, even if the Department had the authority to promulgate the Proposed Rule (which it does not), the Proposed Rule is so untethered to congressional language and intent that it must be withdrawn or substantially modified.

V. The Rule Attempts Impermissibly Transform the Referenced Statutes Into Shields for Inadequate or Discriminatory Care.

The Proposed Rule not only distorts the definitions of words in the statutes, but also alters their substantive provisions in other ways to attempt to expand the ability of entities and individuals to deny care in contravention of legal and ethical requirements and to the severe detriment of patients. Some of these additional statutory expansions, are highlighted below.

A. Examples of Impermissible Church Amendment Expansions.

Subsection (b) of the Church Amendments, for example, specifies only that the receipt of Public Health Service Act funding *in and of itself* does not permit a court or other public authority to require that an individual perform or assist in the performance of abortion or sterilization, or require that an entity provide facilities or personnel for such performance. *See, e.g.*, 42 U.S.C. 300a-7(b) ("The receipt of any grant, contract or loan guarantee under the Public Health Service Act . . . by any individual does not authorize any court or any public official or other public authority to require . . . such individual to perform or assist in the performance of any sterilization procedure or abortion if [doing so] would be contrary to his religious beliefs or moral convictions."). The Proposed Rule, however, attempts to transform that limited prohibition – that receipt of certain federal funds alone does not create an obligation to provide abortions or sterilizations – into an across-the-board shield that forbids any public entity from determining that *any* source of law requires that the entities provide these services. 83 FR 3924-25. If the Rule is not withdrawn, the Department should modify the Rule so that it does not exceed the statute.

Similarly, the Proposed Rule apparently aims to vastly expand the prohibitions contained in subsection (d) of the Church Amendments in a manner that is contrary to the legislative language, the statutory scheme, and congressional intent. Congress enacted Subsection (d) of the Church Amendment in 1974 as part of Public Law 93-348, a law that addressed biomedical and behavioral research, and appended that new Subsection (d) to the pre-existing subsections of Church from 1973, which all are codified within 42 U.S.C. § 300a-7: the "Sterilization or Abortion" section within the code subchapter that relates to "Population Research and Voluntary Family Planning Programs."

Despite this explicit and narrow context for Subsection (d), the Proposed Rule attempts to transform this Subsection into a much more general prohibition that would apply to *any* programs or services administered by the Department, and that would assertedly prevent any entity that receives federal funding through those programs or services from requiring individuals to perform or assistance in the performance of *any* actions contrary to their religious beliefs or moral convictions. *See* 83 FR 3894, 3906, 3925. This erroneous expansion of Church (d) could prevent health care institutions from ensuring that their employees provide appropriate care and information: It would purportedly prevent taking action against members of their workforce who refuse to provide any information or care that they "sincerely understand" may have an "articulable connection" to some eventual procedure to which they object, no matter what medical ethics, their job requirements, Title VII or laws directly protecting patient access to care may require.

The ACLU is particularly concerned that the Proposed Rule's erroneous expansion of Church (d) could be used to deny services because of the identity of the individual seeking help. To name a few of the many possibilities that could result from the Proposed Rule's emboldening of personal-belief-based care denials:

- A nurse could deny access to reproductive services to members of same-sex or inter-racial couples, because her religious beliefs condemn them;
- A physician could refuse to provide treatment for sexually transmitted infections to unmarried individuals, because of her opposition to non-marital sex;
- Administrative employees could refuse to process referrals or insurance claims, just as health care professionals could deny care itself, because they object to recognizing transgender individuals' identity and medical needs.

This inappropriately expanded conception of Church Subsection (d) conflicts with statutory language, the anti-discrimination protections of Section 1557 of the ACA, the requirements of EMTALA, and the balance established by Title VII, and otherwise manifestly overreaches in a number of respects. Instead, the Department should clarify that the Church Amendments are limited to what the statute provides and Congress intended.

B. Examples of Impermissible Coats-Snowe Amendment Expansions.

The Proposed Rule similarly stretches the Coats-Snowe Amendment beyond its language and Congress' clear intent. In 1996, Congress adopted the Coats-Snowe Amendment, entitled "Abortion-related-discrimination in governmental activities regarding training and licensing of physicians," in response to a decision by the Accrediting Council for Graduate Medical Education to require obstetrician-gynecologist residency programs to provide abortion training. The Proposed Rule, however, entirely omits that context.

Rather than being confined to training and licensing activities as the statute is, the Proposed Rule purports to give all manner of health care entities, including insurance companies and hospitals, a broad right to refuse to provide abortion and abortion-related care. In addition, the Rule's expansion of the terms "referral" and "make arrangements for" extends the Coats-Snowe Amendment to shield any conduct that would provide "any information … by any method … that could provide *any assistance* in a person obtaining, assisting, … financing, or performing" an abortion or that "render[s] aid to anyone else reasonably likely" to make such an abortion referral. 83 FR 3894-95, 3924 (emphasis added). This expansive interpretation not only goes far beyond congressional intent and the terms of the statute, it also could have extremely detrimental effects on patient health. For example, it would apparently shield, against any state or federal government penalties, a women's health center that required any obstetrician-gynecologist practicing there who diagnosed a pregnant patient as having a serious uterine health condition to refuse even to provide her with the name of an appropriate specialist, because that person "is reasonably likely" to provide the patient with information about abortion.

Again, if the Proposed Rule is not withdrawn, it should be pared back and clarified so as to be faithful to both the statutory text and congressional intent.

C. Examples of Impermissible Weldon Amendment Expansions.

The Department attempts the same sort of improper regulatory expansion of the Weldon Amendment, which is not a permanent statutory provision but a rider that Congress has attached to the Labor, Health and Human Services and Education Appropriations Act annually since 2004. As written, the Weldon Amendment is no more than a bar on particular appropriated funds flowing to federal agencies or programs, or state or local government, if any of those government institutions discriminate on the basis that a health care entity does not provide, pay for, provide coverage of, or refer for abortion. But the Proposed Rule attempts to vastly increase the Amendment's reach in multiple ways. First, the Proposed Rule explicitly extends the reach of the Weldon Amendment beyond the appropriations act to which it is attached, by stating that it also applies to any entity that receives any other "funds through a program administered by the Secretary," which would include, for example, Medicaid. 83 FR 3925. Second, although the terms of the Amendment itself bind only federal agencies and programs and state and local governments, the Rule expands Weldon's reach to also proscribe the behavior of any person, corporation, or public or private agency that receives any of this newly enlarged category of funds. *Id.*

The Rule then provides that no one of this greatly expanded universe of parties may subject any institutional or individual health care entity[25] to discrimination for refusal to provide, pay for, provide coverage for, or refer for abortions. Such unauthorized expansions of limited appropriations language seem designed to encourage broad and harmful denials of care. For example, under the expanded definitions contained in the Proposed Rule, an employer, even one with no religious or moral objection to abortion, may attempt to claim that it has a right to deny its employees' insurance coverage for abortion irrespective of state law. Or a private health care network that receives Medicaid reimbursement could face employees asserting not only the ability to refuse to participate in certain abortion-related care, but also to remain in their positions without repercussions. This is not implementation of the Weldon Amendment; this is a new scheme. If the Rule is not withdrawn, the Department should modify the Rule so that it does not exceed the statute.[26]

VI. The Proposed Rule Appears Intended to Provide a Shield for Health Care Providers Who Fail to Provide Complete Information to Patients in Violation of Both Medical Ethics and Federal Law.

The Proposed Rule also appears to allow providers to let their own personal preferences distort provider-patient communications and deprive patients of critical health care information about their condition and treatment options. The Proposed Rule's Preamble suggests the Rule will improve physician-patient communication because it will purportedly "assist patients in seeking counselors and other health-care providers who share their deepest held convictions." 83 FR 3916-17. But patients are already free to inquire about their providers' views and providers must already honor patients' own expressions of faith and decisions based on that faith. *Cf. id.* Allowing *providers* to decide what information to share—or not share—with patients, as the Rule would do, regardless of the requirements of informed consent and professional ethics would gravely harm trust and open communication in health care.

As the American Medical Association's Code of Medical Ethics ("AMA Code") explains, the relationship between patient and physician "gives rise to physicians' ethical responsibility to place patients' welfare about the physician's own self-interest[.]" AMA Code § 1.1.1. Even in instances where a provider opposes a particular course of action based on belief, the AMA states that the provider must "[u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects." *Id.* § 1.1.7(e). Similarly, ACOG emphasizes that "the primary duty" is to the patient, and that without exception "health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care." ACOG Committee Opinion No. 385, Recommendations 1-2 (Nov. 2007) (Reaffirmed 2016). Therefore, under well-established principles of informed consent and medical ethics, health care providers must provide patients with all of the information they need to make their own decisions; providers

[25] Although the Weldon Amendment itself defines "health care entity" to include individual health care professionals or "any other kind of health care facility, organization or plan," the Proposed Rule's definitions, as discussed above, try to further extend "health care entity" to also encompass companies or associations whose primary purpose is *not* health care, but who happen to sponsor a health care plan. This appears to reach employers.
[26] Moreover, for any promulgated Rule, the Department must explain its practical operation in detail, so that any affected public or private actors can ascertain the Department's meaning.

may not allow their own religious or moral beliefs to dictate whether patients receive full information about their condition, the risks and benefits of any procedure or treatment, and any available alternatives.

By erroneously expanding the meaning of "assist in the performance of," "refer for" and "make arrangements for," as described above, however, the Proposed Rule purports to allow health care providers to refuse to provide basic information to patients in ways that were never contemplated by the underlying statutes. As described above, these broad definitions may be used to immunize the denial of basic information about a patient's condition as well as her treatment options. Protecting health care professionals when they withhold this vital information from patients violates fundamental legal and ethical principles, deprives patients of the ability to make informed decisions and leads to negligent care. If the Department moves forward with the Proposed Rule, it should modify it to make clear that it does not subvert basic principles of medical ethics and does not protect withholding information from a patient about her condition or treatment options.

VII. The Rule Would Violate the Establishment Clause Because It Authorizes Health Care Providers to Impose their Faith on their Patients, to the Detriment of Patient Health.

The Proposed Rule imposes the significant harms on patients identified above in service of institutional and individual religious objectors. It purports to mandate that their religious choices take precedence over the health care needs of patients. But the First Amendment forbids government action that favors the free exercise of religion to the point of forcing unwilling third parties to bear the burdens and costs of someone else's faith. As the Supreme Court has emphasized, "[t]he principle that government may accommodate the free exercise of religion does not supersede the fundamental limitation imposed by the Establishment Clause." *Lee v. Weisman*, 505 U.S. 577, 587 (1992); *accord Bd. of Educ. of Kiryas Joel Village School Dist. v. Grumet*, 512 U.S. 687, 706 (1994) ("accommodation is not a principle without limits").

Because the Rule attempts to license serious patient harms in the name of shielding others' religious conduct, it is incompatible with our longstanding constitutional commitment to separation of church and state. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708-10 (1985) (rejecting, as Establishment Clause violation, law that freed religious workers from Sabbath duties, because the law imposed substantial harms on other employees); *see also Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 14, 18 n.8 (1989) (plurality opinion) (invalidating sales tax exemption for religious periodicals, in part because the exemption "burden[e]d nonbeneficiaries markedly" by increasing their tax bills). The Department should withdraw the Rule to avoid its violation of the Establishment Clause.

VIII. The Proposed Enforcement Scheme Is Excessive and Fails to Adequately Protect the Due Process and Other Rights of Grantees.

As explained above, the Refusal Statutes carve out specific, narrow exemptions that are only relevant and applicable to certain entities and individuals in certain circumstances. Even with its unfounded expansion of the referenced Refusal Statutes, the Department forecasts only

10-50 complaint investigations or compliance reviews arising under the Refusal Statutes each year, all concerning objections to providing certain health care. 83 FR 3915, 3922. As such, these statutes are quite unlike the various provisions of the Civil Rights Act of 1964, or other civil rights or anti-discrimination statutes that provide broad protection against discrimination to the public or across a wide range of society. Despite these differences, the Proposed Rule claims to model its compliance and enforcement mechanisms on those broad "civil rights laws, such as Title VI and Section 504 of the Rehabilitation Act." 83 FR 3896, 3898. Yet, the Rule's enforcement provisions exceed the ones in place for civil rights laws and, notably, this proposed rulemaking does not anywhere reference basic constitutional limits or specify important due process protections against overzealous enforcement. Taken together, these provisions are ripe for abuse.

