# Exhibit 106

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 Montana Women Vote in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. Montana Women Vote is an organization of low-income women, families, and allies advocating for our communities in the democratic process. Every day too many LGBTQ people face discrimination and other barriers to accessing lifesaving care. These barriers are especially pronounced for transgender patients. The proposed regulation ignores the prevalence of discrimination and damage it causes and will undoubtedly lead to increased discrimination and flat-out denials of care for some of the most vulnerable members of our community. We all deeply value freedom of religion, but sweeping exemptions that obstruct access to care are a fundamental distortion of that principle. Americans deserve better.

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

LGBTQ people, women, and other vulnerable groups around the country already face enormous barriers to getting the care they need.[1] Accessing quality, culturally competent care and overcoming outright discrimination is even a greater challenge for those living in areas with

[1] *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.

already limited access to health providers. The proposed regulation threatens to make access even harder and for some people 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 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.[2] 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.[3]

This means if these patients are turned away or refused treatment, it is 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.[4] 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.

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

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

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[2] 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.

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

[4] 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.

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

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

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

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

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

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

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

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

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

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

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

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

established standard under other federal laws, like Title VII of the Civil Rights Act. Title VII ensures that employers can consider the effect that providing a religious accommodation would have on coworkers, customers, and patients, as well as factors like public safety, public health, and other legal obligations. A standard that appears to allow for none of these considerations, and instead appears to require broad, automatic exemptions, would create confusion and undermine the federal government's ability to properly enforce federal laws.

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

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

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

**Conclusion**

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

# Exhibit 107

March 27, 2018

The Honorable Alex Azar, Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

RE: Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03

Dear Secretary Azar,

On behalf of the Maine Primary Care Association, I am submitting brief comments in response to HHS' intention to strengthen/clarify "conscience violation rules" as relates to the regulations that govern all HHS-funded programs. The Maine Primary Care Association (MPCA), whose members include all 20 of Maine's Federally Qualified Health Centers (referred throughout our comments as both FQHCs and Health Centers), respectfully submits the following comments in relation to HHS' proposal.

As one of the largest primary care delivery networks in the state, we have significant concerns about the unintended consequences of the updated rulemaking as regards conscience violation:

- While much of the description of past and recent issues (and case law) regarding conscience violation has been focused on abortion services, the clarified/updated regulations could reasonably apply to virtually any service (for health centers, this most likely would include services (or referrals) for the LGBTQ population, family planning services, vaccinations, behavioral health/addiction services, advanced directives, etc.). It appears that any staff person could refuse to see a patient, or to provide a patient with a specific service or referral, simply based on that patient's characteristics.

- This ability to refuse services is at odds with federal guidance for the health center program. In fact, as federally funded programs, community health centers are obligated to see anyone who walks through their doors; moreover, the Health Resources and Services Administration itself has put much pressure on the health centers to serve vulnerable populations, including those in the LGBTQ community.

- As the rulemaking suggests, HHS-funded entities will be required to provide proof of compliance with the new regulations. Every application for federal funding from HHS will need to include two documents: an assurance and a certification that the applicant is in compliance with these federal conscience laws. As one of the most heavily regulated HHS programs—and certainly one of the most heavily regulated health care programs in

the country—FQHCs already have particularly onerous reporting and compliance expectations. As these requirements grow, the ability to provide direct patient care is further squeezed.

- The rules suggest that violation issues could extend beyond simply providing specific services, but also to referrals for such services, or to providers that also provide services being objected to. There is a long list of activities the proposed regulations, and many of them are common and expected activities performed at health centers. For example, it appears a staff member could refuse to refer a patient to Planned Parenthood for a mammogram because PP also provides abortions. This example again shows a concerning disconnect from HRSA expectations, chief of which is access to a range of comprehensive services. In fact, the % of women receiving a mammogram is a clinical quality measure that HRSA holds the health centers to through the Uniform Data Set; to the extent that conscience violation empowers staff to change their clinical decision making, there could be patient safety and risk implications, and certainly an overall loss in clinical quality.

- Finally, the rules overall set a concerning precedence of policymakers interjecting into sound, evidence-based clinical decision making. It strikes us an inappropriate intrusion into the exam room, where the health care provider and patient rely on a trusting relationship with each other to ensure the best possible outcome.

Maine's FQHCs serve as a model of how integrated, high quality, primary and preventive medical, behavioral health and dental services should be delivered across a wide swath of the population; we are proud of the tireless work that has earned us that reputation. However, we will only be able to continue serving our communities if we the support of the federal government to make sound clinical decisions. We urge you to consider the impact of such rules on good patient care, and to consider the myriad unintended consequences that could result from enactment of such rules.

Thank you for your consideration. If you require additional information, please feel free to contact Darcy Shargo, CEO at the Maine Primary Care Association (dshargo@mepca.org) or at 207-621-0677.

# Exhibit 108

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March 27, 2018

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

**RE: Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03**

Muslim Advocates, a national legal advocacy and educational organization that works on the frontlines of civil rights to guarantee freedom and justice for people of all faiths, writes to express its profound concern regarding the U.S. Department of Health and Human Services' ("HHS") proposed rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (the "Proposed Rule"). The Proposed Rule, which was first introduced on January 26, 2018, empowers any individual whose work broadly relates to healthcare to wield their personal and/or religious beliefs to deny individuals medical care. While the Proposed Rule is promulgated under the guise of an antidiscrimination provision, it will instead foster discrimination against some of the most marginalized populations in our society. Accordingly, we urge HHS to rescind the Proposed Rule.

## I. The Proposed Rule Creates a Blanket Exemption for Religious or Moral Objections

The Proposed Rule stipulates that its purpose is to more effectively and comprehensively enforce "Federal health care conscience" and associated "anti-discrimination laws."[1] To that end, it creates a blanket exemption that would allow hospitals, insurance companies, health care providers, and other support staff to refuse patients care or even referrals for care.[2] The Proposed Rule deputizes HHS' Office for Civil Rights to police complaints of religious discrimination against recipients of Federal financial assistance.[3] While the Proposed Rule has been introduced under the guise of religious liberty, it will result in the denial of critical medical services to vulnerable populations and the propagation of discriminatory treatment and behavior within the healthcare industry.

[1] *See* Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3881 (Jan. 26, 2018).
[2] *See id.* at 3891-92.
[3] *Id.* at 3881.

By easing the use of moral and religious objections to hamper access to critical medical care and services, the Proposed Rule will disproportionately burden women and LGBTQ individuals. Under the express terms of the Proposed Rule, individuals involved in medical care and services related to procedures such as abortions, sterilizations, and the provision of birth control will be able to opt-out of their duties if it violates their "conscience."[4] Even more disturbingly, the Proposed Rule offers this expansive carve-out broadly, applying to any who "assist in the performance" of conscience-piquing activities:

> [T]o participate in any activity with an articulable connection to a procedure, health service or health service program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity. This includes counseling, referral, training, and other arrangements for the procedure, health service, or research activity.[5]

Thus, this Proposed Rule shelters anyone whose work is Federally funded and touches upon healthcare, allowing them to prioritize their own values and beliefs above the well-being and equality of their patients.

