Exhibit 122

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

I am writing on behalf of the National Coalition of STD Directors (NCSD) in response to the request for public comment regarding the proposed "Protecting Statutory Conscience Rights in Health Care" rule, published January 26, 2018. NCSD is a national public health membership organization representing health department STD directors, their support staff, and community-based partners across 50 states, seven large cities, and eight US territories. As a national organization that represents Americans from all walks of life, one of NCSD's strategic priorities is the promotion of health equity. Health equity refers to the study of the various barriers different populations face when accessing health care and what their root causes are. By examining these social determinants of health, NCSD hopes to address them through all the work it does and ensure that these often marginalized groups are able to access the care they need.

We, at NCSD, recognize the important role that a health care provider plays in determining one's overall wellbeing. As an organization that represents health departments throughout the United States, we see public health professionals accomplish amazing feats every day. However, they are only one line of defense when combatting STDs and HIV, and it is often up to other providers to help patients follow through on obtaining medication and maintaining healthy practices. NCSD is concerned that the Proposed Rule disregards standards of care established by the medical community by allowing providers and related staff to opt out of providing needed medically accurate, evidence-based care to patients, impairing their ability to make the health care decision that is right for them. Specifically, we are concerned that this proposed rule could be interpreted that providers and other facility staff to allow for the refusal to provide care to gay, bisexual, or transgender individuals.

This proposed rule could be misconstrued by providers and their staffs to choose who they do, and do not, want to serve. They 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.[1] In addition, with the expansion of the statutory term "assisting in the performance" of a procedure, the rule could encourage

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

health care workers to obstruct or delay access to a health care service 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. Medical staff could 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 services or even inform patients of their treatment options. This puts the health of the patient, and potentially that of others in the case of sexually transmitted diseases (STDs), at risk. Not only would this prevent patients from accessing the care they need, but it would also dissuade other patients from seeking out services in the first place. Connecting patients to care and ensuring that they remain in care are both pivotal in the field of disease control.

Too many LGBTQ Americans face discrimination and other barriers to accessing lifesaving care every single day. These barriers are especially pronounced for transgender patients and gay and bisexual men of color. The data shows that transgender women are 49 times more likely to be living with HIV when compared to the general population. Additionally, gay and bisexual men of color bear the overwhelming burden of newly acquired HIV and STD diagnoses. Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[2] 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.[3] A major reason that these communities face overwhelming odds in attaining healthy sexual lifestyles and livelihoods is fear of discrimination in a health care setting. This Proposed Rule could make it more difficult for adversely effected communities to seek out the care they need, which would only serve to bolster the barriers that are in their way in the first place. Patients in rural settings face even greater difficulties in accessing care. Lower incomes, longer distances to travel, less access to health insurance, and lower rates of paid sick leave all combine to create extreme difficulties for those seeking to access care in non-urban settings. If a provider or facility believes that they have the right to turn a patient away due to their sexual orientation or gender identity, it will make it that much harder to find care in an area that does not have many providers to begin with.

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.[4] Through robust enforcement of civil rights laws, OCR has worked to

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[2] *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.

[3] *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.

[4] 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

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.[5] Nevertheless, there is still work to be done, and the Proposed Rule would divert limited resources away from ending discrimination.

We appreciate your attention to these comments and the opportunity to provide them. If you have questions related to these comments, please contact NCSD's Senior Manager, Policy and Government Relations, Rebekah Horowitz, at rhorowitz@ncsddc.org or 202-618-4035.

Sincerely,

David C. Harvey
Executive Director

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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.

[5] *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.

Exhibit 123

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By Electronic Submission

March 27, 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 Community Pharmacists Association ("NCPA") appreciates the opportunity to provide comments on the Department of Health and Human Service's Office for Civil Rights' ("OCR") proposed rule, *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority* (the "Proposed Rule"). NCPA represents the interests of America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full and part-time basis.

NCPA Urges OCR to Rescind the Proposed Rule

NCPA urges OCR to rescind the Proposed Rule because the Proposed Rule exceeds statutory authority. The laws referenced as the authority for the Proposed Rule only include health care providers that are involved in settings other than hospitals, clinics, and the medical profession. Thus, pharmacists not in these settings fall outside of scope of the statutory authority for this Proposed Rule. If OCR does not rescind this Proposed Rule, we urge OCR to exempt pharmacies, including licensed pharmacists and non-licensed pharmacy employees, given the potential for negative impact on patients' health and pharmacy operations.

Issues Specific to Community Pharmacists and Pharmacies that OCR Should Consider if OCR does not Rescind the Proposed Rule

NCPA would like to highlight certain issues for community pharmacists and pharmacies that may present themselves with finalization of this Proposed Rule. First, state legislatures, state licensing boards, and provider accreditation bodies currently have robust requirements surrounding discrimination policies that are individual to each state. For example, many states have mandatory dispensing laws that require pharmacists and/or pharmacies to fill all prescriptions presented at the counter subject to certain enumerated exceptions. NCPA supports the rights of each individual state to ensure that the pharmacy profession is regulated in conformity with the differences in policies in each state. Further, NCPA continues to support state boards of pharmacy as the appropriate regulatory bodies to balance the difference between the public's access to care and the rights of licensed pharmacists to exercise their conscience. Thus, NCPA encourages OCR to consider bolstering communications between the federal and state governments to further inform health care professionals and patients of their rights.

As mentioned above, NCPA urges OCR to rescind the Proposed Rule because pharmacists are not the intended provider under the statutory definition of health care professional. However, if pharmacists are considered health care professionals under the statutory authority cited for the Proposed Rule, NCPA would like to highlight that the profession of pharmacy is not a monolith as there are various types of pharmacists and pharmacies, including community, specialty, long term care, and compounding pharmacists and pharmacies. Further, sometimes there is little distinction between the community pharmacist and the community pharmacy as the small-business community pharmacist may be the only pharmacist at the community pharmacy.

Thus, it is important to focus on the potential burdens on small-business community pharmacies and acknowledge that certain requirements under the Proposed Rule may be difficult for community pharmacists and pharmacies to comply with, even if they may not be an issue for chain pharmacists and pharmacies. For example, small-business community pharmacists and pharmacies may have more limited resources and may need more time to comply with the various notice requirements under the Proposed Rule. While the cost to comply may not be prohibitive, it may be difficult to find appropriately formatted language from vendors who supply employee and public notice material for pharmacies. Thus, NCPA requests OCR provide a grace period in which community pharmacies will have adequate time to update their current employee and public notices.

In addition, community pharmacists and pharmacies will continue to comply with assurance and certification requirements under federal law. NCPA encourages OCR to ensure community pharmacists and pharmacies will not be financially burdened by the additional reporting requirements under this Proposed Rule. NCPA urges OCR to exempt community pharmacists and pharmacies if OCR finds a financial burden on community pharmacists and pharmacies. At the very least, NCPA urges OCR to provide appropriate time for community pharmacists and pharmacies to put in place mechanisms to comply with the reporting requirements under the Proposed Rule.

Finally, NCPA requests that OCR clarify its definition of support staff covered under the statutory conscience protections. NCPA questions whether the broad definition of "assist in the performance" would include any employee within or agent of a company. For example, a cashier, stock person, or even distributor refuse to carry out their job functions unrelated to dispensing such as refusing to stock the pharmacy shelf or execute a sale for any legal drug. Thus, to ensure predictable flow of medications in the supply chain, including at the pharmacy counter, NCPA encourages OCR to consider narrowing the scope of the Proposed Rule to only health care professionals defined in federal statute cited as statutory authority in the Proposed Rule.

Conclusion

In conclusion, NCPA appreciates the opportunity to comment on the Proposed Rule. NCPA urges OCR to rescind the Proposed Rule because the Proposed Rule exceeds statutory authority. If OCR does not rescind the Proposed Rule, NCPA encourages OCR to consider NCPA's issues highlighted above to ensure community pharmacists/pharmacies and patients are appropriately served by the Proposed Rule. Thank you.

Exhibit 124

National Council of Jewish Women

To:
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 SW
Washington, DC 20201

From:
Carly Manes
Director, Commission on Social Action of Reform Judaism
Associate Director, Religious Action Center of Reform Judaism
1707 L St. NW
Washington, D.C. 20036

Re: RIN 0945-ZA03
DT: March 27, 2018

To whom it may concern:

I am writing on behalf of the National Council of Jewish Women (NCJW) in response to the proposed rule from the U.S. Department of Health and Human Services, RIN 0945-ZA03, titled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children, and families and by safeguarding individual rights and freedoms.

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 the reasons outlined below, the National Council of Jewish Women 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)."[1] 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.[2] 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.[3] 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.[4] 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

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[1] *See id.* at 12.

[2] *See, e.g., Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; 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.

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

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

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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.[5] 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.[6]

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.[7] 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.[8] 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.[9]

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."[10] 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."[11] 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.[12] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage

[5] *Id.* at 180.
[6] *Id.* at 183.
[7] 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).
[8] *See* Rule *supra* note 1, at 182.
[9] 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.
[10] *See* Rule *supra* note 1, at 180.
[11] *Id.*
[12] *See, e.g.*, *supra* note 3.

management she needed because the hospital objected to this care.[13] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[14] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[15] 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.[16] 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.[17]

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.[18] 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.[19] In rural areas there may be no other sources of health and life preserving medical care.[20] In developing countries

[13] *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.

[14] *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.

[15] *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.

[16] *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.

[17] *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.

[18] 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.

[19] 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.

[20] 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/.

where many health systems are weak, health care options and supplies are often unavailable.[21] 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.[22] 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.[23] 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.[24] 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.[25]

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.[26]

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

By expanding refusals of care the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. 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."[27] The Proposed Rule plainly fails on both counts. Although the Proposed Rule attempts to quantify the costs of compliance, it

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[21] *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.

[22] *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.

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

[24] 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/.

[25] *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.

[26] *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/.

[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.

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 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

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[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.

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

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 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, diabetes, epilepsy, lupus, obesity, and cancer.[41] Individuals seeking reproductive health care, regardless of their reasons for

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[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.

[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).

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.[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 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

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[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.

[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.

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] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[52] 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.[53]

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

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[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).

[52] *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.

[53] *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.

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.[54]

Conclusion

The Proposed Rule will allow personal moral and 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 Council of Jewish Women calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

Jody Rabhan

Director of Washington Operations, National Council of Jewish Women

Exhibit 125

National Council of Jewish Women New York believes a health care provider's personal beliefs should never determine the care a patient receives. In particular, National Council of Jewish Women New York has an interest in ensuring patients have access to health care in New York, 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.

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 National Council of Jewish Women New York 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 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.

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[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.

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 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]

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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.

[7] *Id.* at 183.

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 denied the miscarriage management she needed because the hospital objected to this care.[14]

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[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.
[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.

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 health and life preserving medical care.[21] In developing countries where many health systems

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[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.

[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/.

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 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

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[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/.

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 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 sub

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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).

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

recipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[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 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

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[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.

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 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

[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.").

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 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

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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.

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.

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

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[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.
[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.

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] 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

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[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. 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).