The following provisions, which are not an exhaustive list of the serious enforcement scheme issues, appear particularly problematic:

- Funded entities must disclose any complaints or compliance reviews under the Refusal Statutes or Rule from the last five years in any funding application or renewal request, even if the complaint did not warrant an investigation or the investigation or review closed with no finding of any violation, 83 FR 3930;

- The Rule permits onerous remedies for a "failure or threatened failure to comply," including withholding or terminating funding or referral to the Attorney General for "enforcement in federal court or otherwise" without waiting for any attempts at voluntary compliance or resolution through informal means, 83 FR 8330-31;

- The Rule allows the Department to employ the full array of punishments against funding recipients for infractions by sub-recipients, no matter how independent those sub-recipients' actions and no matter how vigorous the recipients' compliance efforts;[27]

- The Rule creates violations for failure to satisfy *any* information requests, and grants access to "complete records," providing especially expansive access with more stringent enforcement than in the Department's Title VI regulations, without any reference to the Fourth Amendment protections developed under Title VI and other similar laws, 83 FR 3829-30; and

- The Rule's enforcement scheme also appears to lack the robust administrative review process, including proceedings before a hearing officer and required findings on the

[27] As proposed subsection 88.6(a) provides, if a sub-recipient violation is found, the recipient "from whom the sub-recipient received funds shall be subject to the imposition of funding restrictions and other appropriate remedies available under this part." 83 FR 3930. This language lacks clarity as to whether imposing a penalty is mandatory or an option, but regardless, not every violation by a sub-recipient should open the recipient to the possibility of sanctions. Moreover, fund termination under the Proposed Rule does not appear to be restricted by the "pinpointing" concept that applies under Title VI, which ensures against vindictive, broad funding terminations and excessive harms to program beneficiaries. Neither this proposed subsection nor the other new enforcement provisions should be added to Part 88, but if they are, subsection 88.6(a) should, like the Proposed Rule's other unfounded enforcement expansions, be clarified and much more strictly limited.

> record, that must precede any suspension or termination of federal funding under, for example, Title VI's enforcement regulations. *See* 45 C.F.R. Part 81. If the Rule is not withdrawn, the Department should make clear that those same rigorous protections apply here.

In addition, while claiming such vast, unauthorized enforcement powers, the Department also repeatedly states that it proposes to uphold "the maximum protection" for the rights of conscience and "the broadest prohibition on" actions against any providers acting to follow their own beliefs. 83 FR 3899, 3931. This combination of a pre-ordained inclination in favor of refusers and excessive enforcement powers further threatens to undermine federal health programs by harming funding recipients who are serving patients well.

If the Rule is not withdrawn, it should be modified in accordance with these comments to ensure that providers of health care are not subjected to unduly broad inquiries or investigations, unfairly penalized, or deprived of due process, all to the detriment of focusing on care for their patients.

IX. The Department Has Not Shown the Need for Expanded Enforcement Authority and Requirements, Uses Faulty Regulatory Impact Analyses, and Proposes a Rule That Will Only Add Compliance Burdens and Significant Costs to Health Care.

Finally, the Department itself estimates hundreds of millions of dollars in cost, almost all imposed on entities providing health care, to undertake the elaborate compliance and enforcement actions the Rule contemplates. But the Proposed Rule's regulatory impact analysis severely underestimates the cost and other burdens it would impose. At virtually every step of its purported tallying of costs, the Department grossly underestimates the time that a covered institution's lawyers, management and employees will have to spend to attempt to understand the Rule, interpret its interplay with other legal and ethical requirements, train staff, modify manuals and procedures, certify and assure compliance, and monitor the institution's actions on an ongoing basis. For example, the Rule considers a single hour by a single lawyer enough for covered entities to "familiarize themselves with the content of the proposed rule and its requirements." 83 FR 3912. It allocates 10 minutes per Refusal Statute, for the roughly two dozen laws referenced, for an entity to execute the assurance and certification of compliance—thus allocating no time for actually reviewing an entity's records or operations in order to do so. 83 FR 3913. Similarly, the impact analysis mentions the time necessary to disclose investigations or compliance reviews, but not the much more significant amount of time needed to respond to and cooperate in those processes. Moreover, the Department does not factor into cost *at all* the cost to the institution when employees refuse to perform care or provide information, or the costs to the refused patients, who must seek help elsewhere and suffer harms to their health.

In estimating benefits, the analysis does not demonstrate barriers to entry for health professionals, or exits from the health profession that are occurring, nor does it substantiate the contention that the medical field does not already include professionals with a wide diversity of religious and other beliefs. As discussed above, it claims benefits to provider-patient

communication and relationships that are non-existent. The Proposed Rule offers no evidence that either greater protection for refusals or expanded enforcement mechanisms are needed.

The Department's prior rulemaking, which emphasized outreach and enforcement, remains in effect and makes clear that OCR has sufficient enforcement authority, consistent with the specific governing statutes, to address any meritorious complaints or other violations. 45 C.F.R. Part 88; 76 FR 9968. In fact, the Department itself estimates that, even with adoption of the Proposed Rule, it would initiate only 10-50 OCR investigations or compliance reviews per year. Since 2008, the number of Refusal Statute complaints per year has averaged 1.25, with 34 complaints filed in the recent November 2016 to mid-January 2018 period.[28] The Proposed Rule contemplates an enormous outlay of funds to implement an elaborate and unnecessary enforcement system that will only divert resources away from enforcing patients' civil rights protections and the provision of high-quality health care to those who need it most.

Thus, the Rule's analysis of economic impacts, including under Executive Orders 12866 and 13563, is seriously flawed and fails to demonstrate that any benefits of the Proposed Rule justify its enormous costs, many of which go unacknowledged. In addition, the Secretary proposes to falsely "certify that this rule will not result in a significant impact on a substantial number of small entities." 83 FR 3918. Small health care entities will have to bear the same regulatory analysis and ongoing compliance costs as larger entities, will face the same loss of employee time and effort from religious and other refusals, and yet have fewer resources and other employees to fall back on. While some small entities may be relieved of routinely certifying their compliance in writing, that compliance is still required – and the compliance itself imposes the much more significant cost and interference with its operations. Similarly, the Secretary erroneously "proposes to certify that this proposed rule … will not negatively affect family well-being," 83 FR 3919, when expanded refusals of medical information and health care by federally funded providers would significantly affect the stability, disposable income, and well-being of low-income families.

The Rule's regulatory impact analyses utterly fail to support its adoption. This expansive rulemaking exceeds any statutory authority and overwhelms any need, and would leave health care institutions, patients, and their families suffering.

* * *

For all these reasons, the Department should withdraw the Proposed Rule.

Sincerely,

Louise Melling
Deputy Legal Director

Faiz Shakir
National Political Director

[28] For context, in FY 2017, OCR received a total of 30,166 complaints under all of the federal statutes it enforces.

Exhibit 3

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March 21, 2018

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Hubert H. Humphrey Building, Room 509F
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Submitted electronically

Re: Proposed New 45 CFR Part 88 Regarding Refusals of Medical Care

The ACLU of Alabama submits these comments on the proposed rule published at 83 FR 3880 (January 28, 2018), RIN 0945-ZA03, with the title "Ensuring that the Department of Health and Human Services [the "Department"] Does Not Fund or Administer Programs or Activities that Violate Conscience and Associated Anti-Discrimination Laws" (the "Proposed Rule" or "Rule").

The ACLU of Alabama has a long history of vigorously defending religious liberty. We are equally vigilant in our efforts to safeguard reproductive rights and to end discrimination against those who have historically been excluded or diminished by more powerful actors in society, including in health care settings. The ACLU is thus particularly well-positioned to comment on the Proposed Rule and the serious concerns it raises about access to reproductive and other health care, based on the religious or other beliefs of institutions or individual providers. We steadfastly protect the right to religious freedom. But that right does not include a right to harm others as this Proposed Rule contemplates.

Without any regulatory authority, the Department has proposed a rule that vastly expands narrow statutory sections in ways Congress never intended, in a manner unsupportable by the terms of the statutes, and in a way that upsets the careful balance struck by other federal laws, all in an effort to grant health care providers unprecedented license to refuse to provide care and information to patients. In so doing, the Proposed Rule does not mention, much less grapple with, the consequences of refusals to provide full information and necessary health care to patients. The denials that the Rule proposes to protect will have significant consequences for individuals in terms of their health and well-being, in addition to financial costs. And, because the Proposed Rule is tied to entities that receive federal funding, those consequences will fall most heavily on poor and low-income people who must rely on government-supported programs and institutions for their care and who will have few, if any, other options if they are denied appropriate care. The Proposed Rule

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amounts to a license to discriminate, made all the worse because the federal purse will be used to further that discrimination.

The Proposed Rule is not only extremely detrimental to patient health, it is also entirely unnecessary. Individual providers' religious and moral beliefs are already strongly protected by federal law that, among other things, forbids religious discrimination and requires employers to provide reasonable accommodation of an employee's religious objections.

Because the Proposed Rule harms patient health, encourages discrimination against patients, and exceeds the Department's rulemaking authority, it should be withdrawn. If the Department refuses to do so, it must, at a minimum, revise the Proposed Rule so that it aligns with the statutory provisions it purports to implement, makes clear that it is not intended to conflict with or preempt other state or federal laws that protect and expand access to health care, and mitigates the Rule's harm to patients' health and well-being.

1. **The Proposed Rule Ignores Its Impact on Patients' Health and Invites Harms That Will Disproportionately Fall on Women and Marginalized Populations**

The Proposed Rule seeks to immunize refusals of health care, yet utterly fails to consider the harmful impact it would have on patients' health. But this failure to address the obvious consequences of giving federally subsidized providers *carte blanche* to decide whom to treat or not treat based on religious or moral convictions – or indeed, based on any reasoning or none at all[1] – does not mean the harm does not exist. In fact, the harms would be substantial. For example, the Proposed Rule:

- Appears to provide immunities for health care institutions that receive federal funding and professionals who work in federally funded programs to refuse to provide complete information to patients about their condition and treatment options;
- Purports to create new "exemptions," so that patients who rely on federally subsidized health care programs, such as Title X, may be unable to obtain services those programs are required by law to provide;
- Causes confusion about whether hospitals can prevent staff from providing emergency care to pregnant women who are suffering miscarriages or otherwise need emergency abortion care; and

[1] Although the Notice of Proposed Rulemaking highlights religious freedom and rights of conscience, a number of the referenced statutes – and the proposed expansions of those in the Rule – do not turn on the existence of any religious or moral justification. The Proposed Rule would empower not only those acting based on conscience, but others acting, for example, out of bare animus toward a patient's desired care or any aspect of their identity.

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- Invites health care providers to discriminate against individuals based on who they are, for example, by refusing to provide otherwise available services to a patient for the sole reason that the patient is transgender.

These harms would fall most heavily on historically disadvantaged groups and those with limited economic resources. As the ACLU's own cases and requests for assistance reflect, women, LGBT (lesbian, gay, bisexual and transgender) individuals, people of color, immigrants, young people, and members of other groups who continue to struggle for equal rights are those who most often experience refusals of care. Likewise, poor and low-income people will also suffer acutely under the Proposed Rule. They are more likely to rely on health care that is in some manner tied to federal funding, and less likely to have other options at their disposal if they are denied access to care or information. Because it will limit access to health care, harm patients' outcomes, and undermine the central, public health mission of the Department, the Proposed Rule should be withdrawn.

2. **The Department Lacks the Authority to Issue the Proposed Rule**

The Proposed Rule references the Church Amendments, 42 U.S.C. § 300a-7, the Coats-Snowe Amendment, 42 U.S.C. § 238n, the Weldon Amendment, Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. H, Tit. V, § 507(d), and other similar "protections" or "exemptions," *see* 83 FR 3880, that sometimes allow, under narrow circumstances, health care professionals to avoid providing certain medical procedures or that limit the actions that may be taken against them if they refuse to provide care (collectively, the "Refusal Statutes"). The Preamble to the Rule focuses most extensively on the Church, Coats, and Weldon Amendments (the "Amendments"), and the Rule itself purports to establish extraordinarily expansive new substantive requirements, compliance steps, and enforcement authority under them.

But the Department does not possess *any* legislative rulemaking powers under those Amendments and wholly lacks the authority to promulgate the Proposed Rule as it applies to them. None of those Amendments includes, or references, any explicit delegation of regulatory authority. *Compare, e.g.*, 42 U.S.C. § 2000d-1 (expressly directing all relevant federal agencies to issue "rules, regulations, or orders of general applicability" to achieve the objectives of Title VI). Nor does any implicit delegation of legislative rulemaking authority exist for these provisions. For this reason alone, the Department cannot properly proceed to adopt the Proposed Rule or any similar variation of it.

3. **The Proposed Rule Impermissibly Expands the Narrow Referenced Statutes and Does So In Ways That Ignore The Statutes' Limited Terms and Purposes**

Even if the Department had the necessary rulemaking authority (which it does not), the Proposed Rule's virtually unbounded definition of certain terms and expansions of the

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Refusal Statutes' reach would broaden the Refusal Statutes beyond reason and recognition, create conflict with federal law, and lead to denials of appropriate care to patients. While we do not attempt to catalogue each way in which the Proposed Rule impermissibly expands the Refusal Statutes, a few examples follow.