## II. The Proposed Rule Contravenes Longstanding Antidiscrimination Principles

The values of religious liberty and antidiscrimination are both bedrock principles of the U.S. Constitution. These values work not in opposition but in concert to support a pluralistic society in which religious freedom and diversity are honored. Federal courts have regularly balanced religious liberty and equality, ensuring that no right is subjugated by the other. In *Anderson v. U.S.F. Logistics (IMC), Inc.*, 274 F.3d 470, 476 (7th Cir. 2001), the Seventh Circuit found that there was no absolute right to say "Have a Blessed Day" to clients who voice an objection to the phrase. In *Wilson v. U.S. W. Commc'ns*, 58 F.3d 1337, 1342 (8th Cir. 1995), the Eighth Circuit determined that no absolute right to wear a graphic and religiously-motivated anti-abortion button in an office existed when it upset coworkers. And in *United States v. Lee*, 455 U.S. 252, 261 (1982), the Supreme Court held that "When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity." By undermining the antidiscrimination principles that courts routinely rely on to carefully harmonize religious liberty and antidiscrimination, this Proposed Rule weakens religious liberty protections, particularly for minority communities, who regularly rely on such safeguards to ensure equal treatment.

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[4] *Id.* at 3892.
[5] *See generally*, *id.*

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History makes clear that arguments seeking to undermine antidiscrimination principles in the name of "religious liberty" often reflect bigotry and injustice. As recently as 1983, Bob Jones University, an Evangelical institution, effectuated a racially discriminatory policy based on their religious belief that the Bible forbade interracial dating and marriage.[6] In 1867, the Pennsylvania Supreme Court upheld segregated railway cars because "following the order of Divine Providence, human authority ought not to compel these widely separated races to intermix….it is not prejudice, nor caste, nor injustice of any kind, but simply to suffer men to follow the law of races established by the Creator himself."[7] In writing a 1959 lower court opinion for *Loving v. Virginia*, a federal judge upheld anti-miscegenation laws, drawing support for his decision from his faith, writing, "Almighty God created the races white, black, yellow, malay and red, and he placed them on separate continents. And but for the interference with his arrangement there would be no cause for such marriages. The fact that he separated the races shows that he did not intend for the races to mix."[8] Politicians continued to rely on the Bible's Old Testament to oppose civil rights laws at the very height of the civil rights movement.[9] In light of this stark history, federal agencies should pay particular attention to policies like the Proposed Rule to ensure that "religious liberty" is not brandished as a bludgeon of oppression or as a shield for discrimination.

## III. Conclusion

As discussed above, this Proposed Rule conflicts with fundamental American values, and cannot be reconciled with longstanding antidiscrimination law and precedent. For these reasons, we ask that HHS rescind the Proposed Rule.

Please do not hesitate to let us know if we can provide any further information regarding our concerns. You may contact us directly at nimra@muslimadvocates.org or (202) 897-2564.

Sincerely,

Nimra H. Azmi
*Staff Attorney*
Muslim Advocates

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[6] *See Bob Jones Univ. v. United States*, 580, 103 S. Ct. 2017, 2022 (1983).
[7] *W. Chester & P. R. Co. v. Miles*, 55 Pa. 209, 213 (1867).
[8] *Loving v. Virginia*, 87 S. Ct. 1817, 1819 (1967) (quoting Circuit Court, Caroline County opinion of Leon M. Bazile, J.).
[9] *See, e.g.*, 110 Cong. Rec. 13,206-08 (1964).

# Exhibit 109

**Submitted VIA:** https://www.regulations.gov

March 23, 2018

Roger Severino
Director, Office for Civil Rights
Department of Health and Human Services
Office for Civil Rights
200 Independence Ave. SW
Washington, DC 20201

**RE: Department of Health and Human Services, Office for Civil Rights: RIN 0945-ZA03 (Proposed Rule – Protecting Statutory Conscience Rights in Health Care; Delegations of Authority)**

Dear Director Severino:

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to comment on the proposed rule, *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*. NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS' nearly 100 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 152,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 20 countries. Please visit www.NACDS.org

We strongly urge the Department of Health and Human Services (Department) and the Office for Civil Rights (OCR) to rescind the proposed rule given the absence of any convincing evidence that it is necessary, and because the reach of the proposed rule is broader than permitted by the supporting statutes. For example, none of the laws referenced as the authority for the proposal include health care providers that are involved in settings other than hospitals, clinics, and the medical profession. The proposed rule attempts to incorporate health care settings such as retail community pharmacies that are far outside the reach of clinical medical practices. Absent a rescission of the proposed rule, we urge the Department to exempt pharmacies, including licensed pharmacists and non-licensed pharmacy employees, from the

proposal given the potential for negative impact on access to necessary prescribed medications and thus patients' health and pharmacy operations.

**Federal Conscience Protections are Already in Place and are Effective**

The Department fails to show that non-compliance with conscience protections has been a problem and that the current laws have not provided sufficient protection against discrimination in covered health care settings. The Department attempts to justify the need for the proposed rule by 1) citing examples of allegations and evidence that coercion and discrimination have occurred in the last ten years, and 2) stating there has been provider confusion about the scope and applicability of current conscience law protections. However, in providing example lawsuits intended to illustrate the problem, the Department notes that it has not "opined on or judged the legal merits or sufficiency of any of the above-cited lawsuits or challenged laws." This hardly rises to the level of justification needed to impose new rules on providers already burdened with overreaching regulations and administrative requirements.

The proposed rule also cites the recent increase in complaints received by OCR as an indication that further action is needed through a proposed rule. The vast majority of complaints, thirty-four (34) out of forty-four (44) in the last ten (10) years, have been received since the November 2016 election. However, the proposed rule notes that of the ten (10) complaints received before the November 2016 election, only two (2) remain open. The proposed rule details the actions taken by OCR on the other complaints and supports the fact that the OCR has been successful in investigating and enforcing its conscience rights obligations. This does not support the need for the proposed rule, but rather supports the idea that the proposed rule is unnecessary as the current protections are working and being properly enforced.

The proposed rule notes that recipients of federal funds already certify compliance with federal nondiscrimination laws.[1] Thus, there appears to be no need to require additional certification for notification of non-discrimination based on individuals' exercise of their conscience. If each federal agency were to require unique certifications for activities that fall within their jurisdiction, the single all-encompassing non-discrimination certification currently in use would be rendered meaningless. As the federal government already requires certification of compliance with this and other nondiscrimination laws, the current proposal is unnecessary.