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

National Council of Jewish Women New York is committed to ensuring that all patients in New York 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 National Council of Jewish Women New York calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

Andrea Salwen Kopel

Executive Director

National Council of Jewish Women New York

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

Exhibit 126

March 27, 2018

Secretary Alex Azar
Department of Health and Human Services
Office for Civil Rights
200 Independence Ave SW
Washington, DC 20201

Re: "Protecting Statutory Conscience Rights in Health Care"

Dear Secretary Azar:

The National Council on Aging (NCOA) appreciates the opportunity to comment on the proposed rule, "Protecting Statutory Conscience Rights in Health Care." The National Council on Aging (NCOA) is one of the nation's leading nonprofit service and advocacy organizations representing older adults and the community organizations that serve them. Our goal is to improve the health and economic security of 10 million older adults by 2020.

In this regulation, the Office of Civil Rights (OCR) proposes to revise regulations to ensure that health care professionals have the right to decline to participate in medical procedures to which they are opposed on moral or religious grounds. HHS also announced the creation of the Conscience and Religious Freedom Division. While these actions by HHS do not appear to suggest the creation of new rights or obligations under federal law, they do signal an intent to broaden the scope of existing conscience objection regulations and promote stricter enforcement of those laws.

NCOA is deeply concerned that these actions could restrict access to care for vulnerable older adults seeking the aid of their health care professionals. NCOA recognizes and respects the rights of health care professionals to decline to participate in care that violates their personal code of ethics. However, it is important that all patients have access to health care, regardless of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus or national origin. There is a distinct difference between declining to participate in a procedure versus denying access to care to an individual patient. The former is a protected right, the latter is unacceptable.

At a minimum, we ask HHS to clarify that this rule will not pre-empt state laws related to the transfer of patients when a provider raises a conscience objection. 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. Under the proposed rule,

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providers may refuse to make an effort to transfer the patient to another provider who will carry out the action that the provider is objecting to.

This raises a potential conflict as to whether the federal rule preempts state law that contradicts the proposed rule. According to section 88.8 of the rule, "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 preemption only if the state, federal, or local law is **more** protective of the exercise of religious or moral convictions. This provision doesn't address whether the federal rule preempts situations where the state or local law is not as favorable to those asserting a conscience objection. 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. NCOA therefore urges HHS to make clear that the rule does not preempt state conscience rule procedural requirements, such as requiring notice to the patient about the reason the provider refuses to provide treatment, and efforts to transfer the patient.

NCOA will continue to monitor the actions of HHS and its Conscience and Religious Freedom Division. We caution HHS to abide by its insistence that the division's focus would be on "actions" and not on denying care to specific groups of people.

Thank you again for this opportunity to share our comments. If you have any questions or if we can be of any further assistance, please contact Samantha Zenlea at Samantha.Zenlea@ncoa.org.

Sincerely,

Samantha Zenlea
Senior Regulatory Policy Specialist

Exhibit 127

1201 16th St., N.W. | Washington, DC 20036 | Phone: (202) 833-4000

Lily Eskelsen García
President

Rebecca S. Pringle
Vice President

Princess R. Moss
Secretary-Treasurer

John C. Stocks
Executive Director

March 27, 2018

VIA ELECTRONIC SUBMISSION
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

ATTN: HHS–OCR– 2018–0002

To Whom It May Concern:

On behalf of our 3 million members and the 50 million students they serve, the National Education Association is writing to express its deep concern about the proposed rule "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." The proposed rule would expand the ability for individuals and health care entities to apply personal beliefs to deny health care services, and it would broaden the types of entities that could take such actions. If implemented, therefore, the rule would inappropriately permit discriminatory beliefs to dictate access to health care for NEA members, their families, and students. We strongly urge the Department of Health and Human Services to withdraw the proposed rule in its entirely.

The proposed rule's expansion of the ability to refuse to provide health care cannot be minimized by suggesting that if care is refused by one entity or provider, the individual who is refused care could simply find care elsewhere. In fact, vulnerable people who are refused access to care cannot always find appropriate alternatives. This can be the case, for example, for people in rural or remote areas with limited access to providers, individuals without the financial means to travel to receive care, and working people without the ability to take time off from work to receive care far from home. Similarly, patients seeking more specialized health care may already face hurdles receiving the care they need, so the exclusion of providers and facilities could make their care even more difficult.

The National Women's Law Center (NWLC) has succinctly summarized several concerns about the proposed rule:[1]

> "The Proposed Rule would allow individuals to refuse to provide any part of a health service program. The Trump Administration's intent is to protect, for example, doctors who refuse to provide services to transgender individuals or

[1] National Women's Law Center, "Trump Administration Proposes Sweeping Rule to Permit Personal Beliefs to Dictate Health Care," February 2018. Available on the Internet at https://nwlc.org/resources/trump-administration-proposes-sweeping-rule-to-permit-personal-beliefs-to-dictate-health-care/. NEA Access date: March 21, 2018.

> nurses who refuse to participate in fertility treatment for same sex couples. This is a misinterpretation – and unlawful expansion – of a provision of current federal law, which applies only in the context of biomedical research.
>
> The Proposed Rule provides a broad definition of what it means to 'assist in the performance' of an activity to which an individual or entity is opposed. The definition greatly expands not only the types of services that can be refused, but also the individuals who can refuse. The definition includes any 'member of the workforce' whose actions have merely an 'articulable connection to a procedure, health service or health service program, or research activity.' It specifically includes 'counseling, referral, training, and other arrangements for the procedure, health service, or research activity.' This definition could sweep in a broad range of people, including receptionists, hospital room schedulers, and other staff, volunteers, or trainees who could assert a new right to refuse to do their jobs.
>
> The Proposed Rule creates a definition of 'referral' where one did not exist before. The definition goes beyond any common understanding of the term, allowing refusals to provide any information that could help an individual to get the care they need. The Proposed Rule does not even require that patients be informed of the individual's or entity's refusal to provide care, information, referrals, or other services, leaving patients unaware that they might not be getting the care they need from someone in whom they have placed their trust."

The NWLC has articulated other concerns with the proposed rule, including that it fails to ensure that people receive emergency room care and that it "subverts the language of landmark civil rights statues to shield those who would discriminate rather than to protect against discrimination."[2]

The potential for the proposed rule to impede access to health care and promote discrimination leads us to strongly reiterate our call for its withdrawal.

Thank you for your attention.

Sincerely,

Dale Templeton
Director
Collective Bargaining and Member Advocacy Department

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[2] Ibid.

Exhibit 128

National
Family Planning
& Reproductive Health Association

March 27, 2018

US 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

Attn: Protecting Statutory Conscience Rights in Health Care NPRM, RIN 0945-ZA03

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to provide comments on the US Department of Health and Human Services' (HHS) notice of proposed rulemaking (NPRM), "Protecting Statutory Conscience Rights in Health Care," RIN 0945-ZA03.

NFPRHA is a national membership organization representing the nation's publicly funded family planning providers, including nurse practitioners, nurses, administrators, and other key health care professionals. NFPRHA's members operate or fund a network of more than 3,500 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers and other private nonprofit organizations.

NFPRHA is deeply concerned that this NPRM ignores the needs of the patients and individuals served by HHS' programs and creates confusion about the rights and responsibilities of health care providers and entities. Because they receive Title X, Medicaid, and other HHS funds, NFPRHA members would have no choice but to comply with this rule: failure to do so could lead to termination of current or pending HHS funds, as well as return of money previously paid to NFPRHA members for services they have provided. This means hundreds of millions of dollars in federal funding are at stake for NFPRHA members if they run afoul of the rule. Without federal support, many of our members would be forced to drastically scale back the services they provide to their patients or to close completely. Because NFPRHA members represent the vast majority of Title X clinical locations that serve people who cannot afford to pay for health care on their own, this would leave many low-income and uninsured or under-insured patients without access to family planning and other critical health care services.

Although this NPRM claims the authority to interpret numerous statutes of concern and interest, NFPRHA will limit its comments primarily to the unjustified and unauthorized expansion of the Church amendments (42 USC 300a-7), Coats-Snowe amendment (42 USC 238n), and Weldon amendment (e.g. Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. H, Tit. V, sec. 507(d)) (together, "Federal health care refusal statutes"). Because this NPRM encourages unprecedented discrimination against patients and opens the door to undermining the intent and integrity of key HHS programs, including the Title X family planning program, it should be withdrawn.

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Background on the 2008 Health Care Refusal Regulations

In the decades-long history of the federal health care refusal statutes, none of which delegate rulemaking authority to HHS, regulations purporting to clarify and interpret these laws have been promulgated only once, in late 2008.

In 2008, HHS promulgated an NPRM purporting to interpret and enforce the federal health care refusal statutes claiming "concern…that there is a lack of knowledge on the part of States, local governments, and the health care industry" of the refusal rights contained within these statutes. (73 Fed. Reg. at 50, 278). Despite allowing only a 30-day comment period, HHS received more than 200,000 comments in response to the proposed rule—the vast majority of which opposed the rule as unnecessary, unauthorized, and overbroad.[1] Notably, HHS conceded, it received "no Comments indicating that there were any [federal] funding recipients not currently compliant with [the underlying statutes]" (73 Fed. Reg. at 78,095). HHS published a final rule on December 19, 2008, which did not materially differ from the NPRM and was immediately subject to legal challenge by multiple parties, including NFPRHA and seven state attorneys general.[2]

In 2011, HHS rescinded those aspects of the 2008 rule that were "unclear and potentially overbroad in scope," but maintained those parts of the rule establishing an enforcement process for the Federal health care refusal statutes and began an "initiative designed to increase the awareness of health care providers about the protections provided by the health care provider conscience statutes, and the resources available to providers who believe their rights have been violated." (76 Fed. Reg. at 9969). This rule remains in effect.

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[1] Comments to Provider Conscience Regulations, 73 Fed. Reg. 50274 (August 26, 2008) (to be codified at 45 CFR 88).

[2] *National Family Planning and Reproductive Health Association et al v. Leavitt*, No. 09-cv-00055 (Dist. Conn. Jan. 15, 2009) *State of Conn. et al. v. United States of America*, No. 09-cv-00054 (Dist. Conn. Jan. 15, 2009); *Planned Parenthood Federation of America v. Leavitt*, No. 09-cv-00057 (Dist. Conn. Jan. 15, 2009); *State of Conn. et al. v. United States of America*, No. 09-cv-00054 (Dist. Conn. Jan. 15, 2009).

According to the current NPRM, since 2008, "OCR [Office for Civil Rights] has received a total of forty-four complaints [related to Federal health care refusal laws], the large majority of which (thirty-four) were filed since the November 2016 election." (83 Fed. Reg. at 3886). To place that figure into context, OCR in total received approximately 30,166 complaints in fiscal year (FY) 2017.

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The NPRM overstates statutory authority and seeks to dramatically expand the reach of the underlying statutes.