A. Assist in the Performance

For example, Subsection (c)(1) of the Church Amendments prohibits recipients of certain federal funds from engaging in employment discrimination against health care providers who have objected to performing or "assist[ing] in the performance of" an abortion or sterilization. 42 U.S.C. § 300a-7(c)(1). Under the Proposed Rule, however, the Department defines "assist in the performance" of an abortion or sterilization to include not only assistance *in the performance* of those actual procedures – the ordinary meaning of the phrase – but also to participation in any other activity with "an articulable connection to a procedure[.]" 83 FD 8892, 3923. Through this expanded definition, the Department explicitly aims to include activities beyond "direct involvement with a procedure" and to provide "broad protection" – despite the fact that the statutory references are limited to "assistance in the performance of" an abortion or sterilization procedure itself. 83 FR 3892.; *cf. e.g.*, 42 U.S.C. § 300a-7(c)(1).

This means, for example, that simply admitting a patient to a health care facility, filing her chart, transporting her from one part of the facility to another, or even taking her temperature could conceivably be considered "assist[ing] in the performance" of an abortion or sterilization, as any of those activities could have an "articulable connection" to the procedure. As described more fully below, the Proposed Rule could even be cited by health care providers who withhold basic information from patients seeking information about abortion or sterilization on the grounds that "assist[ing] in the performance" of a procedure "includes but is not limited to counseling, referral, training, and other arrangements for the procedure." 83 FR 3892, 3923.

But the term "assist in the performance" simply does not have the virtually limitless meaning the Department proposes ascribing to it. The Department has no basis for declaring that Congress meant anything beyond actually "assist[ing] in the performance of" the specified procedure – given that it used that phrasing, 42 U.S.C. §§ 300a-7(c)(1) – and instead meant any activity with any connection that can be articulated, regardless of how attenuated the claimed connection, how distant in time, or how non-procedure-specific the activity.

B. Referral or Refer for

Others of the Refusal Statutes provide limited protections to certain health care entities and individuals that refuse to, among other things, "refer for" abortions. For those statutes, the Proposed Rule expands "referral or refer for" beyond recognition, by proposing to define

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a referral as "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, assisting, ... financing, or performing" it, where the entity (including a person) doing so "sincerely understands" the service, activity, or procedure to be a "possible outcome[.]" 83 FR 3894-95 (emphasis added), 3924. This wholesale re-definition of the concept of "referral" could have dire consequences for patients. For example, a hospital that prohibits its doctors from even discussing abortion as a treatment option for certain serious medical conditions could attempt to claim that the Rule protects this withholding of critical information because the hospital "sincerely understands" the provision of this information to the patient may provide some assistance to the patient in obtaining an abortion.

Providing a green light for the refusal to provide information that patients need to make informed decisions about their medical care not only violates basic medical ethics, but also far exceeds Congress's language and intent. A referral – as used in common parlance and the underlying statutes – has a far more limited meaning than providing *any* information that *could* provide *any assistance whatsoever* to a person who may ultimately decide to obtain, assist, finance, or perform a given procedure sometime in the future. The meaning of "referral or refer for" in the health care context is to *direct* a patient elsewhere for care. *See* Merriam-Webster, https//www.merriam-webster.com/dictionary/referral ("referral" is "the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment").

C. Discriminate or Discrimination

These expansive definitions are all the more troubling given the Proposed Rule's definition of "discrimination," which purports to provide unlimited immunity for institutions that receive some federal funds to deny abortion care, to block coverage for such care, or to stop patients' access to information, no matter what the patients' circumstances or the mandates of state or federal law. Likewise, the definition appears aimed at providing immunity for employees who refuse to perform central parts of their job, regardless of the impact on the ability of a health care entity to provide appropriate care to its patients. This expansion of "discrimination" would apparently treat virtually any adverse action – including government enforcement of a patient non-discrimination or access-to-care law – against a health care facility or individual as *per se* discrimination. But "discrimination" does not mean any negative action, and instead requires an assessment of context and justification, with the claimant showing unequal treatment on prohibited grounds under the operative circumstances. The Proposed Rule abandons, for example, the nuanced and balanced approach required by Title VII, and also ignores other federal laws, state laws, and providers' ethical obligations to their patients. *See infra* Parts 4-6.

D. Other Expansions of the Scope of the Refusal Statutes

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The Proposed Rule not only distorts the definitions of words in the statutes, but also alters the statutes' substantive provisions in other ways to attempt to expand the ability of individuals and entities to deny care in contravention of legal and ethical requirements and to the severe detriment of patients. Again, these comments do not attempt to exhaustively catalogue all of the unauthorized expansions but instead provide a few illustrative examples.

For example, Congress enacted Subsection (d) of the Church Amendment in 1974 as part of Public Law 93-348, a law that addressed biomedical and behavioral research, and appended that new Subsection (d) to the pre-existing subsections of Church from 1973, which all are codified within 42 U.S.C. § 300a-7: the "Sterilization or Abortion" section within the code subchapter that relates to "Population Research and Voluntary Family Planning Programs." Despite this explicit context for Subsection (d), and Congress' intent that it apply narrowly, however, the Proposed Rule attempts to import into this Subsection an unduly broad definition of "health service program," along with the expansive definitions discussed above, to purportedly transform it into a much more general prohibition that would apply to any programs or services administered by the Department, and that would prevent any entity that receives federal funding through those programs or services from requiring individuals to perform or assist in the performance of actions contrary to their religious beliefs or moral convictions. *See* 83 FR 3894, 3906, 3925. This erroneous expansion of Church (d), as described in this attempted rule-making, could prevent health care institutions from ensuring that their employees provide appropriate care and information. It would purportedly prevent institutions taking action against members of their workforce who refuse to provide any information or care that they "sincerely understand" may have an "articulable connection" to some eventual procedure to which they object—no matter what medical ethics, their job requirements, Title VII or laws directly protecting patient access to care may require.

The Rule similarly attempts to expand the Coats Amendment beyond its limited provisions, which apply to certain "governmental activities regarding training and licensing of physicians," 42 U.S.C. § 238n (quoting title), to apply *regardless* of context. Thus, rather than being confined to residency training programs as Congress intended, the Proposed Rule purports to give all manner of health care entities, including insurance companies and hospitals, a broad right to refuse to provide abortion and abortion-related care. In addition, the Rule's expansion of the terms "referral" and "make arrangements for" extends the Coats Amendment to shield any conduct that would provide "any information ... by any method ... that could provide *any assistance* in a person obtaining, assisting, ... financing, or performing" an abortion or that "render[s] aid to anyone else reasonably likely" to make an abortion referral. 83 FR 3894-95 (emphasis added), 3924. This expansive interpretation not only goes far beyond congressional intent and the terms of the statute, it also could have extremely detrimental effects on patient health. For example, it would apparently shield, against any state or federal government penalties, a women's health center that required any obstetrician-gynecologist practicing there who diagnosed a pregnant patient as having

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a serious uterine health condition to refuse to provide her with even the name of an appropriate specialist, because that specialist "is reasonably likely" to provide the patient with information about abortion.

Similarly, as written, the Weldon Amendment is no more than a bar on particular appropriated funds flowing to a "Federal agency or program, or State or local government," if any of those government institutions discriminate on the basis that a health care entity does not provide, pay for, provide coverage of, or refer for abortion. Pub. L. No. 115-31, Div. H, Tit. V, § 507(d)(1). Yet again, however, the Proposed Rule attempts to vastly increase its reach by (i) expanding the scope of the federal funding streams to which the Weldon Amendment prohibition reaches and (ii) binding "any entity" that receives such funding – not just the government entities listed in the Amendment – to its proscriptions. 83 FR 3925. These unauthorized expansions, combined with the expansive definitions discussed *supra*, can lead to broad and harmful denials of care. For example, under this unduly expansive interpretation of Weldon, an organization that refuses to discuss the option of abortion with people who discover they are pregnant may claim a right to participate in the Title X program, despite the fact that both federal law and medical ethics require that Title X patients be provided with counseling about all of their options. *See, e.g.*, 42 C.F.R. § 59.5(a)(5).

The Department should withdraw the Rule to prevent it from impeding health care and harming patients. But if it does not do so, each of the definitions must be clarified and revert to the terms' proper meaning, and each of the substantive requirements should track only those provisions actually found in the Refusal Statutes themselves.

4. **The Rule Undermines Legal and Ethical Requirements of Fully Informed Consent**

The Proposed Rule appears to allow institutional and individual health care providers to manipulate and distort provider-patient communications and deprive patients of critical health care information about their condition and treatment options. While the Proposed Rule's Preamble suggests the Rule will improve physician-patient communication because it will purportedly "assist patients in seeking counselors and other health-care providers who share their deepest held convictions," 83 FR 3916-17, the notion that empowering health care providers to deny care to and withhold information from some patients is somehow necessary to enable other patients to identify like-minded providers strains credulity: Patients are already free to inquire about their providers' views and patients' own expressions of faith and decisions based on that faith must already be honored. *Cf. id.* Allowing *providers* to decide what information to share – or not share – with patients, regardless of the patient's needs or the requirements of informed consent and professional ethics would gravely harm trust and open communication in health care, rather than aiding it.

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As the American Medical Association's Code of Medical Ethics ("AMA Code") explains, the relationship between patient and physician "gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest[.]" AMA Code § 1.1.1. Even in instances where a provider's beliefs are opposed to a particular course of action, the provider must "[u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects." *Id.* § 1.1.7(e).

By erroneously expanding the meaning of "assist in the performance of," "refer for" and "make arrangements for," as described above, however, the Proposed Rule purports to allow health care providers to refuse to provide basic information to patients in ways that were never contemplated by the underlying statutes. As described above, these broad definitions may be used to immunize the denial of basic information about a patient's condition as well as her treatment options.

Withholding this vital information from patients violates fundamental legal and ethical principles, deprives patients of the ability to make informed decisions, and leads to negligent care. If the Department moves forward with the Proposed Rule, it should, among other necessary changes, modify it to make clear that it does not subvert basic principles of medical ethics and does not protect withholding information from a patient about her condition or treatment options.

5. **By Failing to Acknowledge Other Federal Laws, the Proposed Rule Will Lead to Confusion, Denials for Care, and Harm to Patients**

A. Title VII

The Proposed Rule is not only unauthorized and harmful to patients, it is also unnecessary to accommodate individual workers – federal law already amply protects individuals' religious freedom in the workplace. For more than four decades, Title VII has required employers to make reasonable accommodations for current and prospective employers' religious beliefs so long as doing so does not pose an "undue hardship" to the employer. 42 U.S.C. §§ 2000e(j), 2000e-(2)(a); *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 84 (1977); EEOC Guidelines, 29 C.F.R. § 1605.2(e)(1).[2] Thus, Title VII – while protecting freedom of religion – establishes an essential balance. It recognizes that an employer cannot subject an employee to less favorable treatment because of that individual's religion and that generally an employer must accommodate an employee's religious practices. However, it does not require accommodation when the employee objects to performing core job functions, particularly when those objections harm patients, depart from the standard

[2] Religion for purposes of Title VII includes not only theistic beliefs, but also non-theistic "moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." Equal Employment Opportunity Commission ("EEOC") Guidelines, 29 C.F.R. §1605.1.

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of care, or otherwise constitute an undue hardship. *Id.* This careful balance between the needs of employees, patients, and employers is critical to ensuring that religious beliefs are respected while at the same time health care employers are able to provide quality health care to their patients.

Despite this long-standing balance and the lack of any evidence that Congress intended the Refusal Statutes to disrupt it, the Proposed Rule does not even mention these basic federal legal standards or the need to ensure patient needs are met. Instead, by presenting a seemingly unqualified definition of what constitutes "discrimination," 83 FR 3892-93, 3923-24, and expansive refusal rights, the Department appears to attempt to provide complete immunity for religious refusals in the workplace, no matter how significantly those refusals undermine patient care, informed consent, or the essential work of institutions established for the purpose of promoting health. Indeed, the Rule is explicit in seeking not simply a "level playing field" and reasonable accommodation, but rather an unlimited ability for individuals to "be[] free not to act contrary to one's beliefs," regardless of the harm it causes others and without any repercussions. *Id.* Such an interpretation could have a drastic impact on the nation's safety-net providers' ability to provide high quality care by requiring, for example, a family planning provider to hire a counselor to provide pregnancy options counseling even if the counselor refuses to comply with ethical and legal obligations to inform patients of the availability of abortion. If the Department does not withdraw the entire Rule, therefore, it should explicitly limit its reach and make clear that Title VII provides the governing standard for employment situations.

B. EMTALA

The Proposed Rule also puts patients at risk by ignoring the federal Emergency Medical Treatment and Labor Act ("EMTALA") and hospitals' obligations to care for patients in an emergency. As Congress has recognized, a refusal to treat patients facing an emergency puts their health and, in some cases, their lives at serious risk. Through EMTALA, Congress has required hospitals with an emergency room to provide stabilizing treatment to any individual experiencing an emergency medical condition or to provide a medically beneficial transfer. 42 U.S.C. § 1395dd(a)-(c).