While the agency may wish to raise awareness about federal conscience protections, exercise of agency rulemaking authority is improper for this purpose. Licensing boards and provider accreditation bodies should be left to guide provider communities about practices within their professions or trade. These bodies have the expertise and membership reach to ensure that pertinent information about these and other federal

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[1] Conscience Clause Proposed Rule, 83 Federal Register 380 (proposed January 26, 2018); note 177 at 50276. 3920.

laws are widely known. In addition, state licensing boards are charged not only with licensure but also with protecting the public and are appropriate bodies to weigh the rights of the public to access care with the rights of licensed professionals to exercise their conscience. If the Department has reason to believe that providers are unaware of their rights, these and other avenues should be explored to raise awareness about federal and state protections instead of the current proposal.

**The Scope of the Proposed Rule Exceeds Statutory Authority and Should Not Apply to Community Retail Pharmacies**

The federal statutes on which the proposal relies, focused primarily on clinical or research settings, neither expressly nor by implication apply to community retail pharmacies or their pharmacists. Further, the proposed rule fails to make any connection between the community retail pharmacy and the perceived problem described in the proposed rule. Nonetheless, the impact analysis section of the proposed rule states that over 44,000 pharmacies could be impacted by the proposed rule. Despite absence of any indication in the underlying federal laws that community retail pharmacies and the services they provide are meant to be covered, the proposed rule seeks to expand the reach of the statutes to the community retail pharmacy settings. In expanding the application of these laws, the Department exceeds its statutory authority. However, even if the underlying statutes were applicable, there are several other reasons why the proposed rule should not apply to community retail pharmacies.

**The Proposed Rule Will Force Pharmacies to Violate State Dispensing Laws**

The current proposal is at odds with many state laws that require pharmacists and pharmacies to fill prescriptions presented at the counter. These states have recognized the importance of access to lifesaving drugs and pharmacy services and have crafted their mandatory dispensing laws in a manner that ensures public health and safety. As proposed, the rule would not allow pharmacies to be certain of compliance with both their state law and the conscience rule.

State laws and regulations governing pharmacy practice are promulgated and implemented under the authority granted to the state boards of pharmacy, which are comprised of licensed pharmacists and consumers working together to ensure the health and safety of the states' citizens. If the current proposal is adopted, pharmacists and pharmacies could be in legal jeopardy in many states for their refusal to dispense prescriptions presented at the counter. Pharmacies have adjusted their practices according to the laws of their states and should not be forced to choose between compliance with state pharmacy practice laws or the requirements of the proposed rule. State boards of pharmacy have tremendous expertise on these issues and their judgment about pharmacy practice should not be replaced by the Secretary's.

**Pharmacies Should be Exempt from Assurance and Certification of Compliance Requirements**

The proposed rule contains several exemptions from the proposed requirements for written assurance and certification of compliance, including:

(1) Physicians, physician offices, and other health care practitioners participating in Part B of the Medicare program;

(2) Recipients of Federal financial assistance or other Federal funds from the Department awarded under certain grant programs currently administered by the Administration for Children and Families, whose purpose is unrelated to health care provision as specified;

(3) Recipients of Federal financial assistance or other Federal funds from the Department awarded under certain grant programs currently administered by the Administration on Community Living, whose purpose is unrelated to health care provision as specified; and

(4) Indian Tribes and Tribal Organizations when contracting with the Indian Health Service under the Indian Self-Determination and Education Assistance Act.

In validating the need for the exemptions, the Department states:

> *"[r]equiring the large number of entities in these four categories to submit assurance and certification requirements would pose significant implementation hurdles for Departmental components, programs, and services. Furthermore, the Department believes that, due primarily to their generally smaller size, several of the excepted categories of recipients of Federal financial assistance or other Federal funds from the Department are less likely to encounter the types of issues sought to be addressed in this regulation."*

Retail pharmacies are the perfect examples of providers that should be exempt based on these criteria. Not only will the management of retail pharmacy certifications and re-certifications cause enormous challenges to the Department, but the amount of money received by pharmacies for services intended to be covered by the regulation are, at most, quite insignificant.

In addition to these criteria, the Secretary should also consider the amount of federal funds reimbursed for products for which there may be a conscience objection. A very small percentage of a typical pharmacy's reimbursement would be for products for which there may be a conscience objection (2.13% of all prescriptions for 2017[2]). It

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[2] Source® PHAST Prescription Monthly, data drawn 3/2/2018 and includes contraceptives (including plan B) and Mifepristone.

would be inappropriate and unduly burdensome for the Secretary to place a pharmacy's total federal reimbursement at risk for the small percentage of prescriptions filled that are likely to be the subject of a conscience objection.

**The Proposed Rule Forces Pharmacies to Interfere with the Decision of the Patient and his/her Physician to Use Appropriate, Legal Medications**

The proposed rule requires pharmacies to interfere with the decision of the patient and his/her doctor to use a drug that has been approved for safe and effective use without requisite clinical basis for the interference. By refusing to fill prescriptions, pharmacies would effectively step between the patient and the prescriber without appropriate clinical reasons for the refusal. Pharmacists have a role in counseling patients on the proper use of medications and to make appropriate recommendations based on their professional knowledge. Where a refusal to fill a necessary prescription as determined by the licensed prescriber and the patient is based on considerations outside of professional, clinical opinion or knowledge of the pharmacist, the pharmacy's core role in health care delivery becomes undermined and the patient's clinical status is unnecessarily endangered.

While the proposal creates barriers to patients' access to care determined necessary by their licensed prescriber, the rule as proposed does not provide sufficient protections for patients to receive legal medications. In many cases, an appropriate window of opportunity to use a medication may have passed by the time a patient ultimately receives the medication if the patient is turned away to accommodate the pharmacist's objection, even though it is based on considerations other than his/her professional clinical judgment. In these cases, effective protections should be in place to ensure that a patient's life or health is not placed at unnecessary risk.

**Proposed Rule Should Only Apply to Licensed Health Care Providers and Should Not Cover Pharmacy Support Staff**

The proposed rule seeks to expand the statutory conscience protections beyond licensed health care providers to include support staff by broadly defining "assist in the performance" as:

> *"to participate in any activity with an articulable connection to a procedure, health service or health service program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity. This includes counseling, referral, training, and other arrangements for the procedure, health service, or research activity."*

Under this proposal, the federal conscience laws would be rendered meaningless as *any employee* within a company could make a discrimination claim regardless of whether their job functions are truly incompatible with their religious or moral beliefs. Despite

clear indication from current protections that non-discrimination protections apply to physicians or health care personnel, the proposed rule expands the scope of coverage to other members of the workforce through an improper definition of "assist."