For decades, federal health care refusal statutes have given specified individuals and institutions certain rights to refuse to perform, assist in the performance, and/or refer for abortion and/or sterilization services. Despite the lack of a congressional mandate to do so, the NPRM seeks to dramatically expand the scope and reach of these laws, as well as grant overall responsibility for ensuring and enforcing compliance with those statutes to OCR, using identical language to many aspects of the now-rescinded 2008 regulation that faced widespread opposition at that time.[3]

The Church amendments were enacted by Congress in the 1970s in response to debates about whether the receipt of federal funds required recipients to provide abortion or sterilization services. These provisions make clear, among other things, that:

- The receipt of federal funding under the Public Health Service Act (PHSA) (42 U.S.C. § 201 et seq.) does not itself obligate any individual to perform or assist in the performance of sterilization or abortion procedures if those procedures are contrary to the individual's religious or moral beliefs (Church (b)(1)); and,
- Health care personnel employed by certain federally funded programs and facilities cannot be discriminated against in terms of employment, promotion, or the extension of staff or other privileges for performing or assisting in the performance of sterilization or abortion services, or refusing to perform or assist in the performance of such services based on their religious or moral beliefs (Church (c)(1)).

In 1996, Congress adopted the Coats amendment in response to a decision by the accrediting body for graduate medical education to require OB/GYN residency programs to provide or permit abortion training. The Coats amendment prohibits federal, state, and local governments from discriminating against health care entities, such as "individual physicians, postgraduate physician training programs, or . . . participant[s] in a program of training in the health profession," that refuse to provide or require training in abortions or individuals who refuse to be trained to provide abortions.

[3] Comment of the National Family Planning & Reproductive Health Association to Provider Conscience Regulations, Tracking Number 8072403d to 73 Fed. Reg. 50274 (proposed August 26, 2008) (comment dated September 25, 2008) (to be codified at 45 CFR 88).

Since 2004, Congress has attached the Weldon amendment to the annual appropriations measure that funds the Departments of Labor, Health and Human Services, and Education (Labor-HHS). That amendment prohibits federal agencies and programs and state and local governments that receive money under the Labor-HHS Appropriations Act from discriminating against individuals, health care facilities, insurance plans, and other entities because they refuse to provide, pay for, provide coverage of, or refer for abortion.

The Church, Coats-Snowe, and Weldon amendments were never intended to provide individual health care providers and/or entities with the myriad and expansive rights of refusal this NPRM seeks to achieve. Without statutory authorization, the NPRM expands the reach of the Church, Coats-Snowe, and Weldon Amendment beyond what was contemplated by Congress and is permitted by existing federal law, by expanding the categories of individuals and entities whose refusals to provide information and services are protected; expanding the types of services that individuals and entities are allowed to refuse to provide; and expanding the types of entities that are required to accept such refusals. For example:

- Despite the plain language of the Weldon amendment, the NPRM attempts to extend it to apply to funding beyond that appropriated by Labor-HHS appropriations and to non-governmental entities, as well. The statute of the Weldon amendment states:

  > "(1) None of the funds ***made available in this Act*** may be made available to ***a Federal agency or program, or to a State or local government***, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

  Yet § 88.3(c) of the NPRM adds new language that applies the Weldon amendment's prohibitions not only to federal agencies and programs and state and local governments that receive Labor-HHS funds, but also to "***[a]ny entity that receives funds through a program administered by the Secretary or under an appropriations act for the Department that contains the Weldon amendment***" [emphasis added].

  This language broadens Weldon's reach in two impermissible ways: 1) it extends the restrictions to entities that do not even receive funding via Labor-HHS appropriations, to apply to funding through any program administered by HHS; and, 2) it applies the restrictions of the Weldon amendment beyond the statutory reach of federal agencies or programs, or state or local governments, to any entity receiving certain federal funds. These extensions of Weldon's reach are clearly contrary to both the plain language of the Weldon amendment and to congressional intent.

- While the Church amendment prevents PHSA funds from being used to require individuals and institutions to, among other things, "assist in the performance" of abortions and sterilizations, and prevents employment discrimination against those who refuse to do so, § 88.3 of the NPRM

transforms this statutory shield into a sword, creating out of whole cloth a categorical right of refusal for any recipient of PHSA funds. Moreover, § 88.2 of the NPRM provides an unprecedentedly and unjustifiably broad definition of the term “assist in the performance” that runs counter to congressional intent and common sense. The NPRM would define “assist in the performance” as participating “in ***any activity*** with an ***articulable connection*** to a procedure, health service or health service program, or research activity” [emphasis added]. In other words, HHS proposes to create refusal rights for anyone who can ***simply express a connection*** between something they do not want to do and an abortion or sterilization procedure (e.g., scheduling appointments, processing payments, or treating complications). Even the sole instance of previous rulemaking under the Church amendments in 2008, which was rescinded before it ever took effect, was not so broad.

- Likewise, the NPRM’s definition of referral/refer seeks to dramatically expand the scope and reach of the Coats-Snowe and Weldon amendments and runs counter to congressional intent and common sense. Section 88.2 of the NPRM defines “referral/refer for” abortion to include:

> “the provision of any information (including but not limited to name, address, phone number, email, website, instructions, or description) by any method (including but not limited to notices, books, disclaimers, or pamphlets, online or in print), pertaining to a health care service, activity, or procedure, including related to availability, location, training, information resources, private or public funding or financing, or directions that could provide any assistance in a person obtaining, assisting, training in, funding, financing, or performing a particular health care service, activity, or procedure, where the entity or health care entity making the referral sincerely understands that particular health care service, activity, or procedure to be a purpose or possible outcome of the referral.”

This definition would impair the ability of health care professionals to fulfill their legal and ethical duties of providing complete, accurate, and unbiased information to their patients. For example, as discussed further below, the NPRM could be read to permit employees of Title X-funded health centers and other federally funded entities to refuse to provide information and referrals to patients, without ever addressing patient needs and in clear violation of the fundamental tenets of informed consent.

As interpreted by the NPRM, the Church, Coats-Snowe, and Weldon amendments would be radically expanded to create far-reaching protections for individuals and entities that would refuse to provide patients not only with health care services, but also the most basic information about their medical options and that seek to obstruct the ability of certain patients to access any care at all. This is impermissible and, as discussed below, would cause unprecedented harm to patients and undermine the integrity of key HHS programs.

This NPRM goes beyond HHS' statutory authority and should be withdrawn. If HHS promulgates a final rule, however, it must identify the source of its legal authority, if any at all, to promulgate these regulations and to alter and expand the meaning of the statutory language.

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The NPRM attempts to grant OCR oversight authority and enforcement discretion that is overly broad and vague; unduly punitive; and ripe for abuse.

While some of the investigative authority and enforcement powers of the current NPRM appear to comport with similar provisions in other areas subject to OCR oversight and enforcement authority, the NPRM 1) includes new, troubling provisions that are vague, overly broad, and overly punitive; and 2) as a whole, appear to impart in OCR authority and enforcement discretion that is ripe for abuse.

Indeed, while the NPRM claims to "borrow...from enforcement mechanisms already available to OCR to enforce similar civil rights laws," the NPRM contains troubling differences. For example, the NPRM states that investigations may be based on anything from 3rd party-complaints to news reports, and yet at the same time appears to give OCR the authority to withhold federal financial assistance and suspend award activities, based on "threatened violations" alone, without first allowing for the completion of an informal resolution process. (See 83 Fed. Reg. at 3891, 3930-31). By contrast, the Department of Justice (DOJ) regulations implementing Title VI of the Civil Rights Act of 1964 (prohibiting discrimination on the basis of race in federally funded programs) state that DOJ will not take such drastic steps to respond to actual or threatened violations unless noncompliance cannot first be corrected by informal means. (See 28 C.F.R. § 42.108(a)). When combined with other aspects of the NPRM, concern over the breadth and potential harm of such provisions is obvious and legitimate. For instance:

- Under § 88.6, the NPRM includes a 5-year reporting requirement that requires any recipient or sub-recipient subject to an OCR compliance review, investigation, or complaint related to the health care refusal rules to inform any current HHS "funding component" of the review/investigation/complaint, as well as to disclose that information in any application for new or renewed "Federal financial assistance or Departmental funding." Once again, this is distinct from the DOJ regulations enforcing Title VI, which only require disclosure of compliance reviews (not every investigation or complaint, regardless of whether it is unfounded) over the past two years. (28 C.F.R. § 42.406(3)). Yet the NPRM fails to explain the purpose of the vastly expanded reporting requirement and period. In light of the broad investigative authority and harsh penalties described above, this leaves affected entities with significant concern about how such information is intended to be used and whether it will unfairly prejudice consideration of applicants for federal funds or penalize currently funded entities in ways that could be extremely harmful.

The NPRM also includes very troubling language that appears to be little more than a pretext for defunding entire classes of providers, which it cannot do. The preamble text accompanying § 88.7

states, "The Director may, in coordination with a relevant Department component, restrict funds for noncompliant entities in whole or in part, including by ***limiting funds to certain programs and particular covered entities, or by restricting a broader range of funds or broader categories of covered entities***" [emphasis added]. This delegation of authority is not only far beyond the scope of the underlying laws but seems designed to grant arbitrary authority that is ripe for abuse, with no mechanism of due process or oversight to prevent entire categories of providers or programs from being penalized without cause. To the extent § 88.7 seeks to create a back door to excluding certain family planning providers from the Title X and Medicaid programs—efforts that have been repeatedly rejected by the courts—it, again, exceeds the scope of the agency's authority and will do nothing more than harm the health and well-being of patients.

Given the lack of evidence that the system currently in place cannot adequately handle complaints, as well as any sufficient justification for departing from the processes used to ensure compliance with other federal statutes, HHS must, at a minimum, adequately explain the reason for these changes, what safeguards exist to prevent abuse, and demonstrate that this language is not simply a pretext for unlawfully excluding certain categories of providers from participating in federally funded programs.

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The NPRM opens the door to undermining the intent and integrity of key HHS programs, including the Title X family planning program.

The NPRM ignores the reality that some individuals and entities are opposed to the essential health services that are the foundation of longstanding, critical HHS programs like Title X. In the arena of health care, and particularly family planning and sexual health, HHS-funded programs cannot achieve their fundamental, statutory objectives if grantees, providers, and contractors have a categorical right to refuse to provide essential services, such as non-directive pregnancy options counseling.

The Title X family planning program was created by Congress in 1970 "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services" (42 USC 300). Title X projects are designed to "consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children" (42 CFR 59).