The Refusal Statutes do not override the requirements of EMTALA or similar state laws that require health care providers to provide abortion care to a woman facing an emergency. *See, e.g., California v. U.S.*, Civ. No. 05-00328, 2008 WL 744840, at *4 (N.D. Cal. March 18, 2008) (rejecting notion "[t]hat enforcing [a state law requiring emergency departments to provide emergency care] or the EMTALA to require medical treatment for emergency medical conditions would be considered 'discrimination' under the Weldon Amendment if the required medical treatment was abortion related services").

It is particularly troubling, therefore, to have the Department use attempts to require hospitals to comply with their obligations under EMTALA in its Preamble as *justification*

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for expanding the Refusal Statutes. 83 FR 3888-89. For example, the Preamble discusses the case brought by the ACLU on behalf of Tamesha Means who at 18 weeks of pregnancy began to miscarry and sought care, not once but three times, at her local hospital. 83 FR 3888-89. Despite the fact that she was bleeding, in severe pain, and had developed a serious infection, the hospital repeatedly sent her away and never told her that her health was at risk and that having an abortion was the safest course for her. *See* Health Care Denied 9-10 (May 2016), *available at* https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied. But the ethical imperative is the opposite: "In 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." 83 FR 3888 (quoting American Congress of Obstetricians and Gynecologists ("ACOG") Committee Opinion No. 365) (reaffirmed 2016).

The Proposed Rule suggests that hospitals like the one who put Ms. Means' health at risk should be given a free pass. Yet doing so would not only violate EMTALA, but also other legal, professional, and ethical principles governing access to health care in this country. For that reason, if not withdrawn in its entirety, the Proposed Rule should, at minimum, clarify that it does not disturb health care providers' obligations to provide appropriate care in an emergency.

C. Section 1557

The Proposed Rule also puts patients at risk by ignoring the federal Patient Protection and Affordable Care Act ("ACA"), which explicitly confers on patients the right to receive nondiscriminatory health care in any health program or activity that receives federal funding. 42 U.S.C. § 18116. Incorporating the prohibited grounds for discrimination described in other federal civil rights laws, the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. *Id.* at § 18116(a).

The Refusal Statutes must be read to coexist with the statutory nondiscrimination requirements of the ACA and similar state nondiscrimination laws. If a nondiscrimination requirement has any meaning in the healthcare context, it must mean that a patient cannot be refused care simply because of her race, color, national origin, sex, age, or disability. And as courts have recognized, the prohibition on sex discrimination under the federal civil rights statutes should be interpreted to prohibit discrimination against transgender people. *See Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1049-50 (7th Cir. 2017) (discrimination against transgender students violates Title IX, which is the basis for the ACA's prohibition on sex discrimination);); *see also EEOC v. R.G. & G.R. Funeral Homes, Inc.*, 2018 WL 1177669 at *5-12 (6th Cir. Mar. 7, 2018) (Title VII). Notwithstanding these protections, as well as explicit statutory protections from discrimination based on gender identity and sexual orientation in many

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states (as discussed below), the Proposed Rule invites providers to discriminate against LGBT patients, particularly transgender people.

6. **The Rule Also Appears Aimed at Pre-Empting State Laws That Expand Access to Health Care or Otherwise Immunizing Violations of State Law**

The Proposed Rule creates even more concern with regard to its intended effect on state law. The Preamble devotes extensive discussion to "Recently Enacted State and Local health Government Health Care Laws" that have triggered some litigation by "conscientious objectors," 83 FR 3888, characterizing those disputes as part of the rationale for the Rule. Although the Department states it "has not opined on or judged the legal merits of any of the" catalogued state and local laws, it uses these laws "to illustrate the need for clarity" concerning the Refusal Statutes that are the subject of the Proposed Rule. 83 FR 3889.

But no clarity, only more questions ensue, because the Proposed Rule does not explain how its requirements interact with state and local law (nor does it provide any statutory authority on which those requirements rest under federal law, as discussed above). The Rule's expansion of definitions, covered entities, and enforcement mechanisms appears to impermissibly invite institutions and individuals to violate state law, and to attempt somehow to inhibit states from enforcing their own laws that require institutions to provide care, coverage, or even just information. The Proposed Rule also includes a troubling preemption provision, which specifies only that state and local laws that are "equally or more protective of religious freedom" should be saved from preemption, 83 FR 3931, and ignores the importance of maintaining the protection of other state laws, such as laws mandating non-discrimination in the provision of health care or requiring that state funding be available for certain procedures.

The Rule, if it survives in any fashion, should clarify that it creates no new preemption of state or local laws. That is because any preemption must be limited to that which already existed, if any, by virtue of the extremely limited, pre-existing Refusal Statutes. These regulations cannot create some new gutting of state and local mandates.

7. **The Rule Would Violate the Establishment Clause Because It Forces Unwilling Third Parties to Bear Serious Harms From Others' Religious Exercise**

The Proposed Rule imposes the significant harms on patients identified above in service of institutional and individual religious objectors. It purports to mandate that their religious choices take precedence over providing medical information and health care to patients. But the First Amendment forbids government action that favors the free exercise of religion to the point of forcing unwilling third parties to bear the burdens and costs of someone else's faith. As the Supreme Court has emphasized, "[t]he principle that government may accommodate the free exercise of religion does not supersede the fundamental limitation

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imposed by the Establishment Clause." *Lee v. Weisman*, 505 U.S. 577, 587 (1992); *accord Bd. of Educ. of Kiryas Joel Village School Dist. v. Grumet*, 512 U.S. 687, 706 (1994) ("accommodation is not a principle without limits").

Because the Rule attempts to license serious patient harms in the name of shielding others' religious conduct, it is incompatible with our longstanding constitutional commitment to separation of church and state. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708-10 (1985) (rejecting, as Establishment Clause violation, law that freed religious workers from Sabbath duties, because the law imposed substantial harms on other employees); *see also Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 14, 18 n.8 (1989) (plurality opinion) (invalidating sales tax exemption for religious periodicals, in part because the exemption "burden[e]d nonbeneficiaries markedly" by increasing their tax bills). The Department should withdraw the Rule to avoid its violation of the Establishment Clause.

8. **The Rule Unnecessarily Expands Compliance Tools, Without Clear Due Process Protections, and Risks Overzealous Enforcement That Would Harm Patient Care**

Finally, the Department provides no evidence that existing enforcement mechanisms are insufficient to educate providers, investigate and conduct compliance reviews, and address any meritorious complaints under the Refusal Statutes. Yet the Department itself, in a woefully inadequate and low estimation, concedes that at least hundreds of millions of dollars will be spent by health care providers to attempt to comply with the new requirements the Proposed Rule purports to create. Moreover, the Rule proposes ongoing reporting requirements for five years after any investigation of a complaint or compliance review, regardless of its outcome; purports to empower the Department to revoke federal funding before any opportunity for voluntary compliance occurs; allows punishment of grantees for acts, no matter how independent, of sub-recipients; and lacks clarity as to any procedural protections that a grantee may have in contesting enforcement actions. If the entire Rule is not withdrawn, its enforcement powers and obligations should be substantially scaled back, and full due process protections should clearly be identified and provided if any funding impact is threatened, *see, e.g.*, 45 C.F.R. §§ 80.8-80.10 (Title VI due process protections).

The Rule contemplates an enormous outlay of funds to implement a complex, extreme compliance scheme that will only serve to divert funds away from the provision of high-quality health care to those who need it most.

* * *

For all these reasons, the Department should withdraw the Proposed Rule. If it fails to do so, it must substantially modify the Proposed Rule so as, at a minimum, not to exceed the terms of and congressional intent behind the underlying statutes.

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Alabama

Sincerely,

Randall C. Marshall
Executive Director

Exhibit 4

March 27, 2018

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

Submitted electronically

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Re: Proposed New 45 CFR Part 88 Regarding Refusals of Medical Care

The American Civil Liberties Union Foundation of Florida, Inc. ("ACLU of Florida" or "ACLU-FL") submits these comments on the proposed rule published at 83 FR 3880 (January 28, 2018), RIN 0945-ZA03, with the title "Ensuring that the Department of Health and Human Services [(the "Department")] Does Not Fund or Administer Programs or Activities that Violate Conscience and Associated Anti-Discrimination Laws" (the "Proposed Rule" or "Rule").

The ACLU of Florida works daily in courts, legislative bodies, and communities across Florida to defend and preserve the individual rights and liberties guaranteed by the Constitution and laws of the United States as well as the Constitution and laws of the State of Florida. The ACLU-FL has a long history of vigorously defending religious liberty. We are equally vigilant in our efforts to safeguard reproductive rights and to end discrimination against those who have historically been excluded or diminished by more powerful actors in society, including in health care settings. The ACLU-FL is thus particularly well-positioned to comment on the Proposed Rule and the serious concerns it raises about access to reproductive and other health care, based on the religious or other beliefs of institutions or individual providers. We steadfastly protect the right to religious freedom. But that right does not include a right to harm others, as this Proposed Rule contemplates.

Without any regulatory authority, the Department has proposed a rule that vastly expands narrow statutory sections in ways Congress never intended, in a manner unsupportable by the terms of the statutes, and in a way that upsets the careful balance struck by other federal laws, all in an effort to grant health care providers unprecedented license to refuse to provide care and information to patients. In so doing, the Proposed Rule does not mention, much less grapple with, the consequences of refusals to provide full information and necessary health care to patients. The denials that the Rule proposes to protect will have significant consequences for individuals in terms of their health and well-being, in addition to financial costs. And, because the Proposed Rule is tied to entities that receive federal funding, those consequences will fall most heavily on poor and low-income people who must rely on government-supported programs and institutions for their care and who will have few, if any, other options if they are denied appropriate care. The Proposed Rule amounts to a license to discriminate, made all the worse because the federal purse will be used to further that discrimination.

The Proposed Rule is not only extremely detrimental to patient health, it is also entirely unnecessary. Individual providers' religious and moral beliefs are already strongly protected by federal law that, among other things, forbids religious discrimination and requires employers to provide reasonable accommodation of an employee's religious objections.

Because the Proposed Rule harms patient health, encourages discrimination against patients, and exceeds the Department's rulemaking authority, it should be withdrawn. If the Department refuses to do so, it must, at a minimum, revise the Proposed Rule so that it aligns with the statutory provisions it purports to implement, makes clear that it is not intended to conflict with or preempt other state or federal laws that protect and expand access to health care, and mitigates the Rule's harm to patients' health and well-being.

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1. The Proposed Rule Ignores Its Impact on Patients' Health and Invites Harms That Will Disproportionately Fall on Women and Marginalized Populations

The Proposed Rule seeks to immunize refusals of health care, yet utterly fails to consider the harmful impact it would have on patients' health. But this failure to address the obvious consequences of giving federally subsidized providers *carte blanche* to decide whom to treat or not treat based on religious or moral convictions—or indeed, based on any reasoning, or none at all[1]—does not mean the harm does not exist. In fact, the harms would be substantial. For example, the Proposed Rule:

- Appears to provide immunities for health care institutions that receive federal funding and professionals who work in federally funded programs to refuse to provide complete information to patients about their condition and treatment options;
- Purports to create new "exemptions," so that patients who rely on federally subsidized health care programs, such as Title X, may be unable to obtain services those programs are required by law to provide;
- Causes confusion about whether hospitals can prevent staff from providing emergency care to pregnant women who are suffering miscarriages or otherwise need emergency abortion care; and
- Invites health care providers to discriminate against individuals based on who they are, for example, by refusing to provide otherwise available services to a patient for the sole reason that the patient is transgender.

[1] Although the Notice of Proposed Rulemaking highlights religious freedom and rights of conscience, a number of the referenced statutes—and the proposed expansions of those in the Rule—do not turn on the existence of any religious or moral justification. The Proposed Rule would empower not only those acting based on conscience but others acting, for example, out of bare animus toward a patient's desired care or any aspect of their identity.

These harms would fall most heavily on historically disadvantaged groups and those with limited economic resources. As the ACLU-FL's own cases and requests for assistance reflect, women, LGBT (lesbian, gay, bisexual, and transgender) individuals, people of color, immigrants, young people, and members of other groups who continue to struggle for equal rights are those who most often experience refusals of care. Likewise, poor and low-income people will also suffer acutely under the Proposed Rule. They are more likely to rely on health care that is in some manner tied to federal funding, and less likely to have other options at their disposal if they are denied access to care or information. Because it will limit access to health care, harm patients' outcomes, and undermine the central, public health mission of the Department, the Proposed Rule should be withdrawn.

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2. The Department Lacks the Authority to Issue the Proposed Rule

The Proposed Rule references the Church Amendments, 42 U.S.C. § 300a-7; the Coats-Snowe Amendment, 42 U.S.C. § 238n; the Weldon Amendment, Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. H, Tit. V, § 507(d); and other similar "protections" or "exemptions," *see* 83 FR 3880, that sometimes allow, under narrow circumstances, health care professionals to avoid providing certain medical procedures or that limit the actions that may be taken against them if they refuse to provide care (collectively, the "Refusal Statutes"). The Preamble to the Rule focuses most extensively on the Church, Coats, and Weldon Amendments (the "Amendments"), and the Rule itself purports to establish extraordinarily expansive new substantive requirements, compliance steps, and enforcement authority under them.