Whereas "assist in the performance" could be appropriately interpreted broadly in some health care settings, its application in the retail pharmacy setting will severely debilitate pharmacies' abilities to serve their patients. In addition to over 150,000 pharmacists currently practicing in retail drug stores, supermarkets, and other general merchandising stores, this rule would expand federal conscience laws to millions of support staff and cashiers. Accordingly, an employee with even the most tangential involvement in the retail pharmacy's dispensing operations could refuse to carry out their job functions because of their moral beliefs. For example, from a technician to a cashier with no clinical training or expertise and no direct patient care role, one could refuse to stock the pharmacy shelf or execute a sale for any legal drug or pharmacy service under the proposal. As these pharmacy support staff are not directly involved in the provision of health care, expanding the scope of the proposed rule to them is tantamount to the agency's expansion of the federal laws to include any person employed by an entity. Similar analyses would apply to pharmacy support staff employed at non-retail pharmacy settings.

Moreover, there is a risk that the proposed rule could be read broadly enough that anyone in the drug supply chain could effectively stifle important pharmacy operations based on their moral belief, regardless of whether those beliefs are being threatened or compromised. Pharmacies rely on a predictable flow of medications in the supply chain, including wholesalers and their own warehouses, as well as the pharmacy staff to ensure that patients needing drugs get them in a timely manner. Refusal to carry out one's required responsibilities by a single person in the process could cause severe disruptions and jeopardize patients' health. For example, a pharmacy employee with moral objections to certain drugs or biologicals could refuse to order, stock, or maintain a shipment of these products, which could be rendered useless or deleterious if other employees are not available to promptly store and maintain the shipment according to Food and Drug Administration's protocols. Some may even read the proposed rule to permit the objecting employee to refuse to inform others of the shipment of highly sensitive products.

Further, the broad definition of "assist in the performance" would seem to permit the objecting employee to refuse to refer. This means that a licensed pharmacist would have the right to refuse to leave the legitimate prescription for the necessary drug for the next pharmacist on duty to dispense to the patient as an exercise of their conscience right. In this situation, the patient placed at risk by this refusal to "assist" (the placement of a simple piece of paper on the counter to be dispensed the next shift or next day by another licensed professional) most likely has no relation to federal funds received by the pharmacy. It cannot be ignored that, as written, the proposal when implemented at the pharmacy level will have the most negative effect on privately insured and cash

paying patients who will be denied necessary prescriptions under the guise of federal funding being used as a stick to prevent discrimination. Such refusals by pharmacy personnel to carry out their job functions could have far reaching consequences and place the public in grave danger.

The underlying laws are very clear that the conscience protections apply to certain licensed health care providers and only those who have *direct* assisting duties. The laws did not intend to cover someone simply because they are employed by a pharmacy or have a duty that may support the core function of a pharmacy. Nor do the laws indicate that the simple accepting, processing, and dispensing of a prescription is an activity that can be considered morally objectionable. Therefore, the Department should specifically exclude non-pharmacist pharmacy or retail staff from the reach of the proposed rule.

In addition, the definition of "assist in the performance" should not include referral of the prescription to another pharmacist (e.g. next shift or another staff pharmacist) or another pharmacy if the pharmacist present at the counter has a religious or moral objection to dispensing the prescription. In these cases, the pharmacist would neither be "assisting" nor involved in the dispensing of the drug to which he/she objects. Nonetheless, under the current proposal, an objecting pharmacist would not be required to fill or refer the prescription. When the patient returns to the pharmacy for pick-up, they may find that the pharmacist simply refused to fill the prescription without providing any notification to the patient of his/her objection or providing appropriate referral. In many cases, by the time the situation can be remedied, the optimal window of time for using the medication may have passed, placing the patient's health at risk. Thus, even if the Secretary feels that a pharmacist may refuse to dispense based on his/her moral conviction, the Secretary should not regard the patient's right to legal medications as any less important. Therefore, if the Secretary applies the rule to pharmacists, referral of the prescription to another pharmacist or pharmacy should not be considered "assisting."

**Notice Requirement is Overreaching and Burdensome**

The proposed rule requires covered entities to notify the public, patients, and employees of their protections under the Federal health care conscience and associated anti-discrimination statutes and the proposed regulation. It is proposed that this requirement be accomplished by posting on a covered entity's website and the entity's establishment(s) where notices to the public and their workforce are customarily posted.

These requirements impose significant burdens on retail pharmacies. With over 40,000 chain pharmacy locations, the cost and time required to post materials for both the public and employees would be considerable. This is especially troublesome as it seems the intended audience for the posting is beyond the healthcare providers covered under the proposed rule. As an alternative, the requirement to notify covered licensed health care providers of conscience laws should only apply at the time of initial hiring. There

appears to be no reason to craft a new, unique system of notification that could be operationally difficult to implement.

**Conclusion**

The proposed rule fails to provide any evidence that federal conscience laws have not had their intended effect or that discrimination towards health care employees' exercise of conscience is a problem. Thus, we urge the Secretary to rescind the proposed rule and instead rely on appropriate licensing boards to raise awareness of anti-discrimination laws.

Further, the proposal's application to community retail pharmacy is an inappropriate expansion of federal laws. Alternatively, we strongly urge the Secretary to exempt community retail pharmacies from the proposed requirements and ensure that the proposal is limited to licensed health care providers and not support staff.

In its current form, the proposal would cause major disruptions in the practice of pharmacy without any safety-valves to protect the patients' health. Pharmacies already abide by federal conscience laws just as they do with all other federal and state non-discrimination laws. Accordingly, we do not believe that special assurances and certifications and notice to the public and workforce should be required as proposed in this rule. Where appropriate, notification of federal conscience rights should only be required at the time of initial hiring of the licensed health care provider.

Thank you for the opportunity to comment.

# Exhibit 110

March 27, 2018

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

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority NPRM, Docket HHS-OCR-2018-0002, RIN 0945-ZA03

Dear Secretary Azar,

NARAL Pro-Choice America 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 seemingly out of thin air. Such expansions exceed the Department's authority; violate the Constitution; undermine the ability of states to protect their citizens; undermine critical HHS programs like Title X; interfere with the provider-patient relationship; and threaten the health and well-being of people across the country and around the world.

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

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

[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].

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 Amendment 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 Amendment 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

[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.

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

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

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 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 nonsensical and inappropriate. Further, such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

**The Proposed Rule Carries Severe Consequences for Patients and will Exacerbate Already Existing Inequities**

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[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.
[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.*

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

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[13] 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.[14] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[15] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[16] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[17] 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.[18]

*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.[19] This is especially true for low-income and immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[20] In rural areas there may be no

[13] *See, e.g., supra* note 3.
[14] *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.
[15] *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.
[16] *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.
[17] *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.
[18] *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.
[19] 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.
[20] 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

other sources of health and life preserving medical care.[21] In developing countries where many health systems are weak, health care options and supplies are often unavailable.[22] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[23] 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.[24] 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.[25] 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.[26]

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.[27]

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

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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.