In 2014, more than 20.2 million women in the United States were in need of publicly funded contraceptive services. Women in need of publicly funded family planning services is defined as follows: "1) they were sexually active (estimated as those who have ever had voluntary vaginal intercourse, 2) they were able to conceive (neither they nor their partner had been contraceptively sterilized, and they did not believe they were infecund for any other reason); 3) they were neither intentionally pregnant nor trying to become pregnant; and, 4) they have a family income below 250% of the federal poverty level. In addition, all women younger than 20 who need contraceptive services, regardless of their family income are assumed to need publicly funded care because of their heightened need—for reasons of

confidentiality—to obtain care without depending on their family's resources or private insurance."[4] In the face of this widespread need, publicly funded family planning and sexual health care provides a crucial safety net for women and families. The impact of these services cannot be underestimated. Without publicly funded family planning services, there would be 67% more unintended pregnancies (1.9 million more) annually than currently occur.[5]

Congress has specifically required that "all pregnancy counseling shall be non-directive" (Public Law 110-161, p. 327), and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination (42 CFR 59.5(a)(5)). Despite the incredible success of the Title X program and the critical services it provides, Title X has been chronically underfunded, with no new service dollars allocated in nearly a decade. It is a testament to the dedication of the existing Title X network to meeting the goals of the program that, despite limited resources, these providers still serve more than four million patients per year.[6]

However, in addition to the overly broad definitions of "referral" and "assist in the performance" discussed above, by proposing a definition of "discrimination" that appears to jettison the longstanding framework that balances individual conscience rights with the ability of health care entities to continue to provide essential services to their patients, the NPRM seems designed to allow entities that refuse to provide women with the basic information, options counseling, and referrals required by law to compete on the same footing for federal money with family planning providers who adhere to the law and provide full and accurate information and services to patients. The NPRM thus threatens to divert scarce family planning resources away from entities that provide comprehensive family planning services to organizations that refuse to provide basic family planning and sexual health care services. Diverting funds away from providers offering the full range of family planning and sexual health services would not only seriously undermine public health, especially for the low-income, uninsured, and under-insured, but would also be contrary to congressional intent and explicit statutory requirements of the Title X family planning program.

The NPRM likewise creates confusion 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. To the extent that the rule seeks to immunize subrecipients who refuse to provide essential services and complete information about all of a woman's pregnancy options, it undermines the very foundation of the Title X program and the health of the patients who rely on it.

In addition to potential issues with the selection of grantees and subrecipients, the proposed definition of "discrimination" also poses significant employment issues for all Title X-funded health centers. As

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[4] Jennifer Frost et al, *Contraceptive Needs and Services, 2014 Update* (New York: Guttmacher Institute, 2016).
[5] Jennifer Frost et al, *Publicly Funded Contraceptive Services at U.S. Clinics, 2015* (New York: Guttmacher Institute, April 2017).
[6] Christina Fowler, *Family Planning Annual Report: 2016 national summary* (Research Triangle Park, NC: RTI International, 2017).

discussed further below, the language in the NPRM could put Title X-funded health centers in the position of being forced to hire people who intend to refuse to perform essential elements of a position. For example, the rule provides 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 individual refuses to provide non-directive options counseling. Furthermore, the NPRM does not provide guidance on whether it is impermissible "discrimination" for a Title X-funded state or local health department to transfer such a counselor or clinician out of the health department's family planning project to a unit where pregnancy counseling is not done.

Because the NPRM threatens to undermine the integrity of key HHS programs, including the Title X family planning program, HHS must, at a minimum, clarify that any final rule does not conflict with preexisting legal requirements for and obligations of participants in the Title X program, or of employers, as set forth under Title VII of the Civil Rights Act of 1964, discussed below.

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The NPRM fails to sufficiently address patient needs or achieve the careful balance struck by existing civil rights laws and encourages unprecedented discrimination against patients that will likely impede their access to care and harm their health.

The stated mission of HHS is "to enhance and protect the health and well-being of all Americans." Yet, the NPRM elevates the religious and moral objections of health care providers over the health care needs of the patients who HHS is obligated to protect. The NPRM appears to allow individuals to refuse to provide health care services or information about available health care services to which they object on religious or moral grounds, with virtually no mention of the needs of the patient who is turned away. Patients should not be forced to bear the brunt of the objector's religious or moral beliefs, particularly to the detriment of their own health. In fact, legal and ethical principles of informed consent require health care providers to tell their patients about all of their treatment options, including those the provider does not offer or favor, so long as they are supported by respected medical opinion. As such, health care professionals must endeavor to give their patients complete and accurate information about the services available to them.

Furthermore, the NPRM fails to address serious questions as to whether its purpose is to upset the careful balance struck in current federal law between respecting employee's religious and moral beliefs and employers' ability to provide their patients with health care services. Title VII provides a balance between health care employers' obligations to accommodate their employees' religious beliefs and practices (including their refusal to participate in specific health care services to which they have religious objection) with the needs of the patients they serve. Under Title VII, employers have a duty to reasonably accommodate an employee or applicant's religious beliefs, unless doing so places an "undue hardship" on the employer. This law provides protection for individual belief while still ensuring patient access to health care services. The NPRM provides no guidance about how, if at all, health care

employers are permitted to consider patients' needs when faced with an employee's refusal to provide services.

The NPRM ignores the needs of patients and fails to consider whether an employer can accommodate such a refusal without undue hardship. In so doing, the NPRM invites health care professionals to violate their legal and ethical duties of providing complete, accurate, and unbiased information necessary to obtain informed consent. The failure of health care professionals to provide such information threatens patients' autonomy and their ability to make informed health care decisions.

Title VII is an appropriate standard that protects the needs of patients and strikes an appropriate balance. At a minimum, HHS should clarify that any final rule does not conflict with Title VII.

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The NPRM vastly underestimates the financial burden it would impose on federally funded health care providers who already operate with limited resources.

NFPRHA is particularly well positioned to comment upon the extremely burdensome effect the NPRM will have on the variety of public and private entities awarded federal dollars to provide health services to underserved communities.

As an initial matter, for a non-lawyer to simply read and understand the regulatory language and the lengthy preamble of the NPRM requires numerous hours – much longer than the roughly "10 minutes per law" estimated by HHS. (See 83 Fed. Reg. at 3913). A Final Rule, which would respond to prior comments and provide explanation and commentary elaborating on the Regulation, would require the same at minimum. Moreover, given the magnitude of funds at stake, the complexity and ambiguity of the NPRM's employment provisions, and the diverse staffing arrangements among recipients of federal funds, many NFPRHA members will need to pay for the time of legal counsel to review and consult with them on how to adjust their policies and practices prior to certifying compliance. This will also require time and cost for legal counsel to research and advise how, or if, it is possible for an entity to achieve compliance with the rule as well as with potentially conflicting obligations under State or other Federal laws. A reasonable estimate of these tasks alone would include at least several hours of attorney as well as multiple hours of executive and management staff time – not just the average of 4 hours (total) per year of lawyer and staff time estimated by HHS. (See 83 Fed. Reg. at 3913).

In particular, it appears that policies and practices to comply with the Department's articulated standard will be different than those necessary to comply with existing federal laws such as Title VII. Thus, in estimating an average of 4 hours (total) per year to update policies and procedures *and* retrain staff (see 83 Fed. Reg. at 3913), the NPRM utterly fails to account for:

- Time and cost for legal and human resources or executive staff to review and revise job postings, job descriptions, job application materials, interview and hiring policies and practices, and other employment recruitment and hiring materials.
- Time and cost for legal and human resources or executive staff to review and revise employee manuals and handbooks, and other employment related policies and documents.
- Time and cost to devise and provide trainings for managers and other supervisory staff on interviewing, hiring, and responding to accommodation requests from employees and volunteers who object to participating in the provision of certain health care services.
- Time and cost of hiring and training additional employees and/or paying and retraining existing employees for additional hours to accommodate other employees who refuse to provide services.

While these comments do not attempt to identify and detail each of the likely costs that NFPRHA members and other regulated entities would face if the NPRM was finalized, they demonstrate the qualitatively and quantitatively substantial costs overlooked by HHS in its NPRM. In light of these burdens and the HHS's inability to demonstrate a countervailing need for the rule, NFPRHA strongly urges HHS to withdraw the NPRM. Failure to do so will result in substantial resources being diverted away from providing critical health care to patients in an already underfunded family planning safety net.

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NFPRHA appreciates the opportunity to comment on the NPRM, "Protecting Statutory Conscience Rights in Health Care." If you require additional information about the issues raised in these comments, please contact Robin Summers at rsummers@nfprha.org or 202-552-0150.

Sincerely,

Clare Coleman
President & CEO

Exhibit 129

March 23, 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 SW
Washington, DC 20201

RE: Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority

Dear Secretary Azar:

Thank you for the opportunity to comment on the proposed rule published by HHS on January 26, 2018. The National Health Care for the Homeless Council (NHCHC) is a membership organization representing federally qualified health centers (FQHCs) and other organizations providing health services to people experiencing homelessness. In 2016, there were 295 Health Care for the Homeless (HCH) programs serving nearly 1 million patients in 2,000+ locations across the United States. Our members offer a wide range of services to support people without homes gain better health, to include comprehensive primary care, mental health and addiction treatment, medical respite care, supportive services in housing, case management, outreach, and health education.

We are concerned about the recent proposed rules that expand the ability of employees to refuse to perform standard job functions based on moral and conscience objections. Specifically, we'd like to raise five possible outcomes should these rules become final:

1. **Compromises quality of care:** We are expected to practice evidence-based care and meet HHS quality measures in keeping with prevailing health standards of care. Upholding discrimination, denying care, and facilitating a judgmental environment only serve to erect barriers to care and inhibit achieving the very health outcomes we strive to improve each day. Many of our members are not large providers and do not have additional staff on hand to fill in should a colleague refuse to provide care under these regulations. Denying care and/or treating patients with judgment and disrespect can have catastrophic consequences. This is particularly true for our clients who are suicidal, seeking substance use treatment (particularly for opioids, where overdose is a significant risk), and where continuity of care and medications is critical (e.g., medications to treat HIV, Hepatitis C virus, and tuberculosis treatments).
2. **Stifles our ability to be an employer:** These regulations are extremely broad and apply to just about any service or referral available in the community. This allows for arbitrary and capricious

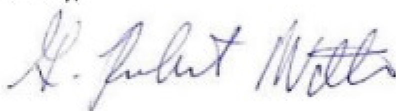
behavior, possibly allowing any staff person to claim a moral objection should they not wish to perform basic job functions. These proposed rules deny employers the ability to supervise and hold staff accountable for actions that can have pervasive impacts on patients, as well as other staff in the agency.

3. **Increases our legal liability:** We cannot deny patient care based on individual characteristics. This is particularly true if the patient is in a protected class (race, ethnicity, disability status, sexual orientation, religion, etc.). Should we implement this rule, we increase our legal liability and lawsuits filed against us for denying care based on discriminatory factors.
4. **Increases health costs:** Denying care doesn't negate health needs. Should patients be refused services or treated disrespectfully by a health care provider, they instead will seek care in emergency rooms, hospitals, and other higher-cost venues. Untreated chronic conditions, mental health, addiction, and other health issues can then worsen and contribute to an overall downward spiral that benefits no one.
5. **Alienates vulnerable people and compromises trust:** People experiencing homelessness and other marginalized populations already struggle to develop trusting relationships with medical providers and engage in the care needed to improve health and wellbeing. This is also a population that is already vastly underserved, with very few providers willing and able to address a broad range of clinical and social issues. When denied care because of their personal characteristics, there may be no other provider available as an alternative. As a result, trust is broken and patients are less likely to engage in care in the future.

While we understand the intent of these proposed rules is to protect some workers, the overall impact could be devastating to community-based organizations who function the same as any other business or employer. For the patients we serve, they often do not have another outpatient health care option that is designed to meet their needs. We request the Administration reconsider these rules in light of the unintended consequences outlined above.