But the Department does not possess *any* legislative rulemaking powers under those Amendments and wholly lacks the authority to promulgate the Proposed Rule as it applies to them. None of those Amendments includes, or references, any explicit delegation of regulatory authority. *Compare, e.g.*, 42 U.S.C. § 2000d-1 (expressly directing all relevant federal agencies to issue "rules, regulations, or orders of general applicability" to achieve the objectives of Title VI). Nor does any implicit delegation of legislative rulemaking authority exist for these provisions. For this reason alone, the Department cannot properly proceed to adopt the Proposed Rule or any similar variation of it.

3. The Proposed Rule Impermissibly Expands the Narrow Referenced Statutes and Does So In Ways That Ignore The Statutes' Limited Terms and Purposes

Even if the Department had the necessary rulemaking authority (which it does not), the Proposed Rule's virtually unbounded definition of certain terms and expansions of the Refusal Statutes' reach would broaden the Refusal Statutes beyond reason and recognition, create conflict with federal law, and lead to denials of appropriate care to patients. While we do not attempt to catalogue each way in which the Proposed Rule impermissibly expands the Refusal Statutes, a few examples follow.

A. <u>Assist in the Performance</u>

For example, Subsection (c)(1) of the Church Amendments prohibits recipients of certain federal funds from engaging in employment discrimination against health care providers who have objected to performing or "assist[ing] in the performance of" an abortion or sterilization. 42 U.S.C. § 300a-7(c)(1). Under the Proposed Rule, however, the Department defines "assist in the performance" of an abortion or sterilization to include not only assistance *in the performance* of those actual procedures – the ordinary meaning of the phrase – but also to participation in any other activity with "an articulable connection to a procedure." 83 FR 3892, 3923. Through this expanded definition, the Department explicitly aims to include activities beyond "direct involvement with a procedure" and to provide "broad protection"—despite the fact that the statutory references are limited to "assistance in the performance of" an abortion or sterilization procedure itself. 83 FR 3892; *cf. also, e.g.*, 42 U.S.C. § 300a-7(c)(1).

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This means, for example, that simply admitting a patient to a health care facility, filing her chart, transporting her from one part of the facility to another, or even taking her temperature could conceivably be considered "assist[ing] in the performance" of an abortion or sterilization, as any of those activities could have an "articulable connection" to the procedure. As described more fully below, the Proposed Rule could even be cited by health care providers who withhold basic information from patients seeking information about abortion or sterilization on the grounds that "assist[ing] in the performance" of a procedure "includes but is not limited to counseling, referral, training, and other arrangements for the procedure." 83 FR 3892, 3923.

But the term "assist in the performance" simply does not have the virtually limitless meaning the Department proposes ascribing to it. The Department has no basis for declaring that Congress meant anything beyond actually "assist[ing] in the performance of" the specified procedure—given that it used that phrasing, 42 U.S.C. §§ 300a-7(c)(1)—and instead meant any activity with any connection that can be articulated, regardless of how attenuated the claimed connection, how distant in time, or how non-procedure-specific the activity.

B. Referral or Refer for

Others of the Refusal Statutes provide limited protections to certain health care entities and individuals that refuse to, among other things, "refer for" abortions. For those statutes, the Proposed Rule expands "referral or refer for" beyond recognition, by proposing to define a referral as "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, assisting, … financing, or performing" it, where the entity (including a person) doing so "sincerely understands" the service, activity, or procedure to be a "possible outcome[.]" 83 FR 3894-95 (emphasis added), 3924. This wholesale re-definition of the concept of "referral" could have dire consequences for patients. For example, a hospital that prohibits its doctors from even discussing abortion as a treatment option for certain serious medical conditions could attempt to claim that the Rule protects this withholding of critical information because the hospital "sincerely

understands" the provision of this information to the patient may provide some assistance to the patient in obtaining an abortion.

Providing a green light for the refusal to provide information that patients need to make informed decisions about their medical care not only violates basic medical ethics, but also far exceeds Congress's language and intent. A referral—as used in common parlance and the underlying statutes—has a far more limited meaning than providing *any* information that *could* provide *any assistance whatsoever* to a person who may ultimately decide to obtain, assist, finance, or perform a given procedure sometime in the future. The meaning of "referral or refer for" in the health care context is to *direct* a patient elsewhere for care. *See* Merriam-Webster, https://www.merriam-webster.com/dictionary/referral (medical definition of "referral" is "the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment").

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C. Discriminate or Discrimination

These expansive definitions are all the more troubling given the Proposed Rule's definition of "discrimination," which purports to provide unlimited immunity for institutions that receive some federal funds to deny abortion care, to block coverage for such care, or to stop patients' access to information, no matter what the patients' circumstances or the mandates of state or federal law. Likewise, the definition appears aimed at providing immunity for employees who refuse to perform central parts of their job, regardless of the impact on the ability of a health care entity to provide appropriate care to its patients. This expansion of "discrimination" would apparently treat virtually any adverse action—including government enforcement of a patient non-discrimination or access-to-care law—against a health care facility or individual as *per se* discrimination. But "discrimination" does not mean any negative action; it instead requires an assessment of context and justification, with the claimant showing unequal treatment on prohibited grounds under the operative circumstances. The Proposed Rule abandons, for example, the nuanced and balanced approach required by Title VII, and it also ignores other federal laws, state laws, and providers' ethical obligations to their patients. *See infra* Parts 4-6.

D. Other Expansions of the Scope of the Refusal Statutes

The Proposed Rule not only distorts the definitions of words in the statutes, but it also alters the statutes' substantive provisions in other ways to attempt to expand the ability of individuals and entities to deny care in contravention of legal and ethical requirements and to the severe detriment of patients. Again, these comments do not attempt to exhaustively catalogue all of the unauthorized expansions but instead provide a few illustrative examples.

For example, Congress enacted Subsection (d) of the Church Amendment in 1974 as part of Public Law 93-348, a law that addressed biomedical and behavioral research, and appended that new Subsection (d) to the pre-existing subsections of Church from 1973, all of which are codified within 42 U.S.C. § 300a-7: the "Sterilization or

Abortion" section within the code subchapter that relates to "Population Research and Voluntary Family Planning Programs." Despite this explicit context for Subsection (d), and Congress' intent that it apply narrowly, however, the Proposed Rule attempts to import into this Subsection an unduly broad definition of "health service program," along with the expansive definitions discussed above, to purportedly transform it into a much more general prohibition that would apply to any programs or services administered by the Department, and that would assertedly prevent any entity that receives federal funding through those programs or services from requiring individuals to perform or assist in the performance of actions contrary to their religious beliefs or moral convictions. *See* 83 FR 3894, 3906, 3925. This erroneous expansion of Church (d), as described in this attempted rule-making, could prevent health care institutions from ensuring that their employees provide appropriate care and information. It would purportedly prevent institutions from taking action against members of their workforce who refuse to provide any information or care that they "sincerely understand" may have an "articulable connection" to some eventual procedure to which they object—no matter what medical ethics, their job requirements, Title VII, or laws directly protecting patient access to care may require.

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The Rule similarly attempts to expand the Coats Amendment beyond its limited provisions, which apply to certain "governmental activities regarding training and licensing of physicians," 42 U.S.C. § 238n (quoting title), to apply *regardless* of context. Thus, rather than being confined to residency training programs as Congress intended, the Proposed Rule purports to give all manner of health care entities, including insurance companies and hospitals, a broad right to refuse to provide abortion and abortion-related care. In addition, the Rule's expansion of the terms "referral" and "make arrangements for" extends the Coats Amendment to shield any conduct that would provide "any information … by any method … that could provide *any assistance* in a person obtaining, assisting, … financing, or performing" an abortion or that "render[s] aid to anyone else reasonably likely" to make an abortion referral. 83 FR 3894-95 (emphasis added), 3924. This expansive interpretation not only goes far beyond congressional intent and the terms of the statute, it also could have extremely detrimental effects on patient health. For example, it would apparently shield, against any state or federal government penalties, a women's health center that required any obstetrician-gynecologist practicing there who diagnosed a pregnant patient as having a serious uterine health condition to refuse to provide her with even the name of an appropriate specialist, because that specialist "is reasonably likely" to provide the patient with information about abortion.

Similarly, as written, the Weldon Amendment is no more than a bar on particular appropriated funds flowing to a "Federal agency or program, or State or local government," if any of those government institutions discriminate on the basis that a health care entity does not provide, pay for, provide coverage of, or refer for abortion. Pub. L. No. 115-31, Div. H, Tit. V, § 507(d)(1). Yet again, however, the Proposed Rule attempts to vastly increase its reach by (i) expanding the scope of the federal funding streams to which the Weldon Amendment prohibition reaches, and (ii) binding "any entity" that receives such funding—not just the government entities listed in the Amendment—to its proscriptions. 83 FR 3925. These unauthorized expansions, combined with the expansive definitions discussed *supra,* can lead to broad and harmful

denials of care. For example, under this unduly expansive interpretation of Weldon, an organization that refuses to discuss the option of abortion with people who discover they are pregnant may claim a right to participate in the Title X program, despite the fact that both federal law and medical ethics require that Title X patients be provided with counseling about all of their options. *See, e.g.*, 42 C.F.R. § 59.5(a)(5).

The Department should withdraw the Rule to prevent it from impeding health care and harming patients. But if it does not do so, each of the definitions must be clarified and must revert to the terms' proper meaning, and each of the substantive requirements should track only those provisions actually found in the Refusal Statutes themselves.

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4. The Rule Undermines Legal and Ethical Requirements of Fully Informed Consent

The Proposed Rule appears to allow institutional and individual health care providers to manipulate and distort provider-patient communications and deprive patients of critical health care information about their condition and treatment options. While the Proposed Rule's Preamble suggests the Rule will improve physician-patient communication because it will purportedly "assist patients in seeking counselors and other health-care providers who share their deepest held convictions," 83 FR 3916-17, the notion that empowering health care providers to deny care to and withhold information from some patients is somehow necessary to enable other patients to identify like-minded providers strains credulity: Patients are already free to inquire about their providers' views, and patients' own expressions of faith and decisions based on that faith must already be honored. *Cf. id.* Allowing *providers* to decide what information to share– or not share—with patients, regardless of the patient's needs or the requirements of informed consent and professional ethics, would gravely harm trust and open communication in health care, rather than aiding it.

As the American Medical Association's Code of Medical Ethics ("AMA Code") explains, the relationship between patient and physician "gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest." AMA Code § 1.1.1. Even in instances where a provider's beliefs are opposed to a particular course of action, the provider must "[u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects." *Id.* § 1.1.7(e).

By erroneously expanding the meaning of "assist in the performance of," "refer for," and "make arrangements for," as described above, however, the Proposed Rule purports to allow health care providers to refuse to provide basic information to patients in ways that were never contemplated by the underlying statutes. As described above, these broad definitions may be used to immunize the denial of basic information about a patient's condition as well as her treatment options.

Withholding this vital information from patients violates fundamental legal and ethical principles, deprives patients of the ability to make informed decisions, and leads to negligent care. If the Department moves forward with the Proposed Rule, it should,

among other necessary changes, modify it to make clear that it does not subvert basic principles of medical ethics and does not protect withholding information from a patient about her condition or treatment options.

5. By Failing to Acknowledge Other Federal Laws, the Proposed Rule Will Lead to Confusion, Denials for Care, and Harm to Patients

A. Title VII

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The Proposed Rule is not only unauthorized and harmful to patients, it is also unnecessary to accommodate individual workers—federal law already amply protects individuals' religious freedom in the workplace. For more than four decades, Title VII has required employers to make reasonable accommodations for current and prospective employers' religious beliefs so long as doing so does not pose an "undue hardship" to the employer. 42 U.S.C. §§ 2000e(j), 2000e-(2)(a); *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 84 (1977); EEOC Guidelines, 29 C.F.R. § 1605.2(e)(1).[2] Thus, Title VII—while protecting freedom of religion—establishes an essential balance. It recognizes that an employer cannot subject an employee to less favorable treatment because of that individual's religion and that generally an employer must accommodate an employee's religious practices. However, it does not require accommodation when the employee objects to performing core job functions, particularly when those objections harm patients, depart from the standard of care, or otherwise constitute an undue hardship. *Id.* This careful balance between the needs of employees, patients, and employers is critical to ensuring that religious beliefs are respected while at the same time ensuring that health care employers are able to provide quality health care to their patients.