[21] 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/.

[22] *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.

[23] *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.

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

[25] 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/.

[26] *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.

[27] *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/.

By expanding refusals of care, the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on society."[28] 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.[29]

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.[30] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[31]

**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.[32] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[33] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[34] Under the Proposed Rule, the Department would seemingly allow

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[28] 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.

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

[30] 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).

[31] 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.

[32] *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.

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

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

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.[35] 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.[36] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[37]

**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.[38] 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.[39] Informed consent requires providers to 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.[40] 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.[41]

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[35] *See, e.g.*, Rule *supra* note 1, at 180-185.
[36] *See* NFPRHA *supra* note 34.
[37] *See id.*
[38] *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.
[39] *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).
[40] *See id.*
[41] *See* Rule *supra* note 1, at 150-151.

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[42] 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 Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[43] No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion.

**The Department is Abdicating its Responsibility to Patients**

The Proposed Rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.[44] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied

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[42] 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).

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

[44] *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.").

to the laws the Proposed Rule seeks to enforce.[45] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[46] 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.[47]

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.[48] 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.[49] Further, the disparity in maternal mortality is growing rather than decreasing,[50] 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

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

[46] 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.

[47] *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.

[48] *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.

[49] *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.

[50] *See id.*

routinely undertreated and often dismissed.[51] And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[52] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[53] 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.[54]

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

**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,[56] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[57] 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.[58] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The Proposed Rule, however, sets out an entirely different

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[51] *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).
[52] *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).
[53] *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.
[54] *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.
[55] *See supra* note 46.
[56] 42 U.S.C. § 2000e-2 (1964).
[57] *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.
[58] *See id.*

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.[59]

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.[60] 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.[61] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[62] 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.

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

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

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[59] 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.

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

[61] 42 U.S.C. § 1295dd(a)-(c) (2003).

[62] 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).

have licensed medical staff, as well as state laws that require health insurance plans to cover abortion.[63] 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.[64]

**Conclusion**

The Proposed Rule will allow personal 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 NARAL Pro-Choice America calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

NARAL Pro-Choice America

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

# Exhibit 111

NARAL Pro-Choice Maryland believes a health care provider's personal beliefs should never determine the care a patient receives. In particular, our statewide membership organization has an interest in ensuring patients have access to health care in Maryland, and that religious beliefs do not dictate patient access to care. 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 seemingly out of thin air. Such expansions exceed the Department's authority; violate the Constitution; undermine the ability of states to protect their citizens; undermine critical HHS programs like Title X; interfere with the provider-patient relationship; and threaten the health and well-being of people across the country and around the world.

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

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

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

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

The Proposed Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion and transition-related care. Specifically, the Department and OCR are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[2] Read in conjunction with the rest of the Proposed Rule, it is clear this is intended to allow any

[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].
[2] *See id.* at 12.

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 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

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

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 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 nonsensical and inappropriate. Further such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

**The Proposed Rule Carries Severe Consequences for Patients and will Exacerbate Already Existing Inequities**

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

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[13] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was

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[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.
[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.*, *supra* note 3.

denied the miscarriage management she needed because the hospital objected to this care.[14] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[15] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[16] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[17] 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.[18]

*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.[19] 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.[20] In rural areas there may be no other sources of

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[14] *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.

[15] *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.

[16] *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.

[17] *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.

[18] *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.

[19] 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.

[20] 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.

health and life preserving medical care.[21] In developing countries where many health systems are weak, health care options and supplies are often unavailable.[22] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[23] 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.[24] 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.[25] 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.[26]

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.[27]

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

[21] 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/.

[22] *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.

[23] *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.

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

[25] 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/.

[26] *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.

[27] *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/.

on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on society."[28] 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.[29]

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.[30] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[31]

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

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[28] 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.

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

[30] 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).

[31] 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.

[32] *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.

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

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

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.[35] 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.[36] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[37]

**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.[38] 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.[39] 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.[40] 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

[35] *See, e.g.*, Rule *supra* note 1, at 180-185.
[36] *See* NFPRHA *supra* note 34.
[37] *See id.*
[38] *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.
[39] *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).
[40] *See id.*

providers, in truth it will deter open, honest conversations that are vital to ensuring that a patient can control their medical circumstances.[41]

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[42] 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.[43] No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion.

**The Department is Abdicating its Responsibility to Patients**

The Proposed Rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.[44] Instead, the Proposed Rule appropriates

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

[42] 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).

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

[44] *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.").

language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce.[45] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[46] 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.[47]

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

[45] *See* Rule *supra* note 1, at 203-214.
[46] 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.
[47] *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.

of hospitals that serve predominantly people of color.[48] 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.[49] Further, the disparity in maternal mortality is growing rather than decreasing,[50] 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.[51] And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[52] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[53] 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.[54]

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

**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.

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[48] *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.
[49] *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.
[50] *See id.*
[51] *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).
[52] *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).
[53] *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.
[54] *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.
[55] *See supra* note 46.

For example, the Proposed Rule makes no mention of Title VII,[56] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[57] 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.[58] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal 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.[59]

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.[60] 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.[61] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[62]

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[56] 42 U.S.C. § 2000e-2 (1964).
[57] *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.
[58] *See id.*
[59] 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.
[60] *See* Rule *supra* note 1, at 180-181.
[61] 42 U.S.C. § 1295dd(a)-(c) (2003).
[62] 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.*

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.

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

NARAL Pro-Choice Maryland is committed to ensuring that all patients in Maryland have access to medical care according to the standard of care. 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.[63] 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.[64]

**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 NARAL Pro-Choice Maryland calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

Diana Philip, Executive Director
NARAL Pro-Choice Maryland
8905 Fairview Road, Suite 401
Silver Spring, MD 20910

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*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).

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

[64] *See id.*

# Exhibit 112

The Honorable Alex Azar
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW.
Washington, DC 20201

Re: Comments on Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03

The National Abortion Federation (NAF) is the professional association of abortion providers. Our mission is to ensure safe, legal, and accessible abortion care, which promotes health and justice for women. Our members include private and non-profit clinics, Planned Parenthood affiliates, women's health centers, physicians' offices, and hospitals, who together care for approximately half of the women who choose abortion in the US and Canada each year.

As an association with members from a wide range of health care backgrounds with a shared commitment to the health and well-being of their patients, NAF believes that a health care provider's personal beliefs should never determine the care a patient receives. Instead, health care should be provided based on the patient's medical needs and informed consent, during which patients are informed of all of the options available to them.