Thank you for the opportunity to comment on these proposed rules for moral and conscience rights in health care. Please contact us if you should wish to discuss any aspect of these comments further. I can be reached at bwatts@nhchc.org or at 615-226-2262.

Sincerely,



G. Robert Watts
Chief Executive Officer

Exhibit 130

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Executive Director

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Senior Advisor to the Board
Rep. Henry A. Waxman
Waxman Strategies

General Counsel
Marc Fleischaker
Arent Fox, LLP

March 27, 2018

Via Electronic Submission

The Honorable Alex M. Azar II
Secretary, U.S. Department of Health and Human Services
Office for Civil Rights
Hubert H. Humphrey Building, Room 209F
200 Independence Avenue SW
Washington, DC 20201

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

Dear Secretary Azar,

On behalf of National Health Law Program, 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."

The regulations as proposed would introduce broad and poorly defined language to the existing law that already provides ample protection for the ability of health care providers to refuse to participate in a health care service to which they have moral or religious objections. While the proposed regulations purport to provide clarity and guidance in implementing existing federal religious exemptions, in reality they are vague and confusing. The proposed rule creates the potential for exposing patients to medical care that fails to comply with established medical practice guidelines, negating long-standing principles of informed consent, and undermines the ability of health facilities to provide care in an orderly and efficient manner.

Most important, the regulations fail to account for the significant burden that will be imposed on patients, a burden that will fall disproportionately and most harshly on women, people of color, people living with disabilities, and Lesbian, Gay, Bisexual, Transgender, and Queer ("LGBTQ") individuals. These

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communities already experience severe health disparities and discrimination, conditions that will be exacerbated by the proposed rule, possibly ending in in poorer health outcomes. By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the Department seeks to use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. For these reasons, the National Health Law Program calls on the Department and OCR to withdraw the proposed rule in its entirety.

I. Under the guise of civil rights, the proposed rule seeks to deny medically necessary care

Civil rights laws and Constitutional guarantees, such as due process and equal protection, are designed to ensure full participation in civil society. The proposed rule, while cloaked in the language of non-discrimination, is designed to deny care and exclude disadvantaged and vulnerable populations. The adverse consequences of health care refusals and other forms of discrimination are well documented. As the Department stated in its proposed rulemaking for § 1557 of the Affordable Care Act ("ACA"),

> "[e]qual access for all individuals without discrimination is essential to achieving" the ACA's aim to expand access to health care and health coverage for all, as "discrimination in the health care context can often…exacerbate existing health disparities in underserved communities."[1]

The Department and OCR have an important role to play in ensuring equal health opportunity and ending discriminatory practices that contribute to health disparities. Yet, this proposed rule represents a dramatic, harmful, and unwarranted departure from OCR's historic and key mission. The proposed rule appropriates language from civil rights statutes and regulations that were designed to improve access to health care and applies that language to deny medically necessary care.

The federal government argues that robust religious refusals, as implemented by this proposed rule, will facilitate open and honest conversations between patients and physicians.[2] As an outcome of this rule, the government believes that patients, particularly those who are "minorities", including those who identify as people of faith, will face fewer obstacles in accessing care.[3] The proposed rule will not achieve these outcomes. Instead, the proposed rule will increase barriers to care, harm patients by allowing health care professionals to ignore established medical guidelines, and undermine open communication between providers and patients. The harm caused by this proposed rule will fall hardest on those most in need of care.

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[1] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,194 (Sept. 8, 2015) (codified at 45 C.F.R. pt. 2).
[2] U.S. Dep't. of Health & Human Serv., Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3917 (Jan. 26, 2018) (hereinafter "proposed rule").
[3] *Id.*

II. The expansion of religious refusals under the proposed rule will disproportionately harm communities who already lack access to care

Women, individuals living with disabilities, LGBTQ persons, people living in rural communities, and people of color face severe health and health care disparities, and these disparities are compounded for individuals who hold these multiple identities. For example, among adult women, 15.2 percent of those who identified as lesbian or gay reported being unable to obtain medical care in the last year due to cost, as compared to 9.6 percent of straight individuals.[4] Women of color experience health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.[5] Meanwhile, people of color in rural America are more likely to live in an area with a shortage of health professionals, with 83 percent of majority-Black counties and 81 percent of majority-Latino/a counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

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

a. *The proposed rule will block access to care for low-income women, including immigrant women and African American women*

Broadly-defined and widely-implemented refusal clauses undermine access to basic health services for all, but can particularly harm low-income women. The burdens on low-income women can be insurmountable when women and families are uninsured,[6] underinsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services nor travel to another location. This is especially true for immigrant women. In comparison to their U.S. born peers, immigrant women are more likely to be uninsured.[7] Notably, immigrant, Latina women have far higher rates of uninsurance than Latina women born in the United States (48 percent versus 21 percent, respectively).[8]

[4] Brian P. Ward et al., *Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey*, NAT'L CTR. FOR HEALTH STATISTICS, 2013 9 (2014), https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf.
[5] In 2014, Latinas had the highest rates of contracting cervical cancer and Black women had the highest death rates. *Cervical Cancer Rates By Rates and Ethnicity*, CTRS. FOR DISEASE CONTROL & PREVENTION, (Jun. 19, 2017), https://www.cdc.gov/cancer/cervical/statistics/race.htm.; At the end of 2014, of the total number of women diagnosed with HIV, 60 percent were Black. *HIV Among Women,* CTRS. FOR DISEASE CONTROL & PREVENTION, Nov. 17, 2017, https://www.cdc.gov/hiv/group/gender/women/index.html.
[6] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. KAISER FAMILY FOUND., *Women's Health Insurance Coverage* 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.
[7] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf.
[8] *Id.* at 8, 16.

According to a recent report, doctors often fail to inform Black women of the full range of reproductive health options regarding labor or delivery possibly due to stereotypes about Black women's sexuality and reproduction.[9] Young Black women noted that they were shamed by providers when seeking sexual health information and contraceptive care in part, due to their age, and in some instances, sexual orientation.[10]

New research also shows that women of color in many states disproportionately receive their care at Catholic hospitals, subjecting them to treatment that does not comply with the standards of care.[11] In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[12] In New Jersey, for example, women of color make up 50 percent of women of reproductive age in the state, yet have twice the number of births at Catholic hospitals compared to their white counterparts.[13] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on wide range of hospital matters, including reproductive health care. In practice, the ERDs prohibit the provision of emergency contraception, sterilization, abortion, fertility services, and some treatments for ectopic pregnancies. 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, risking their health.[14] The proposed rule will give health care providers a license, such as Catholic hospitals, to opt out of evidence-based care that the medical community endorses. If this rule were to be implemented, more women, particularly women of color, will be put in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services. For many, this choice does not exist.

b. The proposed rule will negatively impact rural communities

The ability to refuse care to patients will leave many individuals in rural communities with no health care options. Medically underserved areas already exist in every state,[15] with

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[9] CTR. FOR REPROD. RIGHTS, NAT'L LATINA INST. FOR REPROD. HEALTH & SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter *Reproductive Injustice*]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), *available at* http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

[10] *Reproductive Injustice*, *supra* note 9, at 16-17.

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

[12] *Id* at 12.

[13] *Id* at 9.

[14] Lori R. Freedman et al., *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/.

[15] Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA, (last visited Mar. 21, 2018).

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over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[16] Many rural communities experience a wide array of mental health, dental health, and primary care health professional shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.[17] Among the many geographic and spatial barriers that exist, individuals in rural areas often must have a driver's license and own a private car to access care, as they must travel further distances for regular checkups, often on poorer quality roads, and have less access to reliable public transportation.[18] This scarcity of accessible services leaves survivors of intimate partner violence (IPV) in rural areas with fewer shelter beds close to their homes, with an average of just 3.3 IPV shelter beds per rural county as compared to 13.8 in urban counties.[19] Among respondents of one survey, more than 25 percent of survivors of IPV in rural areas have to travel over 40 miles to the nearest support service, compared to less than one percent of women in urban areas.[20]

Other individuals in rural areas, such as people with disabilities, people with Hepatitis C, and people of color, have intersecting identities that further exacerbate existing barriers to care in rural areas. Racial and ethnic minority communities often live in concentrated parts of rural America, in communities experiencing rural poverty, lack of insurance, and health professional shortage areas.[21] People with disabilities experience difficulties finding competent physicians in rural areas who can provide experienced and specialized care for their specific needs, in buildings that are barrier free.[22] Individuals with Hepatitis C infection find few providers in rural areas with the specialized knowledge to manage the emerging treatment options, drug toxicities and side effects.[23] All of these barriers will worsen if providers are allowed to refuse care to particular patients.

Meanwhile, immigrant, Latina women and their families often face cultural and linguistic barriers to care, especially in rural areas.[24] These women often lack access to

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[16] M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH (2010), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/.
[17] Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations*, ECON. RESEARCH SERV. (2009), *available at* https://www.ers.usda.gov/publications/pub-details/?pubid=44427.
[18] Thomas A. Arcury et al., *The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region*, 40 HEALTH SERV. RESEARCH (2005) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361130/.
[19] Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources*, 20 J. OF WOMEN'S HEALTH (Nov. 2011) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216064/.
[20] *Id.*
[21] Janice C. Probst et al., *Person and Place: The Compounding Effects of Race/Ethnicity and Rurality on Health*, AM. J. PUB. HEALTH (2011), *available at* http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1695.
[22] Lisa I. Iezzoni et al., *Rural Residents with Disabilities Confront Substantial Barriers to Obtaining Primary Care*, 41 HEALTH SERV. RESEARCH (2006), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1797079/.
[23] Sanjeev Arora et al., *Expanding access to hepatitis C virus treatment – Extension for Community Healthcare Outcomes (ECHO) Project: Disruptive Innovation in Specialty Care*, 52 HEPATOLOGY (2010), *available at* http://onlinelibrary.wiley.com/doi/10.1002/hep.23802/full.
[24] Michelle M. Casey et al., *Providing Health Care to Latino Immigrants: Community-Based Efforts in the Rural Midwest*, AM. J. PUB. HEALTH (2011), *available at* http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1709.

transportation and may have to travel great distances to get the care they need.[25] In rural areas, there may simply be no other sources of health and life preserving medical care. When these women encounter health care refusals, they have nowhere else to go.

c. *The proposed rule would harm LGBTQ communities who continue to face rampant discrimination and health disparities*

The proposed rule will compound the barriers to care that LGBTQ individuals face, particularly the effects of ongoing and pervasive discrimination by potentially allowing providers to refuse to provide services and information vital to LGBTQ health.