Despite this long-standing balance and the lack of any evidence that Congress intended the Refusal Statutes to disrupt it, the Proposed Rule does not even mention these basic federal legal standards or the need to ensure patient needs are met. Instead, by presenting a seemingly unqualified definition of what constitutes "discrimination," 83 FR 3892-93, 3923-24, and expansive refusal rights, the Department appears to attempt to provide complete immunity for religious refusals in the workplace, no matter how significantly those refusals undermine patient care, informed consent, or the essential work of institutions established for the purpose of promoting health. Indeed, the Rule is explicit in seeking not simply a "level playing field" and reasonable accommodation, but rather an unlimited ability for individuals to "be[] free not to act contrary to one's beliefs," regardless of the harm it causes others and without any repercussions. *Id.* Such an interpretation could have a drastic impact on the nation's safety-net providers' ability to provide high quality care by requiring, for example, a family planning provider to hire a counselor to provide pregnancy-options counseling even if the counselor refuses to comply with ethical and legal obligations to inform patients of the availability of abortion. If the Department does not withdraw the entire Rule, therefore, it should explicitly limit its reach and make clear that Title VII provides the governing standard for employment situations.

[2] Religion for purposes of Title VII includes not only theistic beliefs, but also non-theistic "moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." Equal Employment Opportunity Commission ("EEOC") Guidelines, 29 C.F.R. §1605.1.

B. EMTALA

The Proposed Rule also puts patients at risk by ignoring the federal Emergency Medical Treatment and Labor Act ("EMTALA") and hospitals' obligations to care for patients in an emergency. As Congress has recognized, a refusal to treat patients facing an emergency puts their health and, in some cases, their lives at serious risk. Through EMTALA, Congress has required hospitals with an emergency room to provide stabilizing treatment to any individual experiencing an emergency medical condition or to provide a medically beneficial transfer. 42 U.S.C. § 1395dd(a)-(c); *see also* Fla. Stat. § 395.1041 ("Access to emergency services and care").

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The Refusal Statutes do not override the requirements of EMTALA or similar state laws that require health care providers to provide abortion care to a woman facing an emergency. *See, e.g.*, *California v. U.S.*, Civ. No. 05-00328, 2008 WL 744840, at *4 (N.D. Cal. March 18, 2008) (rejecting notion "[t]hat enforcing [a state law requiring emergency departments to provide emergency care] or the EMTALA to require medical treatment for emergency medical conditions would be considered 'discrimination' under the Weldon Amendment if the required medical treatment was abortion related services").

It is particularly troubling, therefore, to have the Department use attempts to require hospitals to comply with their obligations under EMTALA in its Preamble as *justification* for expanding the Refusal Statutes. 83 FR 3888-89. For example, the Preamble discusses the case brought by the ACLU on behalf of Tamesha Means who at 18 weeks of pregnancy began to miscarry and sought care, not once but three times, at her local hospital. 83 FR 3888-89. Despite the fact that she was bleeding, in severe pain, and had developed a serious infection, the hospital repeatedly sent her away and never told her that her health was at risk and that having an abortion was the safest course for her. *See* Health Care Denied 9-10 (May 2016), *available at* https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied. But the ethical imperative is the opposite: "In 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." 83 FR 3888 (quoting American Congress of Obstetricians and Gynecologists ("ACOG") Committee Opinion No. 365) (reaffirmed 2016).

The Proposed Rule suggests that hospitals like the one who put Ms. Means' health at risk should be given a free pass. Yet doing so would not only violate EMTALA but also other legal, professional, and ethical principles governing access to health care in this country. For that reason, if not withdrawn in its entirety, the Proposed Rule should, at minimum, clarify that it does not disturb health care providers' obligations to provide appropriate care in an emergency.

C. Section 1557

The Proposed Rule also puts patients at risk by ignoring the federal Patient Protection and Affordable Care Act ("ACA"), which explicitly confers on patients the right to receive nondiscriminatory health care in any health program or activity that receives federal funding. 42 U.S.C. § 18116. Incorporating the prohibited grounds for discrimination described in other federal civil rights laws, the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. *Id.* at § 18116(a).

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The Refusal Statutes must be read to coexist with the statutory nondiscrimination requirements of the ACA and similar state nondiscrimination laws. If a nondiscrimination requirement has any meaning in the healthcare context, it must mean that a patient cannot be refused care simply because of her race, color, national origin, sex, age, or disability. And as courts have recognized, the prohibition on sex discrimination under the federal civil rights statutes should be interpreted to prohibit discrimination against transgender people. *See Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1049-50 (7th Cir. 2017) (discrimination against transgender students violates Title IX, which is the basis for the ACA's prohibition on sex discrimination);); *see also EEOC v. R.G. & G.R. Funeral Homes, Inc.*, No. 16-2424, --- F.3d ----, ----, 2018 WL 1177669, at *5-12 (6th Cir. Mar. 7, 2018) (Title VII). Notwithstanding these protections, as well as explicit statutory protections from discrimination based on gender identity and sexual orientation in many states (as discussed below), the Proposed Rule invites providers to discriminate against LGBT patients, particularly transgender people.

6. The Rule Also Appears Aimed at Pre-Empting State Laws That Expand Access to Health Care or Otherwise Immunizing Violations of State Law

The Proposed Rule creates even more concern with regard to its intended effect on state law. The Preamble devotes extensive discussion to "Recently Enacted State and Local Government Health Care Laws" that have triggered some litigation by "conscientious objectors," 83 FR 3888, characterizing those disputes as part of the rationale for the Rule. Although the Department states it "has not opined on or judged the legal merits of any of the" catalogued state and local laws, it uses these laws "to illustrate the need for clarity" concerning the Refusal Statutes that are the subject of the Proposed Rule. 83 FR 3889.

But no clarity, only more questions, ensue, because the Proposed Rule does not explain how its requirements interact with state and local law (nor does it provide any statutory authority on which those requirements rest under federal law, as discussed above). The Rule's expansion of definitions, covered entities, and enforcement mechanisms appears to impermissibly invite institutions and individuals to violate state law, and to attempt somehow to inhibit states from enforcing their own laws that require institutions to provide care, coverage, or even just information. The Proposed Rule also includes a troubling preemption provision that specifies only that state and local laws that are "equally or more protective of religious freedom" should be saved from preemption, 83 FR 3931, and ignores the importance of maintaining the protection of other state laws,

such as laws mandating non-discrimination in the provision of health care or requiring that state funding be available for certain procedures.

Thus, the Proposed Regulation and its treatment of state and local laws puts at risk—for example—Florida's own emergency-services statute, which complements EMTALA by offering unique remedies not available under the federal provision, *see* Fla. Stat. § 395.1041, as well as the Florida Department of Health's policy of non-discrimination in the delivery of services, http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/equal-opportunity/DOHP220314F.pdf.

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The Rule, if it survives in any fashion, should clarify that it creates no new preemption of state or local laws. That is because any preemption must be limited to that which already existed, if any, by virtue of the extremely limited, pre-existing Refusal Statutes. These regulations cannot create some new gutting of state and local mandates.

7. The Rule Would Violate the Establishment Clause Because It Forces Unwilling Third Parties to Bear Serious Harms From Others' Religious Exercise

The Proposed Rule imposes the significant harms on patients identified above in service of institutional and individual religious objectors. It purports to mandate that their religious choices take precedence over providing medical information and health care to patients. But the First Amendment forbids government action that favors the free exercise of religion to the point of forcing unwilling third parties to bear the burdens and costs of someone else's faith. As the Supreme Court has emphasized, "[t]he principle that government may accommodate the free exercise of religion does not supersede the fundamental limitation imposed by the Establishment Clause." *Lee v. Weisman*, 505 U.S. 577, 587 (1992); *accord Bd. of Educ. of Kiryas Joel Village School Dist. v. Grumet*, 512 U.S. 687, 706 (1994) ("accommodation is not a principle without limits").

Because the Rule attempts to license serious patient harms in the name of shielding others' religious conduct, it is incompatible with our longstanding constitutional commitment to separation of church and state. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708-10 (1985) (rejecting, as Establishment Clause violation, law that freed religious workers from Sabbath duties, because the law imposed substantial harms on other employees); *see also Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 14, 18 n.8 (1989) (plurality opinion) (invalidating sales-tax exemption for religious periodicals, in part because the exemption "burden[e]d nonbeneficiaries markedly" by increasing their tax bills). The Department should withdraw the Rule to avoid its violation of the Establishment Clause.

8. The Rule Unnecessarily Expands Compliance Tools, Without Clear Due Process Protections, and Risks Overzealous Enforcement That Would Harm Patient Care

ACLU Florida

Finally, the Department provides no evidence that existing enforcement mechanisms are insufficient to educate providers, investigate and conduct compliance reviews, and address any meritorious complaints under the Refusal Statutes. Yet the Department itself, in a woefully inadequate and low estimation, concedes that at least hundreds of millions of dollars will be spent by health care providers to attempt to comply with the new requirements the Proposed Rule purports to create. Moreover, the Rule proposes ongoing reporting requirements for five years after any investigation of a complaint or compliance review, regardless of its outcome; purports to empower the Department to revoke federal funding before any opportunity for voluntary compliance occurs; allows punishment of grantees for acts, no matter how independent, of sub-recipients; and lacks clarity as to any procedural protections that a grantee may have in contesting enforcement actions. If the entire Rule is not withdrawn, its enforcement powers and obligations should be substantially scaled back, and full due process protections should be clearly identified and provided if any funding impact is threatened. *Compare, e.g.*, 45 C.F.R. §§ 80.8-80.10 (Title VI due process protections).

The Rule contemplates an enormous outlay of funds to implement a complex, extreme compliance scheme that will only serve to divert funds away from the provision of high-quality health care to those who need it most.

* * *

For all these reasons, the Department should withdraw the Proposed Rule. If it fails to do so, it must substantially modify the Proposed Rule so as, at a minimum, not to exceed the terms of and congressional intent behind the underlying statutes.

Sincerely,

Kirk Bailey
Political Director

Nancy Abudu
Legal Director

Exhibit 5

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATIONS
California

March 27, 2018

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

Submitted electronically

Re: Proposed New 45 CFR Part 88 Regarding Refusals of Medical Care

The ACLU of Northern California, the ACLU of Southern California, and the ACLU of San Diego and Imperial Counties (collectively "ACLU of California") submit these comments on the proposed rule published at 83 FR 3880 (January 28, 2018), RIN 0945-ZA03, with the title "Ensuring that the Department of Health and Human Services [the "Department"] Does Not Fund or Administer Programs or Activities that Violate Conscience and Associated Anti-Discrimination Laws" (the "Proposed Rule" or "Rule").

The ACLU of California is a collaboration of the three California-based ACLU affiliates with more than 300,000 members and supporters, working to protect and advance the civil rights and civil liberties of all Californians. The ACLU of California has a long history of vigorously defending religious liberty. We are equally vigilant in our efforts to safeguard reproductive rights and to end discrimination against those who have historically been excluded or diminished by more powerful actors in society, including in health care settings. The ACLU of California is thus particularly well-positioned to comment on the Proposed Rule and the serious concerns it raises about access to reproductive and other health care, based on the religious or other beliefs of institutions or individual providers. We steadfastly protect the right to religious freedom. But that right does not include a right to harm others as this Proposed Rule contemplates.

Without any regulatory authority, the Department has proposed a rule that vastly expands narrow statutory sections in ways Congress never intended, in a manner unsupportable by the terms of the statutes, and in a way that upsets the careful balance struck by other federal laws, all in an effort to grant health care providers unprecedented license to refuse to provide care and information to patients. In so doing, the Proposed Rule does not mention, much less grapple with, the consequences of refusals to provide full information and necessary health care to patients. The denials that the Rule proposes to protect will have significant consequences for individuals in terms of their health and well-being, in addition to financial costs. And, because the Proposed Rule is tied to entities that receive federal funding, those consequences will fall most heavily on poor and low-income people who must rely on government-supported programs

and institutions for their care and who will have few, if any, other options if they are denied appropriate care. The Proposed Rule amounts to a license to discriminate, made all the worse because the federal purse will be used to further that discrimination.

The Proposed Rule is not only extremely detrimental to patient health, it is also entirely unnecessary. Individual providers' religious and moral beliefs are already strongly protected by federal law that, among other things, forbids religious discrimination and requires employers to provide reasonable accommodation of an employee's religious objections.

Because the Proposed Rule harms patient health, encourages discrimination against patients, and exceeds the Department's rulemaking authority, it should be withdrawn. If the Department refuses to do so, it must, at a minimum, revise the Proposed Rule so that it aligns with the statutory provisions it purports to implement, makes clear that it is not intended to conflict with or preempt other state or federal laws that protect and expand access to health care, and mitigates the Rule's harm to patients' health and well-being.

1. The Proposed Rule Ignores Its Impact on Patients' Health and Invites Harms That Will Disproportionately Fall on Women and Marginalized Populations

The Proposed Rule, cloaked in the language of non-discrimination, tramples on fundamental civil rights principles to protect those who discriminate rather than those who are discriminated against. In so doing, the Department wholly ignores harm to people seeking health care, thereby abandoning its mission to "protect the health and well-being of all Americans." *See* HHS, https://www.hhs.gov/about/index.html.