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 seemingly out of thin air. Such expansions exceed the Department's authority, violate the Constitution, undermine the ability of states to protect their citizens, undermine critical HHS programs like Title X, interfere with the provider-patient relationship, and threaten the health and well-being of people across the country and around the world.

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

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

[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].

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. 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 Amendment 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 Amendment 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

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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.

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

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

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 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 nonsensical and inappropriate. Further such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

**The Proposed Rule Carries Severe Consequences for Patients and will Exacerbate Already Existing Inequities**

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[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.
[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.*

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

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[13] 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.[14] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[15] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[16] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[17] 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.[18]

*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.[19] 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.[20] In rural areas there may be no other sources of

[13] *See, e.g., supra* note 3.
[14] *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.
[15] *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.
[16] *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.
[17] *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.
[18] *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.
[19] 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.
[20] 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

health and life preserving medical care.[21] In developing countries where many health systems are weak, health care options and supplies are often unavailable.[22] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[23] 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.[24] 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.[25] 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.[26]

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

By expanding refusals of care the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on

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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.

[21] 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/.

[22] *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.

[23] *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.

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

[25] 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/.

[26] *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.

society."[27] 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.[28]

Moreover, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant religious exemptions and, in fact, bars granting an exemption when it would detrimentally affect any third party.[29] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[30]

**The Proposed Rule Will Undermine Critical Federal Health Programs, including Title X**

The Proposed Rule would seemingly allow health care entities to receive grants and contracts under HHS-funded programs or other federal health programs, such as Title X, the only domestic family planning program, while refusing to provide key services required by those programs.[31] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[32] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[33] Under the Proposed Rule, the Department would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such funds are generally conditioned.[34] The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of

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[27] Improving Regulation and Regulatory Review, Executive Order 13563 (Jan. 18, 2011), https://obamawhitehouse.archives.gov/the-press-office/2011/01/18/executive-order-13563-improving-regulation-and-regulatory-review.

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

[29] U.S. Const. amend. I; *Cutter v. Wilkinson*, 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).

[30] Respecting religious exercise may not "unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling." *See Burwell v. Hobby Lobby*, 134 S. Ct. at 2787. When considering whether the birth control coverage requirement was the least restrictive means in Hobby Lobby, the Court considered that the accommodation offered by the government ensured that affected employees "have precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing coverage." *See id.* at 2759. In other words, the effect of the accommodation on women would be "precisely zero." *Id.* at 2760.

[31] *See* Rule *supra* note 1, at 180-181, 183. *See also Title X Family Planning*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2018), https://www.hhs.gov/opa/title-x-family-planning/index.html; *Title X an Introduction to the Nation's Family Planning Program*, NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOC. (2017) (*hereinafter* NFPRHA), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf.

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

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

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

federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[35] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[36]

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

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care. Hospital systems across the country use religious beliefs to prevent their employees from treating patients regardless of the professional, ethical, or moral convictions of these providers.[37] The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions, including foreign and international organizations, to bind the hands of providers and attempt to limit the types of care they can provide.

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health care providers and patients and ensure patient-centered decision-making.[38] Informed consent requires providers disclose relevant and medically accurate information about treatment choices and alternatives so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[39] By allowing providers, including hospital and health care institutions, to refuse to provide patients with information, the Proposed Rule makes it impossible for patients to have full information regarding treatment options. While the Department claims the Proposed Rule improves communication between patients and providers, in truth it will deter open, honest conversations that are vital to ensuring that a patient can control their medical circumstances.[40]

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

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[35] *See* NFPRHA *supra* note 34.
[36] *See id.*
[37] *See* Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[38] *See* TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).
[39] *See id.*
[40] *See* Rule *supra* note 1, at 150-151.

diabetes, epilepsy, lupus, obesity, and cancer.[41] 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 care. Moreover, the Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[42] No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion.

**The Department is Abdicating its Responsibility to Patients**

The Proposed Rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.[43] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce.[44] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes

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

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

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

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

and health disparities.[45] If finalized, however, the Proposed Rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities. Through robust enforcement of civil rights laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities, segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[46]

Nevertheless, there is still work to be done, and the Proposed Rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.[47] And these disparities do not occur in isolation. Black women, for example, are three to four times more likely than white women to die during or after childbirth.[48] Further, the disparity in maternal mortality is growing rather than decreasing,[49] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resulting health disparities. For example, women's pain is routinely undertreated and often dismissed.[50] And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[51]

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[45] As one of its first official acts in 1967, the Office of Equal Health Opportunity undertook the massive effort of inspecting 3,000 hospitals to ensure they were complying with Title VI's prohibition against discrimination on the basis of race, color, or national origin. 42. U.S.C. § 2000d (1964). After this auspicious start, the Office of Equal Health Opportunity which would eventually become OCR would go on to ensure that health programs and activities it regulated complied with key anti-discrimination laws including Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1973), Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 (1972), the Age Discrimination Act of 1976, 42 U.S.C. § 6101 (1976), and Section 1557 of the Affordable Care Act, 42 U.S.C. §18116 (2010), among others. Through robust enforcement of these laws, OCR has worked to reduce discrimination in health care.

[46] *See, e.g., Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html; *Protecting the Civil Rights and Health Information Privacy Rights of People Living with HIV/AIDS*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/hiv/index.html; *National Origin Discrimination*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/national-origin/index.html; *Health Disparities*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/health-disparities/index.html.

[47] *See* Skinner et al., *Mortality after Acute Myocardial Infarction in Hospitals that Disproportionately Treat African-Americans*, NAT'L INSTIT. OF HEALTH 1 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1626584/pdf/nihms13060.pdf.

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

[49] *See id.*

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

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

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.[52]

**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,[53] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[54] 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.[55] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal 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.[56]

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.[57] 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.

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[52] *See supra* note 46.
[53] 42 U.S.C. § 2000e-2 (1964).
[54] *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.
[55] *See id.*
[56] 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.
[57] *See* Rule *supra* note 1, at 180-181.

In addition, the Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion care, 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.[58] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[59] 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.

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

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.[60] 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.[61]

**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, the National Abortion Federation calls on the Department to withdraw the Proposed Rule in its entirety.

[58] 42 U.S.C. § 1295dd(a)-(c) (2003).
[59] 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).
[60] *See, e.g.*, Rule, *Supra* note 1, at 3888-89.
[61] *See id.*

# Exhibit 113

March 27, 2018

Sarah Bayko Albrecht, J.D.
Conscience and Religious Freedom Analyst
Office for Civil Rights
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW, Washington, DC 20201.

**Subject: Conscience NPRM, RIN 0945-ZA03**

Dear Ms. Albrecht,

Thank you for the opportunity to comment on RIN 0945-ZA03, *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*. NAELA is concerned that the proposed rule could pre-empt state law protections already in place. As such, we ask the Department of Health and Human Services (HHS) to clarify that this rule will not pre-empt certain state laws related to the transfer of patients when a provider raises a conscience objection.