LGBTQ people continue to face discrimination in many areas of their lives, including health care, based on their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[26] LGBTQ people still face discrimination in a wide variety of services affecting access to health care, including reproductive services, adoption and foster care services, child care, homeless shelters, and transportation services – as well as physical and mental health care services.[27] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.[28] They concluded that discrimination as well as insensitivity or disrespect on the part of health care providers were key barriers to health care access and that increasing efforts to provide culturally sensitive services would help close the gaps in health care access.[29]

i. Discrimination against the transgender community

Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[30] Numerous

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[25] NAT'L LATINA INST. FOR REPROD. HEALTH & CTR. FOR REPROD. RIGHTS, NUESTRA VOZ, NUESTRA SALUD, NUESTRO TEXAS: THE FIGHT FOR WOMEN'S REPRODUCTIVE HEALTH IN THE RIO GRANDE VALLEY, 7 (2013), *available at* http://www.nuestrotexas.org/pdf/NT-spread.pdf.
[26] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 8, 2018).
[27] HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.
[28] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.
[29] *Id.*
[30] *See, e.g., EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018); *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (Title IX and Equal Protection Clause); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *A.H. ex rel. Handling v. Minersville Area School District*, 3:17-CV-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and Equal Protection Clause); *Stone v. Trump*, ---F.Supp.3d ---, No. 17–2459 (D. Md. Nov. 21, 2017) (Equal Protection Clause); Doe v. Trump, ---F.Supp.3d ---, 2017 WL

federal courts have found that federal sex discrimination statutes reach these forms of gender-based discrimination.[31] In 2012, the Equal Employment Opportunity Commission (EEOC) likewise held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[32]

Twenty-nine percent of transgender individuals were refused to be seen by a health care provider because of their perceived or actual gender identity and 29 percent experienced unwanted physical contact from a health care provider.[33] Additionally, the 2015 U.S. Transgender Survey found that 23 percent of respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[34]
Data obtained by Center for American Progress (CAP) under a FOIA request indicates the Department's enforcement was effective in resolving issues of anti-LGBTQ discrimination. CAP received information on closed complaints of discrimination based on sexual orientation, sexual orientation-related sex stereotyping, and gender identity that were filed with the Department under § 1557 of the ACA from 2012 through 2016.

- "In approximately 30% of these claims, patients alleged denial of care or insurance coverage simply because of their gender identity – not related to gender transition."

4873042 (D.D.C. Oct. 30, 2017) (Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, ---F.Supp.3d ---, 2017 WL 4310756 (S.D. Cal. Sept. 27, 2017) (Section 1557); *E.E.O.C. v. Rent-a-Center East, Inc.*, ---F.Supp.3d ---, 2017 WL 4021130 (C.D. Ill. Sept. 8, 2017) (Title VII); *Brown v. Dept. of Health and Hum. Serv.*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017) (Equal Protection Clause); *Smith v. Avanti*, 249 F.Supp.3d 1194 (D. Colo. 2017) (Fair Housing Act); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); *Mickens v. Gen. Elec. Co.* No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hosp. of Cent. Conn.*, 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016) (Section 1557); *Doe v. State of Ariz.*, No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016) (Title VII); *Dawson v. H&H Elec., Inc.*, No. 4:14CV00583 SWW, 2015 WL 5437101 (E.D. Ark. Sept. 15, 2015) (Title VII); *U.S. v. S.E. Okla. State Univ.*, No. CIV–15–324–C, 2015 WL 4606079 (W.D. Okla. 2015) (Title VII); *Rumble v. Fairview Health Serv.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557); *Finkle v. Howard Cty.*, 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Lopez v. River Oaks Imaging & Diagnostic Grp.*, Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); *Mitchell v. Axcan Scandipharm*, Inc., No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); *Tronettiv. Healthnet Lakeshore Hosp.*, No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII).

[31] *See, e.g.*, *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

[32] *Macy v. Holder*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).

[33] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AMERICAN PROGRESS, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

[34] NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf [hereinafter *2015 U.S. Transgender Survey*].

- "Approximately 20% of the claims were for misgendering or other derogatory language."
- "Patients denied care due to their gender identity or transgender status included a transgender woman denied a mammogram and a transgender man refused a screening for a urinary tract infection."[35]

As proposed, the rule could allow religiously affiliated hospitals to not only refuse to provide transition related treatment for transgender people, but to also deny surgeons who otherwise have admitting privileges to provide transition related surgery in the hospital. Transition-related care is not only medically necessary, but for many transgender people it is lifesaving.

ii. Discrimination based upon sexual orientation

Many LGBTQ people lack insurance and providers are not competent in health care issues and obstacles that the LGBTQ community experiences.[36] According to one survey, 8 percent of LGBQ individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and 7 percent experienced unwanted physical contact and violence from a health care provider.[37]

Fear of discrimination causes many LGB people to avoid seeking health care, and, when they do seek care, LGB people are frequently not treated with the respect that all patients deserve. The study "When Health Care Isn't Caring" found that 56 percent of LGB people reported experiencing discrimination from health care providers – including refusals of care, harsh language, or even physical abuse – because of their sexual orientation.[38] Almost 10 percent of LGB respondents reported that they had been denied necessary health care expressly because of their sexual orientation.[39] Delay and avoidance of care due to fear of discrimination compound the significant health disparities that affect the lesbian, gay, and bisexual population. These disparities include:

- LGB individuals are more likely than heterosexuals to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities.[40]

[35] Sharita Gruberg & Frank J. Bewkes, Center for American Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (March 7, 2018), *available at* https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.

[36] Medical schools often do not provide instruction about LGBTQ health concerns that are not related to HIV/AIDS. Jen Kates et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S*, KAISER FAMILY FOUND.12 (2017), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US.

[37] Mirza, *supra* note 33.

[38] LAMBDA LEGAL, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 5 (2010), *available at* .http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

[39] *Id.*

[40] David J. Lick, Laura E. Durso & Kerri L. Johnson, *Minority Stress and Physical Health Among Sexual Minorities*, 8 PERS. ON PSYCHOL. SCI. 521 (2013), *available at*

- Lesbian and bisexual women report poorer overall physical health than heterosexual women.[41]
- Gay and bisexual men report more cancer diagnoses and lower survival rates, higher rates of cardiovascular disease and risk factors, as well as higher total numbers of acute and chronic health conditions.[42]
- Gay and bisexual men and other men who have sex with men (MSM) accounted for more than half (56 percent) of all people living with HIV in the United States, and more than two-thirds (70 percent) of new HIV infections.[43]
- Bisexual people face significant health disparities, including increased risk of mental health issues and some types of cancer.[44]

This discrimination affects not only the mental health and physical health of LGBTQ people, but that of their families as well. One pediatrician in Alabama reported that "we often see kids who haven't seen a pediatrician in 5, 6, 7 years, because of fear of being judged, on the part of either their immediate family or them [identifying as LGBTQ]".[45] It is therefore crucial that LGBTQ individuals, who have found unbiased and affirming providers, be allowed to remain with them. If turned away by a health care provider, 17 percent of all LGBTQ people, and 31 percent of LGBTQ people living outside of a metropolitan area, reported that it would be "very difficult" or "not possible" to find the same quality of service at a different community health center or clinic.[46]

The proposed rule allowing providers to deny needed care would reverse recent gains in combatting discrimination and health care disparities for LGBTQ persons. Refusals also implicate standards of care that are vital to LGBTQ health. Medical professionals are expected to provide LGBTQ individuals with the same quality of care as they would anyone else. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and competency with LGBTQ issues as they pertain to any health services provided.[47] The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.[48] The

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http://williamsinstitute.law.ucla.edu/research/health-and-hiv-aids/minority-stress-and-physical-health-among-sexual-minorities/.

[41] *Id.*

[42] *Id.*

[43] CTRS FOR DISEASE CONTROL & PREVENTION, *CDC Fact Sheet: HIV Among Gay and Bisexual Men* 1(Feb. 2017), https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf.

[44] HUMAN RIGHTS CAMPAIGN ET AL., *Health Disparities Among Bisexual People* (2015) *available at* http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/HRC-BiHealthBrief.pdf.

[45] HUMAN RIGHTS WATCH, *supra* note 27.

[46] Mirza, *supra* note 33.

[47] *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, GAY LESBIAN BISEXUAL & TRANSGENDER HEALTH ACCESS PROJECT, http://www.glbthealth.org/CommunityStandardsofPractice.htm (last visited Jan. 26, 2018, 12:59 PM); *Creating an LGBTQ-friendly Practice*, A.M.A., https://www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice#Meet a Standard of Practice (last visited Jan. 26, 2018, 12:56 PM).

[48] *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, WORLD PROF. ASS'N FOR TRANSGENDER HEALTH (2011), https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf.

American College of Obstetricians and Gynecologists ("ACOG") warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.[49] LGBTQ individuals already experience significant health disparities, and denying medically necessary care based on sexual orientation or gender identity exacerbates these disparities.

In addition, LGBTQ individuals face disparities in medical conditions that may implicate the need for reproductive health services. For example, lesbian and bisexual women report heightened risk for and diagnosis of some cancers and higher rates of cardiovascular disease.[50] The LGBTQ community is significantly at risk for sexual violence.[51] Eighteen percent of LGB students have reported being forced to have sex.[52] Transgender women, particularly women of color, face high rates of HIV.[53]

Refusals to treat individuals according to medical standards of care put patients' health at risk, particularly for women and LGBTQ individuals. Expanding religious refusals will further put needed care, including reproductive health care, out of reach for many. Given the broadly written and unclear language of the proposed rule, if implemented, some providers may misuse this rule to deny services to LGBTQ individuals based on perceived or actual sexual orientation and gender identity. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care impairs the ability of patients to make a health decision that expresses their self-determination.

Finally, the proposed rule threatens to turn back the clock to the darkest days of the AIDS pandemic when same-sex partners were routinely denied hospital visitation and health care providers scorned sick and dying patients.

d. The proposed rule will hurt people living with disabilities

Many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously-affiliated providers. Historically, people with disabilities who rely on these services have sometimes faced discrimination, exclusion, and a loss of autonomy due to provider objections. Group homes have, for example, refused to allow residents with intellectual disabilities who were married to live together in the group home.[54] Individuals with HIV – a recognized disability under the

[49] *Committee Opinion 512: Health Care for Transgender Individuals*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Dec. 2011), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals.
[50] Kates, *supra* note 36, at 4.
[51] Forty-six percent of bisexual women have been raped and 47 percent of transgender people are sexually assaulted at some point in their lifetime. This rate is particularly higher for transgender people of color. Kates, *supra* note 36, at 8.; *2015 U.S. Transgender Survey*, *supra* note 34, at 5.
[52] *Health Risks Among Sexual Minority Youth*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/healthyyouth/disparities/smy.htm (last updated May 24, 2017).
[53] More than 1 in 4 transgender women are HIV positive. Kates, *supra* note 36, at 6.
[54] See *Forziano v. Independent Grp. Home Living Prog.*, No. 13-cv-00370 (E.D.N.Y. Mar. 26, 2014) (dismissing lawsuit against group homes, including a religiously affiliated group home, that refused to allow married couple with intellectual disabilities live together). Recent regulations have reinforced protections to ensure available choice of roommates and guests. 42 C.F.R. §§ 441.301(c)(4)(vi)(B) & (D).