But this failure to address the obvious consequences of giving federally subsidized providers *carte blanche* to decide whom to treat or not treat based on religious or moral convictions—or indeed, based on any reasoning or none at all[1]—does not mean the harm does not exist. In fact, the harms would be substantial. For example, the Proposed Rule:

- Appears to provide immunities for health care institutions that receive federal funding and professionals who work in federally funded programs to refuse to provide complete information to patients about their condition and treatment options;
- Purports to create new "exemptions," so that patients who rely on federally subsidized health care programs, such as Title X, may be unable to obtain services those programs are required by law to provide;
- Causes confusion about whether hospitals can prevent staff from providing emergency care to pregnant women who are suffering miscarriages or otherwise need emergency abortion care; and

[1] Although the Notice of Proposed Rulemaking highlights religious freedom and rights of conscience, a number of the referenced statutes—and the proposed expansions of those in the Rule—do not turn on the existence of any religious or moral justification. The Proposed Rule would empower not only those acting based on conscience, but others acting, for example, out of bare animus toward a patient's desired care or any aspect of their identity.

- Invites health care providers to discriminate against individuals based on who they are, for example, by refusing to provide otherwise available services to a patient for the sole reason that the patient is transgender.

These harms would fall most heavily on historically disadvantaged groups and those with limited economic resources. As the ACLU's own cases and requests for assistance reflect, women, LGBT (lesbian, gay, bisexual and transgender) individuals, people of color, immigrants, young people, people with disabilities, and members of other groups who continue to struggle for equal rights are those who most often experience refusals of care. Likewise, poor and low-income people, and people living in rural communities, will also suffer acutely under the Proposed Rule. They are more likely to rely on health care that is in some manner tied to federal funding, and less likely to have other options at their disposal if they are denied access to care or information. All of these communities already suffer health disparities and discrimination, which could be sanctioned and exacerbated by the Rule. Because it will limit access to health care, harm patients' outcomes, and undermine the central, public health mission of the Department, the Proposed Rule should be withdrawn.

2. The Department Lacks the Authority to Issue the Proposed Rule

The Proposed Rule references the Church Amendments, 42 U.S.C. § 300a-7, the Coats-Snowe Amendment, 42 U.S.C. § 238n, the Weldon Amendment, Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. H, Tit. V, § 507(d), and other similar "protections" or "exemptions," *see* 83 FR 3880, that sometimes allow, under narrow circumstances, health care professionals to avoid providing certain medical procedures or that limit the actions that may be taken against them if they refuse to provide care (collectively, the "Refusal Statutes"). The Preamble to the Rule focuses most extensively on the Church, Coats, and Weldon Amendments (the "Amendments"), and the Rule itself purports to establish extraordinarily expansive new substantive requirements, compliance steps, and enforcement authority under them.

But the Department does not possess *any* legislative rulemaking powers under those Amendments and wholly lacks the authority to promulgate the Proposed Rule as it applies to them. None of those Amendments includes, or references, any explicit delegation of regulatory authority. *Compare, e.g.*, 42 U.S.C. § 2000d-1 (expressly directing all relevant federal agencies to issue "rules, regulations, or orders of general applicability" to achieve the objectives of Title VI). Nor does any implicit delegation of legislative rulemaking authority exist for these provisions. For this reason alone, the Department cannot properly proceed to adopt the Proposed Rule or any similar variation of it.

3. The Proposed Rule Impermissibly Expands the Narrow Referenced Statutes and Does So In Ways That Ignore The Statutes' Limited Terms and Purposes

Even if the Department had the necessary rulemaking authority (which it does not), the Proposed Rule's virtually unbounded definition of certain terms and expansions of the Refusal Statutes' reach would broaden the Refusal Statutes beyond reason and recognition, create conflict with federal law, and lead to denials of appropriate care to patients. While we do not

attempt to catalogue each way in which the Proposed Rule impermissibly expands the Refusal Statutes, a few examples follow.

A. Assist in the Performance

For example, Subsection (c)(1) of the Church Amendments prohibits recipients of certain federal funds from engaging in employment discrimination against health care providers who have objected to performing or "assist[ing] in the performance of" an abortion or sterilization. 42 U.S.C. § 300a-7(c)(1). Under the Proposed Rule, however, the Department defines "assist in the performance" of an abortion or sterilization to include not only assistance *in the performance* of those actual procedures – the ordinary meaning of the phrase – but also to participation in any other activity with "an articulable connection to a procedure[.]" 83 FD 8892, 3923. Through this expanded definition, the Department explicitly aims to include activities beyond "direct involvement with a procedure" and to provide "broad protection"—despite the fact that the statutory references are limited to "assistance in the performance of" an abortion or sterilization procedure itself. 83 FR 3892. *cf. e.g.*, 42 U.S.C. § 300a-7(c)(1).

This means, for example, that simply admitting a patient to a health care facility, filing her chart, transporting her from one part of the facility to another, or even taking her temperature could conceivably be considered "assist[ing] in the performance" of an abortion or sterilization, as any of those activities could have an "articulable connection" to the procedure. As described more fully below, the Proposed Rule could even be cited by health care providers who withhold basic information from patients seeking information about abortion or sterilization on the grounds that "assist[ing] in the performance" of a procedure "includes but is not limited to counseling, referral, training, and other arrangements for the procedure." 83 FR 3892, 3923.

But the term "assist in the performance" simply does not have the virtually limitless meaning the Department proposes ascribing to it. The Department has no basis for declaring that Congress meant anything beyond actually "assist[ing] in the performance of" the specified procedure—given that it used that phrasing, 42 U.S.C. §§ 300a-7(c)(1)—and instead meant any activity with any connection that can be articulated, regardless of how attenuated the claimed connection, how distant in time, or how non-procedure-specific the activity.

B. Referral or Refer for

Others of the Refusal Statutes provide limited protections to certain health care entities and individuals that refuse to, among other things, "refer for" abortions. For those statutes, the Proposed Rule expands "referral or refer for" beyond recognition, by proposing to define a referral as "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, assisting, … financing, or performing" it, where the entity (including a person) doing so "sincerely understands" the service, activity, or procedure to be a "possible outcome[.]" 83 FR 3894-95 (emphasis added), 3924. This wholesale re-definition of the concept of "referral" could have dire consequences for patients. For example, a hospital that prohibits its doctors from even discussing abortion as a treatment option for certain serious medical conditions could attempt to claim that the Rule protects this withholding of critical information because the hospital

"sincerely understands" the provision of this information to the patient may provide some assistance to the patient in obtaining an abortion.

Providing a green light for the refusal to provide information that patients need to make informed decisions about their medical care not only violates basic medical ethics, but also far exceeds Congress's language and intent. A referral—as used in common parlance, the underlying statutes, and the government's own websites—has a far more limited meaning than providing *any* information that *could* provide *any assistance whatsoever* to a person who may ultimately decide to obtain, assist, finance, or perform a given procedure sometime in the future. The meaning of "referral or refer for" in the health care context is to *direct* a patient elsewhere for care. *See* Merriam-Webster, https//www.merriam-webster.com/dictionary/referral ("referral" is "the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment"); U.S. Centers for Medicare & Medicaid Services, https://www.healthcare.gov/glossary/referral/ ("referral" is "a written order from your primary care doctor for you to see a specialist or get certain medical services").

C. Discriminate or Discrimination

These expansive definitions are all the more troubling given the Proposed Rule's definition of "discrimination," which purports to provide unlimited immunity for institutions that receive some federal funds to deny abortion care, to block coverage for such care, or to stop patients' access to information, no matter what the patients' circumstances or the mandates of state or federal law. Likewise, the definition appears aimed at providing immunity for employees who refuse to perform central parts of their job, regardless of the impact on the ability of a health care entity to provide appropriate care to its patients. This expansion of "discrimination" would apparently treat virtually any adverse action – including government enforcement of a patient non-discrimination or access-to-care law – against a health care facility or individual as *per se* discrimination. But "discrimination" does not mean any negative action, and instead requires an assessment of context and justification, with the claimant showing unequal treatment on prohibited grounds under the operative circumstances. The Proposed Rule abandons, for example, the nuanced and balanced approach required by Title VII, and also ignores other federal laws, state laws, and providers' ethical obligations to their patients. *See infra* Parts 4-6.

D. Other Expansions of the Scope of the Refusal Statutes

The Proposed Rule not only distorts the definitions of words in the statutes, but also alters the statutes' substantive provisions in other ways to attempt to expand the ability of individuals and entities to deny care in contravention of legal and ethical requirements and to the severe detriment of patients. Again, these comments do not attempt to exhaustively catalogue all of the unauthorized expansions but instead provide a few illustrative examples.

For example, Congress enacted Subsection (d) of the Church Amendment in 1974 as part of Public Law 93-348, a law that addressed biomedical and behavioral research, and appended that new Subsection (d) to the pre-existing subsections of Church from 1973, which all are codified within 42 U.S.C. § 300a-7: the "Sterilization or Abortion" section within the code

subchapter that relates to "Population Research and Voluntary Family Planning Programs." Despite this explicit context for Subsection (d), and Congress's intent that it apply narrowly, however, the Proposed Rule attempts to import into this Subsection an unduly broad definition of "health service program," along with the expansive definitions discussed above, to purportedly transform it into a much more general prohibition that would apply to any programs or services administered by the Department, and that would assertedly prevent any entity that receives federal funding through those programs or services from requiring individuals to perform or assist in the performance of actions contrary to their religious beliefs or moral convictions. *See* 83 FR 3894, 3906, 3925. This erroneous expansion of Church (d), as described in this attempted rule-making, could prevent health care institutions from ensuring that their employees provide appropriate care and information. It would purportedly prevent institutions taking action against members of their workforce who refuse to provide any information or care that they "sincerely understand" may have an "articulable connection" to some eventual procedure to which they object—no matter what medical ethics, their job requirements, Title VII, or laws directly protecting patient access to care may require.

The Rule similarly attempts to expand the Coats Amendment beyond its limited provisions, which apply to certain "governmental activities regarding training and licensing of physicians," 42 U.S.C. § 238n (quoting title), to apply *regardless* of context. Thus, rather than being confined to residency training programs as Congress intended, the Proposed Rule purports to give all manner of health care entities, including insurance companies and hospitals, a broad right to refuse to provide abortion and abortion-related care. In addition, the Rule's expansion of the terms "referral" and "make arrangements for" extends the Coats Amendment to shield any conduct that would provide "any information … by any method … that could provide *any assistance* in a person obtaining, assisting, … financing, or performing" an abortion or that "render[s] aid to anyone else reasonably likely" to make an abortion referral. 83 FR 3894-95 (emphasis added), 3924. This expansive interpretation not only goes far beyond congressional intent and the terms of the statute, it also could have extremely detrimental effects on patient health. For example, it would apparently shield, against any state or federal government penalties, a women's health center that required any obstetrician-gynecologist practicing there who diagnosed a pregnant patient as having a serious uterine health condition to refuse to provide her with even the name of an appropriate specialist, because that specialist "is reasonably likely" to provide the patient with information about abortion.

Similarly, as written, the Weldon Amendment is no more than a bar on particular appropriated funds flowing to a "Federal agency or program, or State or local government," if any of those government institutions discriminate on the basis that a health care entity does not provide, pay for, provide coverage of, or refer for abortion. Pub. L. No. 115-31, Div. H, Tit. V, § 507(d)(1). Yet again, however, the Proposed Rule attempts to vastly increase its reach by (i) expanding the scope of the federal funding streams to which the Weldon Amendment prohibition reaches and (ii) binding "any entity" that receives such funding—not just the government entities listed in the Amendment—to its proscriptions. 83 FR 3925. These unauthorized expansions, combined with the expansive definitions discussed *supra*, can lead to broad and harmful denials of care. For example, under this unduly expansive interpretation of Weldon, an organization that refuses to discuss the option of abortion with people who discover they are pregnant may claim a right to participate in the Title X program, despite the fact that both federal law and medical

ethics require that Title X patients be provided with counseling about all of their options. *See, e.g.*, 42 C.F.R. § 59.5(a)(5).

The Department should withdraw the Rule to prevent it from impeding health care and harming patients. But if it does not do so, each of the definitions must be clarified and revert to the terms' proper meaning, and each of the substantive requirements should track only those provisions actually found in the Refusal Statutes themselves.

4. The Rule Undermines Legal and Ethical Requirements of Fully Informed Consent

The Proposed Rule appears to allow institutional and individual health care providers to manipulate and distort provider-patient communications and deprive patients of critical health care information about their condition and treatment options. While the Proposed Rule's Preamble suggests the Rule will improve physician-patient communication because it will purportedly "assist patients in seeking counselors and other health-care providers who share their deepest held convictions," 83 FR 3916-17, the notion that empowering health care providers to deny care to and withhold information from some patients is somehow necessary to enable other patients to identify like-minded providers strains credulity: Patients are already free to inquire about their providers' views, and patients' own expressions of faith and decisions based on that faith must already be honored. *Cf. id.* Allowing *providers* to decide what information to share–or not share—with patients, regardless of the patient's needs or the requirements of informed consent and professional ethics would gravely harm trust and open communication in health care, rather than aiding it.