NAELA is a national, non-profit association comprised of 4,500 attorneys who concentrate on legal issues affecting the elderly, people with disabilities, and their families. NAELA members provide advocacy, guidance, and services to enhance the lives of their clients. Its mission is to enhance the lives of persons with disabilities and people as they age.

Virtually every state already provides for a conscience objection and the right to refuse to comply with a patient's directive. However, to the best of our knowledge, they all impose an obligation to inform patients and to make some level of effort to transfer the patient to another provider or facility that will comply with the patient's wishes.

The required level of effort varies by state. For example:

- **District of Columbia**: requires that the provider to "effect transfer…to another physician who will honor the declaration…." Failure to do so constitutes unprofessional conduct. D.C. Code §7-627(b).
- **Alabama** requires that the provider "shall reasonably cooperate to assist … in the timely transfer…" §22- Alabama Stat. §22-8A-8(a)
- **Oklahoma** requires the provider "shall as promptly as practicable take all reasonable steps to arrange care of the declarant by another physician or health care provider." Okla. Stat. Ann. tit. 63, §3101.9

By our reading of the proposed rule, the act of making any effort to transfer the patient to another provider who will carry out the action that the provider is objecting to fits within the definition of actions that the provider may refuse to do under the rule. This comes under the definition of assisting in the performance of an objectionable activity:

**"§ 88.2 Definitions.**
Assist in the Performance means to participate in any program or activity with an articulable connection to a procedure, health service, health program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity. This includes but is not limited to counseling, referral, training, and other arrangements for the procedure, health service, health program, or research activity."

This raises a potential conflict as to whether the federal rule preempts state law that contradicts the proposed regulation. Section 88.8 of the rule addresses the rule's relationship to other laws:

**"§ 88.8 Relationship to other laws.**
Nothing in this part shall be construed to preempt any Federal, State, or local law that is equally or more protective of religious freedom and moral convictions. Nothing in this part shall be construed to narrow the meaning or application of any State or Federal law protecting free exercise of religious beliefs or moral convictions."

This provision appears to prevent pre-emption only if the state, federal, or local law that is more protective of the exercise of religious or moral convictions. It does not address whether the federal rule preempts state conscience rule requirements that may be objectionable by those asserting a conscience objection. However, the regulation's rule of construction suggests that any ambiguity would be decided in favor of broad protection of anyone asserting a conscience objection.

**"§ 88.9 Rule of construction.**
This part shall be construed in favor of a broad protection of free exercise of religious beliefs and moral convictions, to the maximum extent permitted by the terms of the Federal health care conscience and associated antidiscrimination statutes implemented by the Constitution."

Importantly, it cannot be assumed that individuals have the capacity to find a new provider. For instance, individuals with dementia, in a coma, or homebound are often at the mercy of others to ensure care gets provided.

NAELA therefore urges HHS to make clear that the rule does not pre-empt state conscience rule procedural requirements, such as those requiring efforts to transfer the patient.

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Thank you for consideration of our comments. If you have any questions, please contact David Goldfarb, NAELA's Sr. Public Policy Manager (dgoldfarb@naela.org/ 703-942-5711 #232).

Sincerely,

Hyman G. Darling, Esq.
President
National Academy of Elder Law Attorneys

# Exhibit 114

March 27, 2018

**VIA ELECTRONIC SUBMISSION**
Secretary Alex Azar
Department of Health and Human Services, Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority; RIN 0945-ZA03 or Docket HHS-OCR-2018-0002*

Dear Secretary Azar:

On behalf of the National Asian Pacific American Women's Forum, we submit these comments to the federal Department of Health and Human Services ("Department") and its Office for Civil Rights ("OCR") in opposition to the proposed regulation entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."[1]

The National Asian Pacific American Women's Forum ("NAPAWF") is the only national, multi-issue organization seeking to advance the human rights of Asian American Pacific Islander ("AAPI") women and girls in the US. We organize and advocate for reproductive health, immigrant rights, and economic justice.

NAPAWF 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.[2]

The Proposed Rule seeks to unlawfully expand refusals to provide care by attempting to allow individuals and health care entities who receive federal funding to refuse to provide *any* part of a health service or program. In addition, the Proposed Rule unlawfully attempts to create new refusals seemingly out of thin air. Such expansions exceed the Department's authority; violate the Constitution; undermine the ability of states to protect their citizens; undermine critical HHS programs like Title X; interfere with the provider-patient relationship; and threaten the health and well-being of people across the country and around the world.

By issuing the Proposed Rule and creating a new division within the Office of Civil Rights ("OCR") – the new "Conscience and Religious Freedom Division" – the Department seeks to inappropriately use OCR's limited resources in order to affirmatively allow institutions,

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[1] U.S. Dept. of Health and Human Serv., Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880-3931 (Jan. 26, 2018) (hereinafter "proposed rule").
[2] 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].

insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. For these reasons, NAPAWF calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

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

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

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

The Proposed Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion and transition-related care. Specifically, the Department and OCR are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[3] 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.[4] The Proposed Rule attempts to expand these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions specifically related to the service or research activity to which they object.[5] 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.[6] 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,

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[3] *See id.* at 12.
[4] *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.
[5] The Church Amendments, 42 U.S.C. § 300a-7 (2018).
[6] *See* Rule *supra* note 1, at 185.

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.[7] 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.[8]

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.[9] 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.[10] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but goes directly against congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert.[11]

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."[12] 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."[13] In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is nonsensical and inappropriate. Further, such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

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[7] *Id.* at 180.
[8] *Id.* at 183.
[9] 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).
[10] *See* Rule *supra* note 1, at 182.
[11] 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.
[12] *See* Rule *supra* note 1, at 180.
[13] *Id.*

**The Proposed Rule Carries Severe Consequences for Patients and will Exacerbate Already Existing Inequities**

By allowing hospitals, providers, and anyone loosely involved in the provision of health care to determine a patient's care based on their personal beliefs, not based on what is best for the patient, the Proposed Rule will harm those who already face barriers to care, including individuals of color, LGBTQ individuals, people facing language barriers, and uninsured populations, from accessing the care and coverage they need. In ignoring these inevitable harms of the proposed rule, HHS is ignoring its mission.

The Proposed Rule would allow providers and health care entities to discriminate against women and LGBTQ individuals in particular. Providers invoke religious beliefs to deny access to services most often accessed by women such as abortion, sterilization, certain infertility treatments, and miscarriage management. Such practices have resulted in infertility, infection, and even death. Across the country, refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[14] 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.[15] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[16] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[17] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[18] 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.[19]

Furthermore, this discrimination disproportionately affects women of color who already face additional barriers to accessing reproductive health care. For example, the rate of unintended pregnancy is highest among young low-income women, who are disproportionately women of

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

[15] *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.