American Disabilities Act – have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. One man with HIV was refused care by six nursing homes before his family was finally forced to relocate him to a nursing home 80 miles away.[55] Given these and other experiences, the extremely broad proposed language at 45 C.F.R. § 88.3(a)(2)(vi) that would allow any individual or entity with an "articulable connection" to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a moral or religious objection is extremely alarming and could seriously compromise the health, autonomy, and well-being of people with disabilities.

Many people with disabilities live or spend much of their day in provider-controlled settings where they often receive supports and services. They may rely on a case manager to coordinate necessary services, a transportation provider to get them to community appointments, or a personal care attendant to help them take medications and manage their daily activities. Under this broad new proposed language, any of these providers could believe they are entitled to object to providing a service covered under the regulation and not even tell the individual where they could obtain that service, how to find an alternative provider, or even whether the service is available to them. A case manager might refuse to set up a routine appointment with a gynecologist because contraceptives might be discussed. A personal home health aide could refuse to help someone take a contraceptive. An interpreter for a deaf individual could refuse to mediate a conversation with a doctor about abortion. In these cases, a denial based on someone's personal moral objection can potentially affect every facet of life for a person with disabilities – including visitation rights, autonomy, and access to the community.

Finally, due to limited provider networks in some areas and to the important role that case managers and personal care attendants play in coordinating care, it may be more difficult for people with disabilities and older adults to find alternate providers who can help them. For example, home care agencies and home-based hospice agencies in rural areas are facing significant financial difficulties staying open. Seven percent of all zip codes in the United States do not have any hospice services available to them.[56] Finding providers competent to treat people with certain disabilities can increase the challenge. Add in the possibility of a case manager or personal care attendant who objects to helping and the barrier to accessing these services can be insurmountable. Moreover, people with disabilities who identify as LGBTQ or who belong to a historically disadvantaged racial or ethnic group may be both more likely to encounter service refusals and also face greater challenges to receive (or even know about) accommodations.

III. The proposed rule undermines longstanding ethical and legal principles of informed consent

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

[56] Julie A. Nelson & Barbara Stover Gingerich, *Rural Health: Access to Care and Services*, 22 HOME HEALTH CARE MGMT. PRAC. (2010), *available at* http://globalag.igc.org/ruralaging/us/2010/access.pdf.

The proposed rule threatens informed consent, a necessary principle of patient-centered decision-making. Informed consent relies on disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[57] This right relies on two factors: access to relevant and medically accurate information about treatment choices and alternatives, and provider guidance based on generally accepted standards of practice. Both factors make trust between patients and health care professionals a critical component of quality of care.

The proposed rule purports to improve communication between patients and providers, but instead, will deter open, honest conversations that are vital to ensuring that a patient is able to be in control of their medical circumstances. For example, the proposed rule suggests that someone could refuse to offer information, if that information might be used to obtain a service to which the refuser objects. Such an attenuated relationship to informed consent could result in withholding information far beyond the scope of the underlying statutes, and would violate medical standards of care.

In recent decades, the U.S. medical community has primarily looked to informed consent as key to assuring patient autonomy in making decisions.[58] Informed consent is intended to help balance the unequal balance of power between health providers and patients and ensure patient-centered decision-making. Moreover, consent is not a yes or no question but rather is dependent upon the patient's understanding of the procedure that is to be conducted and the full range of treatment options for a patient's medical condition. Without informed consent, patients will be unable to make medical decisions that are grounded in agency, their beliefs and preferences, and that meet their personal needs. This is particularly problematic, as many communities, including women of color and women living with disabilities, have disproportionately experienced abuse and trauma at the hands of providers and institutions.[59] In order to ensure that patient decisions are based on free will, informed consent must be upheld in the patient-provider relationship. The proposed rule threatens this principle and may very well force individuals into harmful medical circumstances.

[57] TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).
[58] BEAUCHAMP & CHILDRESS, *supra* note 58; Robert Zussman, *Sociological perspectives on medical ethics and decision-making*, 23 ANN. REV. SOC. 171-89 (1997).
[59] Gutierrez, E. R. *Fertile Matters: The Politics of Mexican Origin Women's* Reproduction, 35-54 (2008) (discussing coercive sterilization of Mexican-origin women in Los Angeles); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 411-12 (2000) (referencing one 1974 study indicating that Indian Health Services would have coercively sterilized approximately 25,000 Native American Women by 1975); Alexandra Minna Stern, *Sterilized in the Name of Public Health*, 95 AM. J. PUB. H. 1128, 1134 (July 2005) (discussing African-American women forced to choose between sterilization and medical care or welfare benefits and Mexican women forcibly sterilized). *See also Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding state statute permitting compulsory sterilization of "feeble-minded" persons); Vanessa Volz, *A Matter of Choice: Women With Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 WOMEN RTS. L. REP. 203 (2006) (discussing sterilization reform statutes that permit sterilization with judicial authorization).

According to the American Medical Association: "The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."[60] The American Nurses Association ("ANA") similarly requires that patient autonomy and self-determination are core ethical tenets of nursing. According to the ANA, "Patients have the moral and legal right to determine what will be done with their own persons; to be given accurate, complete and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens and available options in their treatment."[61] Similarly, pharmacists are called to respect the autonomy and dignity of each patient.[62]

Various state and federal laws require that health care professionals inform and counsel patients on specific issues such as preventing the spread of HIV/AIDS, non-directional information on family planning and abortion options, and emergency contraception to prevent pregnancy from rape.[63] In *Brownfield v. Daniel Freeman Marina Hospital*, a California court addressed the importance of patients' access to information concerning emergency contraception. The court found that:

> "The duty to disclose such information arises from the fact that an adult of sound mind has 'the right, in the exercise of control over [her] own body, to determine whether or not to submit to lawful medical treatment.' [citation omitted] Meaningful exercise of this right is possible only to the extent that patients are provided with adequate information upon which to base an intelligent decision with regard to the option available."[64]

In addition, the proposed rule does not provide any protections for health care professionals who want to provide, counsel, or refer for health care services that are implicated in this rule, for example, reproductive health or gender affirming care. 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.[65] Due to the rule's aggressive enforcement mechanisms and its vague and confusing language, providers may fear to give care or information. The inability of providers to give comprehensive, medically accurate information and options that will help patients make the best health decisions violates medical principles such as,

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[60] *The AMA Code of Medical Ethics' Opinions on Informing Patients: Opinion 9.09 – Informed Consent*, 14 AM. MED. J. ETHICS 555-56 (2012), http://journalofethics.ama-assn.org/2012/07/coet1-1207.html.

[61] *Code of ethics for nurses with interpretive statements, Provision 1.4 The right to self-determination*, AM. NURSES ASS'N (2001), https://www.truthaboutnursing.org/research/codes/code_of_ethics_for_nurses_US.html.

[62] *Code of Ethics for Pharmacists*, AM. PHARMACISTS ASS'N (1994).

[63] *See, e.g.*, *State HIV Laws*, CTR. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/hiv/policies/law/states/index.html (last visited Nov. 13, 2017, 1:22PM); *Emergency Contraception*, GUTTMACHER INST. (Oct. 1, 2017), https://www.guttmacher.org/state-policy/explore/emergency-contraception.

[64] *Brownfield v. Daniel Freeman Marina Hospital*, 256 Cal. Rptr. 240 (Ct. App. 1989).

[65] *See* 42 U.S.C. § 300a-7(c).

beneficence, nonmaleficence, respect for autonomy, and justice. In particular, the principle of beneficence "requires that treatment and care do more good than harm; that the benefits outweigh the risks, and that the greater good for the patient is upheld."[66] In addition, the proposed rule undermines principles of quality care. Health care should be safe, effective, patient-centered, timely, efficient, and equitable.[67] Specifically, the provision of the care should not vary due to the personal characteristics of patients and should ensure that patient values guide all clinical decisions.[68] The expansion of religious refusals as envisioned in the proposed rule may compel providers to furnish care and information that harms the health, well-being, and goals of patients.

In particular, the principles of informed consent, respect for autonomy, and beneficence are important when individuals are seeking end of life care. These patients should be the center of health care decision-making and should be fully informed about their treatment options. Their advance directives should be honored, regardless of the physician's personal objections. Under the proposed rule, providers who object to various procedures could impose their own religious beliefs on their patients by withholding vital information about treatment options— including options such as voluntarily stopping eating and drinking, palliative sedation or medical aid in dying. These refusals would violate these abovementioned principles by ignoring patient needs, their desires, and autonomy and self-determination at a critical time in their lives. Patients should not be forced to bear the brunt of their provider's religious or moral beliefs regardless of the circumstances.

IV. The regulations fail to consider the impact of refusals on persons suffering from substance use disorders (SUD)

The over breadth of this proposed rule could be devastating to people with Substance Use Disorder (SUD). Rather than promoting the evidence-based standard of care, the rule could allow anyone from practitioners to insurers to refuse to provide, or even recommend, Medication Assisted Treatment (MAT) and other evidence-based interventions due simply to a personal objection.

The opioid epidemic continues to claim too many lives. According to the Centers for Disease Control and Prevention (CDC), over 63,000 people in the U.S. died from drug overdose in 2016.[69] The latest numbers show a 2017 increase in emergency department overdose admissions of 30% across the country, and up to 70% in some areas of the Midwest.[70]

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[66] Amy G. Bryant & Jonas J. Schwartz, *Why Crisis Pregnancy Centers Are Legal but Unethical*, 20 AM. MED. ASS'N J. ETHICS 269, 272 (2018).

[67] INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 3 (Mar. 2001), *available at* http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf.

[68] *Id.*

[69] Holly Hedegaard M.D., et al. *Drug Overdose Deaths in the United States, 1999-2016*, NAT'L CTR. FOR HEALTH STATISTICS1-8 (2017).

[70] *Vital Signs*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/vitalsigns/opioid-overdoses/.

The clear, evidence-based treatment standard for opioid use disorder (OUD) is MAT.[71] Buprenorphine, methadone, and naltrexone are the three FDA-approved drugs for treating patients with opioid use disorder. MAT is so valuable to treatment of addiction that the World Health Organization considers buprenorphine and methadone "Essential Medications."[72] Buprenorphine and methadone are, in fact, opioids. However, while they operate on the same receptors in the brain as other opioids, they do not produce the euphoric effect of other opioids but simply keep the user from experiencing withdrawal symptoms. They also keep patients from seeking opioids on the black market, where risk of death from accidental overdose increases. Patients on MAT are less likely to engage in dangerous or risky behaviors because their physical cravings are met by the medication, increasing their safety and the safety of their communities.[73] Naloxone is another medication key to saving the lives of people experiencing an opioid overdose. This medication reverses the effects of an opioid and can completely stop an overdose in its tracks.[74] Information about and access to these medications are crucial factors in keeping patients suffering from SUD from losing their jobs, losing their families, and losing their lives.