As the American Medical Association's Code of Medical Ethics ("AMA Code") explains, the relationship between patient and physician "gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest[.]" AMA Code § 1.1.1. Even in instances where a provider's beliefs are opposed to a particular course of action, the provider must "[u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects." *Id.* § 1.1.7(e).

Acknowledging the right of every patient to receive basic information necessary to competently make decisions about their own health, California law requires that patients receive full and complete information about the health care services available. Withholding this vital information from patients violates fundamental legal and ethical principles, deprives patients of the ability to make informed decisions, and leads to negligent care.

By erroneously expanding the meaning of "assist in the performance of," "refer for" and "make arrangements for," as described above, the Proposed Rule purports to allow health care providers to refuse to provide basic information to patients in ways that were never contemplated by the underlying statutes. As described above, these broad definitions may be used to immunize the denial of basic information about a patient's condition as well as their treatment options.

If the Department moves forward with the Proposed Rule, it should, among other necessary changes, modify it to make clear that it does not subvert basic principles of medical ethics and does not protect withholding information from a patient about her condition or treatment options.

5. By Failing to Acknowledge Other Federal Laws, the Proposed Rule Will Lead to Confusion, Denials for Care, and Harm to Patients

A. Title VII

The Proposed Rule is not only unauthorized and harmful to patients, it is also unnecessary to accommodate individual workers—federal law already amply protects individuals' religious freedom in the workplace. For more than four decades, Title VII has required employers to make reasonable accommodations for current and prospective employers' religious beliefs so long as doing so does not pose an "undue hardship" to the employer. 42 U.S.C. §§ 2000e(j), 2000e-(2)(a); *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 84 (1977); EEOC Guidelines, 29 C.F.R. § 1605.2(e)(1).[2] Thus, Title VII—while protecting freedom of religion—establishes an essential balance. It recognizes that an employer cannot subject an employee to less favorable treatment because of that individual's religion and that generally an employer must accommodate an employee's religious practices. However, it does not require accommodation when the employee objects to performing core job functions, particularly when those objections harm patients, depart from the standard of care, or otherwise constitute an undue hardship. *Id.* This careful balance between the needs of employees, patients, and employers is critical to ensuring that religious beliefs are respected while at the same time health care employers are able to provide quality health care to their patients.

Despite this long-standing balance and the lack of any evidence that Congress intended the Refusal Statutes to disrupt it, the Proposed Rule does not even mention these basic federal legal standards or the need to ensure patient needs are met. Instead, by presenting a seemingly unqualified definition of what constitutes "discrimination," 83 FR 3892-93, 3923-24, and expansive refusal rights, the Department appears to attempt to provide complete immunity for religious refusals in the workplace, no matter how significantly those refusals undermine patient care, informed consent, or the essential work of institutions established for the purpose of promoting health. Indeed, the Rule is explicit in seeking not simply a "level playing field" and reasonable accommodation, but rather an unlimited ability for individuals to "be[] free not to act contrary to one's beliefs," regardless of the harm it causes others and without any repercussions. *Id.* Such an interpretation could have a drastic impact on the nation's safety-net providers' ability to provide high quality care by requiring, for example, a family planning provider to hire a counselor to provide pregnancy options counseling even if the counselor refuses to comply with ethical and legal obligations to inform patients of the availability of abortion. If the Department does not withdraw the entire Rule, therefore, it should explicitly limit its reach and make clear that Title VII provides the governing standard for employment situations.

[2] Religion for purposes of Title VII includes not only theistic beliefs, but also non-theistic "moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." Equal Employment Opportunity Commission ("EEOC") Guidelines, 29 C.F.R. §1605.1.

B. EMTALA

The Proposed Rule also puts patients at risk by ignoring the federal Emergency Medical Treatment and Labor Act ("EMTALA") and hospitals' obligations to care for patients in an emergency. As Congress has recognized, a refusal to treat patients facing an emergency puts their health and, in some cases, their lives at serious risk. Through EMTALA, Congress has required hospitals with an emergency room to provide stabilizing treatment to any individual experiencing an emergency medical condition or to provide a medically beneficial transfer. 42 U.S.C. § 1395dd(a)-(c).

The Refusal Statutes do not override the requirements of EMTALA or similar state laws, like California's, that require health care providers to provide abortion care to a woman facing an emergency. *See, e.g., California v. U.S.*, Civ. No. 05-00328, 2008 WL 744840, at *4 (N.D. Cal. March 18, 2008) (rejecting notion "[t]hat enforcing [a state law requiring emergency departments to provide emergency care] or the EMTALA to require medical treatment for emergency medical conditions would be considered 'discrimination' under the Weldon Amendment if the required medical treatment was abortion related services").

It is particularly troubling, therefore, to have the Department use attempts to require hospitals to comply with their obligations under EMTALA in its Preamble as *justification* for expanding the Refusal Statutes. 83 FR 3888-89. For example, the Preamble discusses the case brought by the ACLU on behalf of Tamesha Means who at 18 weeks of pregnancy began to miscarry and sought care, not once but three times, at her local hospital. 83 FR 3888-89. Despite the fact that she was bleeding, in severe pain, and had developed a serious infection, the hospital repeatedly sent her away and never told her that her health was at risk and that having an abortion was the safest course for her. *See* Health Care Denied 9-10 (May 2016), *available at* https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied. But the ethical imperative is the opposite: "In 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." 83 FR 3888 (quoting American Congress of Obstetricians and Gynecologists ("ACOG") Committee Opinion No. 365) (reaffirmed 2016).

The Proposed Rule suggests that hospitals like the one who put Ms. Means's health at risk should be given a free pass. Yet doing so would not only violate EMTALA, but also other legal, professional, and ethical principles governing access to health care in this country. For that reason, if not withdrawn in its entirety, the Proposed Rule should, at minimum, clarify that it does not disturb health care providers' obligations to provide appropriate care in an emergency.

C. Section 1557

The Proposed Rule also puts patients at risk by ignoring the federal Patient Protection and Affordable Care Act ("ACA"), which explicitly confers on patients the right to receive nondiscriminatory health care in any health program or activity that receives federal funding. 42 U.S.C. § 18116. Incorporating the prohibited grounds for discrimination described in other

federal civil rights laws, the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. *Id.* at § 18116(a).

The Refusal Statutes must be read to coexist with the statutory nondiscrimination requirements of the ACA and similar state nondiscrimination laws such as California's clear statutory prohibitions on gender identity, gender expression, and sexual orientation discrimination If a nondiscrimination requirement has any meaning in the healthcare context, it must mean that a patient cannot be refused care simply because of her race, color, national origin, sex, age, or disability. And as courts have recognized, the prohibition on sex discrimination under the federal civil rights statutes should be interpreted to prohibit discrimination against transgender people. *See Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1049-50 (7th Cir. 2017) (discrimination against transgender students violates Title IX, which is the basis for the ACA's prohibition on sex discrimination); *see also EEOC v. R.G. & G.R. Funeral Homes, Inc.*, 2018 WL 1177669 at *5-12 (6th Cir. Mar. 7, 2018) (Title VII). Notwithstanding these protections, as well as explicit statutory protections from discrimination based on gender identity and sexual orientation in many states (as discussed below), the Proposed Rule invites providers to discriminate against LGBT patients, particularly transgender people.

6. The Rule Also Appears Aimed at Pre-Empting State Laws That Expand Access to Health Care or Otherwise Immunizing Violations of State Law

The Proposed Rule creates even more concern with regard to its intended effect on state law. The Preamble devotes extensive discussion to "Recently Enacted State and Local Government Health Care Laws" that have triggered some litigation, much of it here in California, by "conscientious objectors," 83 FR 3888, characterizing those disputes as part of the rationale for the Rule. Although the Department states it "has not opined on or judged the legal merits of any of the" catalogued state and local laws, it uses these laws "to illustrate the need for clarity" concerning the Refusal Statutes that are the subject of the Proposed Rule. 83 FR 3889.

The Preamble's "Recently Enacted State and Local Government Health Care Laws" references several California laws, without explaining how the Rule's requirements interact with those or other state and local laws (nor does it provide any statutory authority on which those requirements rest under federal law, as discussed above). The Rule's expansion of definitions, covered entities, and enforcement mechanisms appears to impermissibly invite institutions and individuals to violate state law, and to attempt somehow to inhibit states from enforcing their own laws that require institutions to provide care, coverage, or even just information. The Proposed Rule also includes a troubling preemption provision, which specifies only that state and local laws that are "equally or more protective of religious freedom" should be saved from preemption, 83 FR 3931, and ignores the importance of maintaining the protection of other state laws, such as laws mandating non-discrimination in the provision of health care or requiring that state funding be available for certain procedures.

Thus, the Proposed Regulation and its unclear relationship to state and local laws puts at potential risk several vital California laws that safeguard patients from substandard health care and ensure patients' health, well-being, access, and choice, including but not limited to state laws

that mandate minimum educational requirements for licensed medical professionals, medically necessary services in emergency situations, that managed care health plans cover abortion as basic health care under the Knox-Keene Act, and that patients be informed when they are not offered all of their medical options. Such laws demonstrate California's concerted commitment to patients' health.

The ACLU Foundation of California has a strong history protecting patients' access to necessary medical services. Rebecca Chamorro, for example, decided, in consultation with her doctor, that she would have a tubal ligation following her scheduled C-section, which is the standard of care. Despite the clear health and cost benefits to performing one procedure rather than two separate procedures, the hospital refused her doctor's request to perform the procedure. Consequently, Ms. Chamorro endured additional stress, health risks, and costs, with no benefits to her, her baby, or even her doctor. Similarly, Evan Minton, a transgender man who was scheduled to receive a hysterectomy from his doctor, received notice that the hysterectomy was canceled on the eve of procedure when the hospital learned his gender identity. The Proposed Rule cites Ms. Chamorro's and Mr. Minton's cases as the type of harm the Rule seeks to address, confirming that the Rule facilitates and encourages blatant discrimination, with no regard for a patient's needs.

The Rule, if it survives in any fashion, should clarify that it creates no new preemption of state or local laws. That is because any preemption must be limited to that which already existed, if any, by virtue of the extremely limited, pre-existing Refusal Statutes. These regulations cannot create some new gutting of state and local mandates.

7. The Rule Would Violate the Establishment Clause Because It Forces Unwilling Third Parties to Bear Serious Harms From Others' Religious Exercise

The Proposed Rule imposes the significant harms on patients identified above in service of institutional and individual religious objectors. It purports to mandate that their religious choices take precedence over providing medical information and health care to patients. But the First Amendment forbids government action that favors the free exercise of religion to the point of forcing unwilling third parties to bear the burdens and costs of someone else's faith. As the Supreme Court has emphasized, "[t]he principle that government may accommodate the free exercise of religion does not supersede the fundamental limitation imposed by the Establishment Clause." *Lee v. Weisman*, 505 U.S. 577, 587 (1992); *accord Bd. of Educ. of Kiryas Joel Village School Dist. v. Grumet*, 512 U.S. 687, 706 (1994) ("accommodation is not a principle without limits").

Because the Rule attempts to license serious patient harms in the name of shielding others' religious conduct, it is incompatible with our longstanding constitutional commitment to separation of church and state. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708-10 (1985) (rejecting, as Establishment Clause violation, law that freed religious workers from Sabbath duties, because the law imposed substantial harms on other employees); *see also Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 14, 18 n.8 (1989) (plurality opinion) (invalidating sales tax exemption for religious periodicals, in part because the exemption "burden[e]d nonbeneficiaries

markedly" by increasing their tax bills). The Department should withdraw the Rule to avoid its violation of the Establishment Clause.

8. The Rule Unnecessarily Expands Compliance Tools, Without Clear Due Process Protections, and Risks Overzealous Enforcement That Would Harm Patient Care

Finally, the Department provides no evidence that existing enforcement mechanisms are insufficient to educate providers, investigate and conduct compliance reviews, and address any meritorious complaints under the Refusal Statutes. Yet the Department itself, in a woefully inadequate and low estimation, concedes that at least hundreds of millions of dollars will be spent by health care providers to attempt to comply with the new requirements the Proposed Rule purports to create. Moreover, the Rule proposes ongoing reporting requirements for five years after any investigation of a complaint or compliance review, regardless of its outcome; purports to empower the Department to revoke federal funding before any opportunity for voluntary compliance occurs; allows punishment of grantees for acts, no matter how independent, of sub-recipients; and lacks clarity as to any procedural protections that a grantee may have in contesting enforcement actions. If the entire Rule is not withdrawn, its enforcement powers and obligations should be substantially scaled back, and full due process protections should clearly be identified and provided if any funding impact is threatened, *see, e.g.*, 45 C.F.R. §§ 80.8-80.10 (Title VI due process protections).

The Rule contemplates an enormous outlay of funds to implement a complex, extreme compliance scheme that will only serve to divert funds away from the provision of high-quality health care to those who need it most.

* * *

For all these reasons, the Department should withdraw the Proposed Rule. If it fails to do so, it must substantially modify the Proposed Rule so as, at a minimum, not to exceed the terms of and congressional intent behind the underlying statutes.

Sincerely,

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