[16] *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.

[17] *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.

[18] *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.

[19] *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.

color, highlighting the need for reproductive health care that includes education, counseling, contraception, and abortion. Laotian and Cambodian women have especially low rates of early prenatal care.[20] Recent data has also found that Asian American Pacific Islander (AAPI) women die due to pregnancy-related causes at a rate of 11 deaths per 100,000 births—slightly higher than the rate of white non-Hispanic women at 10.4.[21] According to the Center for American Progress, AAPI women are twice as likely to die from pregnancy-related causes, including embolism and pregnancy-related hypertension.[22] When refusals of care strip away particular options for where AAPI women can receive care, the risk for death and illness in these instances increase.

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. Nearly two-thirds of all Asian Americans are foreign-born, and Asian Americans make up the largest percentage of recent immigrants.[24] Despite the significant achievements in expanding health care coverage in the past decade, many AAPI women and their families cannot obtain affordable health care due to immigration restrictions and language barriers.

Appropriate access to preventive, routine, and critical health services for AAPI women and their families too often relies on their job status, income, immigration status, or language. Of the over 5 million foreign-born AAPI women in the U.S., over half a million of them are undocumented.[25] Foreign-born women are almost twice as likely as U.S.-born women to lack health insurance.[26] Differences in health care coverage for women of reproductive age (ages 15-44) are even more dramatic between native-born citizens and noncitizens: approximately 42 percent are uninsured compared to 13 percent of native-born citizens.[27] For noncitizens who live in poverty, approximately 57 percent are uninsured.[28] In addition, undocumented immigrants are

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[20] Lara Jo Foo, ASIAN AMERICAN WOMEN: ISSUES, CONCERNS, AND RESPONSIVE HUMAN AND CIVIL RIGHTS ADVOCACY. New York: Ford Foundation (2007).

[21] T.J. Mathews et al., "Infant Mortality Statistics from the 2013 Period Linked Birth/Infant Death Data Set." NATIONAL VITAL STATISTICS REPORT: National Center for Health Statistics (Aug 6, 2015). https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf.

[22] Marcus T. Smith, "Fact Sheet: The State of Asian American Women in the United States." Center for American Progress (Nov 7, 2013). https://americanprogress.org/issues/race/report/2013/11/07/79182/face-sheet-the-state-of-asian-american-women-in-the-united-states/.

[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] Pew Research Center, "The Rise of Asian Americans." (Apr 4, 2013). http://www.pewsocialtrends.org/2012/06/19/the-rise-of-asian-americans/ (last visited October 26, 2016).

[25] National Asian Pacific American Women's Forum, "Turning the Page on U.S. Immigration Policy: Immigration and Asian American Women and Families." (Nov 2014). https://napawf.org/wp-content/uploads/2015/03/NAPAWFimmreport_r17.pdf (last visited Aug 16, 2017).

[26] Kaiser Commission on Key Facts, "Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act." The Henry J. Kaiser Family Foundation (March 2013). https://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf (last visited October 26, 2016).

[27] Guttmacher Institute, "Immigrant women need health coverage, not legal barriers," (Jan 19, 2016). https://www.guttmacher.org/infographic/2016/immigrant-women-need-health-coverage-not-legal-barriers (last visited Aug 16, 2017).

[28] *Ibid*.

prohibited from accessing health services through Medicaid and are not allowed to purchase private health insurance through the ACA health insurance exchanges.

Even lawfully present immigrants face restrictions: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 prohibits immigrants from accessing Medicaid and CHIP within the first five years of obtaining lawful immigration status.[29] This "five-year bar" can be a matter of life or death for immigrant women and their families waiting to access vital and necessary health care services. Other lawfully present immigrants, like those present under Deferred Action for Childhood Arrivals (DACA), are not only prohibited from accessing Medicaid and CHIP, but are also excluded from ACA marketplaces and subsidies. Compacts of Free Association (COFA) migrants from the Republic of the Marshall Islands, Federated States of Micronesia, and the Republic of Palau, are also excluded from accessing Medicaid and CHIP—despite the fact that many suffer from chronic health conditions due to U.S. nuclear testing.[30] Although the ACA allows COFA migrants to participate in the health care marketplace and to benefit from tax subsidies, without Medicaid, many COFA migrants continue to struggle to afford the new plans.

For AAPI immigrants, the Proposed Rule would further limit the options available for access to basic healthcare services by eliminating affordable, religiously affiliated health centers that often assist refugee and immigrant populations but who do not perform certain services due to personal beliefs.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[31] 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.[32] Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women were delayed care or transferred to other facilities at great risk to their health.[33] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using

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[29] Kinsey Hasstedt, "Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants." *Guttmacher Policy Review* (2013). http://www.guttmacher.org/pubs/gpr/16/1/gpr160102.pdf (last visited Aug 16, 2017).

[30] Asian & Pacific Islander American Health Forum, "Medicaid Reinstatement for COFA Migrants." (Jul 2014). http://www.apiahf.org/sites/default/files/2014.07.15_Medicaid%20Reinstatement%20for%20COFA%20Migrants%20_Factsheet.pdf (last visited Aug 16, 2017).

[31] *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.

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

[33] Lori R. Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.

religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[34]

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

By expanding refusals of care the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on society."[35] 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.[36]

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.[37] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[38]

**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.[39]

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

[35] 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.

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

[37] 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).

[38] 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.

[39] *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*

For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[40] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[41] 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.[42] 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.[43] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[44]

**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.[45] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce.[46] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[47] If finalized, however, the Proposed Rule will represent a radical

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*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.

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

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

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

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

[44] *See id.*

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

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

[47] 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

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.[48]

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.[49] 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.[50] Further, the disparity in maternal mortality is growing rather than decreasing,[51] 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.[52] And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[53] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[54] Eight percent of lesbian, gay, bisexual,

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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.

[48] *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.

[49] *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.

[50] *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.

[51] *See id.*

[52] *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).

[53] *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).

[54] *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

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.[55]

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.[56]

**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,[57] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[58] 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.[59] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal 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.[60]

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

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

[55] *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.

[56] *See supra* note 46.

[57] 42 U.S.C. § 2000e-2 (1964).

[58] *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.

[59] *See id.*

[60] 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.

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.[61] 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.[62] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[63] 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.

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

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.[64] 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.[65]

**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, NAPAWF calls on the Department to withdraw the Proposed Rule in its entirety.

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[61] *See* Rule *supra* note 1, at 180-181.
[62] 42 U.S.C. § 1295dd(a)-(c) (2003).
[63] 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).
[64] *See, e.g.*, Rule, *Supra* note 1, at 3888-89.
[65] *See id.*

Sincerely,

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