However, stigma associated with drug use stands in the way of saving lives.[75] America's prevailing cultural consciousness, after decades of treating the disease of addiction as largely a criminal justice and not a public health issue, generally perceives drug use as a moral failing and drug users as less deserving of care. For example, a needle exchange program designed to protect injection drug users from contracting blood borne illnesses such as HIV, Hepatitis C, and bacterial endocarditis was shut down in October 2017 by the Lawrence County, Indiana County Commission due to their moral objection to drug use, despite overwhelming evidence that these programs are effective at reducing harm and do not increase drug use.[76] One commissioner even quoted the Bible as he voted to shut it

[71] U.S. DEP'T HEALTH & HUM. SERV., PUB NO. (SMA)12-4214, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS (2012), https://store.samhsa.gov/shin/content/SMA12-4214/SMA12-4214.pdf; National Institute on Drug Abuse, *Effective Treatments for Opioid Addiction*, https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction.
[72] World Health Organization, 19th WHO Model List of Essential Medicines (April 2015), http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf
[73] OPEN SOC'Y INST., BARRIERS TO ACCESS: MEDICATION-ASSISTED TREATMENT AND INJECTION-DRIVEN HIV EPIDEMICS 1 (2009), https://www.opensocietyfoundations.org [https://perma.cc/YF94-88AP].
[74] *See* James M. Chamberlain & Bruce L. Klein, *A Comprehensive Review of Naloxone for the Emergency Physician*, 12 AM. J. EMERGENCY MED. 650 (1994).
[75] Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL'Y 49, 56 (2010); German Lopez, *There's a highly successful treatment for opioid addiction. But stigma is holding it back.*, VOX, Nov. 15, 2017, https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone.
[76] German Lopez, *An Indiana county just halted a lifesaving needle exchange program, citing the Bible,* VOX, Oct. 20, 2017, https://www.vox.com/policy-and-politics/2017/10/20/16507902/indiana-lawrence-county-needle-exchange.

down. Use of naloxone to reverse overdose has been decried as "enabling these people" to go on to overdose again.[77]

In this frame of mind, only total abstinence is seen as successful treatment for SUD, usually as a result of a 12-step or faith-based program. MAT is considered by many to be simply "substituting one drug for another drug."[78] This belief is so common that even the former Secretary of the Department is on the record as opposing MAT because he didn't believe it would "move the dial," since people on medication would be not "completely cured."[79] The scientific consensus is that SUD is a chronic disease, and yet many recoil from the idea of treating SUD with medication like any other illness such as diabetes or heart disease.[80] The White House's own opioid commission found that "negative attitudes regarding MAT appeared to be related to negative judgments about drug users in general and heroin users in particular."[81]

People with SUD already suffer due to stigma and have a difficult time finding appropriate care. For example, it can be difficult to find access to local methadone clinics in rural areas.[82] Other roadblocks, such as artificial caps on the number of patients to whom doctors can prescribe buprenorphine, further prevent people with SUD from receiving appropriate care.[83] Only one-third of treatment programs across the country provide MAT, even though treatment with MAT can cut overdose mortality rates in half and is considered the gold standard of care.[84] The current Secretary of the Department has noted that expanding access to MAT is necessary to save lives and that it will be "impossible" to quell the opioid epidemic without increasing the number of providers offering the evidence-based standard of care.[85] This rule, which allows misinformation and personal feelings to get in

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[77] Tim Craig & Nicole Lewis, *As opioid overdoses exact a higher price, communities ponder who should be saved*, WASH. POST, Jul. 15, 2017, https://www.washingtonpost.com/world/as-opioid-overdoses-exact-a-higher-price-communities-ponder-who-should-be-saved/2017/07/15/1ea91890-67f3-11e7-8eb5-cbccc2e7bfbf_story.html?utm_term=.4184c42f806c.
[78] Lopez, *supra* note 75.
[79] Eric Eyre, *Trump officials seek opioid solutions in WV*, CHARLESTON GAZETTE-MAIL, May 9, 2017, https://www.wvgazettemail.com/news/health/trump-officials-seek-opioid-solutions-in-wv/article_52c417d8-16a5-59d5-8928-13ab073bc02b.html.
[80] Nora D. Volkow et al., *Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic*, 370 NEW ENG. J. MED. 2063, http://www.nejm.org/doi/full/10.1056/NEJMp1402780.
[81] Report of the President's Commission on Combating Drug Addiction and the Opioid Crisis, Nov. 1, 2017, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf
[82] Christine Vestal, *In Opioid Epidemic, Prejudice Persists Against Methadone*, STATELINE, Nov. 11, 2016, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/11/11/in-opioid-epidemic-prejudice-persists-against-methadone
[83] 42 C.F.R. §8.610.
[84] Matthais Pierce, et al., *Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England*, 111:2 ADDICTION 298 (Nov. 2015); Luis Sordo, et al., Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies, BMJ (2017), http://www.bmj.com/content/357/bmj.j1550.; Alex Azar, Secretary, U.S. Dep't of Health & Hum. Serv., Plenary Address to National Governors Association, (Feb. 24, 2018), https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/plenary-addres-to-national-governors-association.html.
[85] Azar, *supra* note 84.

the way of science and lifesaving treatment, will not help achieve the goals of the administration; it will instead trigger countless numbers of deaths.

V. The proposed rule permits health care professionals to opt out of providing medical care that the public expects by allowing them to disregard evidence-based standards of care

Medical practice guidelines and standards of care establish the boundaries of medical care that patients can expect to receive and that providers should be expected to deliver. The health services impacted by refusals are often related to reproductive and sexual health, which are implicated in a wide range of common health treatment and prevention strategies. Information, counseling, referral and provisions 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. Many of these conditions disproportionately affect women of color.[86] The expansion of these refusals as outlined in the proposed rule will put women, particularly women of color, who experience these medical conditions at greater risk for harm.

Moreover, a 2007 survey of physicians working at religiously-affiliated hospitals found that nearly one in five (19 percent) experienced a clinical conflict with the religiously-based policies of the hospital.[87] While some of these physicians might refer their patients to another provider who could provide the necessary care, one 2007 survey found that as many as one-third of patients (nearly 100 million people) may be receiving care from physicians who do not believe they have any obligations to refer their patients to other providers.[88] Meanwhile, the number of Catholic hospitals in the United States has increased by 22 percent since 2001, and now own one in six hospital beds across the

[86] For example, Black women are three times more likely to be diagnosed with lupus than white women. Latinas and Asian, Native American, and Alaskan Native women also are likely to be diagnosed with lupus. Office on Women's Health, *Lupus and women*, U.S. DEP'T HEALTH & HUM. SERV. (May 25, 2017), https://www.womenshealth.gov/lupus/lupus-and-women. Black and Latina women are more likely to experience higher rates of diabetes than their white peers. Office of Minority Health, *Diabetes and African Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Jul. 13, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18; Office of Minority Health, *Diabetes and Hispanic Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (May 11, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63. Filipino adults are more likely to be obese in comparison to the overall Asian population in the United States. Office of Minority Health, *Obesity and Asian Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Aug. 25, 2017), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=55. Native American and Alaskan Native women are more likely to be diagnosed with liver and kidney/renal pelvis cancer in comparison to non-Hispanic white women. Office of Minority Health, *Cancer and American Indians/Alaska Natives*, U.S. DEP'T OF HEALTH & HUM. SERV. (Nov. 3, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=31.
[87] Debra B. Stulberg M.D. M.A., et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, J. GEN. INTERN. MED. 725-30 (2010) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881970/.
[88] Farr A. Curlin M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, NEW ENG. J. MED. 593–600 (2007) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2867473/.

country.[89] The increase of Catholic hospitals poses a danger for women seeking reliable access to medical services, many of whom do not understand the full range of services that may be denied them. One public opinion survey found that, among the less than one-third of women who understood that a Catholic hospital might limit care, only 43 percent expected limited access to contraception, and a mere 6 percent expected limited access to the morning-after pill.[90]

a. Pregnancy prevention

The importance of the ability of women to make decisions for themselves to prevent or postpone pregnancy is well established within the medical guidelines across a range of practice areas. Millions of women live with chronic conditions such as cardiovascular disease, diabetes, lupus, and epilepsy, which if not properly controlled, can lead to health risks to the pregnant woman or even death during pregnancy. Denying these women access to contraceptive information and services violates medical standards that recommend pregnancy prevention for these medical conditions. For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care.[91] 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.[92]

Moreover, women who are struggling to make ends meet are disproportionately impacted by unintended pregnancy. In 2011, 45% of pregnancies in the U.S. were unintended – meaning that they were either unwanted or mistimed.[93] Low-income women have higher rates of unintended pregnancy as they are least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy.[94] The Institute of Medicine has documented negative health effects of unwanted pregnancy for mothers and children. Unwanted pregnancy is associated with maternal morbidity and risky health behaviors as well as low-birth weight babies and insufficient prenatal care.[95]

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[89] Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, AM. CIVIL LIBERTIES UNION 22 (2017), *available at* https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[90] Nadia Sawicki, *Mandating Disclosure Of Conscience-Based Limitations On Medical Practice*, 42 AM. J. OF LAW & MED. 85-128 (2016) *available at* http://journals.sagepub.com/doi/pdf/10.1177/0098858816644717.
[91] AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE S115, S117 (2017), available at: http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf
[92] *Id.* at S114.
[93] *Unintended Pregnancy in the United States*, Guttmacher Inst. (Sept. 2016), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.
[94] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in rates of unintended pregnancy in the United States, 1994 and 2001*, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90-6 (2006).
[95] INSTITUTE OF MEDICINE COMMITTEE ON UNINTENDED PREGNANCY, THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES (Sarah S. Brown & Leon Eisenberg eds.,1995).

b. Sexually transmitted infections (STIs)

Religious refusals also affect access to sexual health care more broadly. Contraceptives and access to preventative treatment for STIs are a critical aspect of health care. The CDC estimates that 20 million new STIs occur each year. Chlamydia remains the most commonly reported infectious disease in the U.S., while HIV/AIDS remains the most life threatening. Women, especially young women, and Black women, are hit hardest by Chlamydia—with rates of Chlamydia 5.6 times higher for Black than for white Americans.[96] Consistent use of condoms results in an 80 percent reduction of HIV transmission, and the American Academy of Pediatrics, ACOG, and the World Health Organization all recommend that providers promote condom use.[97]

c. Ending a pregnancy

While there are numerous reasons for why a person would seek to end a pregnancy, there are many medical conditions in which ending a pregnancy is recommended as treatment. These conditions include: preeclampsia and eclampsia, certain forms of cardiovascular disease, and complications for chronic conditions. Significant racial disparities exist in rates of and complications associated with preeclampsia.[98] For example, the rate of preeclampsia is 61 percent higher for Black women than for white women, and 50 percent higher than women overall.[99] 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.[100] ACOG and American Heart Association recommend that a pregnancy be avoided or ended for certain conditions such as severe pulmonary hypertension.[101] Many medications can

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[96] *Sexually Transmitted Disease Surveillance 2016*, CTR. FOR DISEASE CONTROL & PREVENTION (Sept. 2017), https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf.
[97] American Academy of Pediatrics Committee on Adolescence, *Condom Use by Adolescents*, 132 PEDIATRICS (Nov. 2013), http://pediatrics.aappublications.org/content/132/5/973; American Academy of Pediatrics, American College of Obstetricians and Gynecologists, March of Dimes Birth Defects Foundation. Guidelines for perinatal care. 6th ed. Elk Grove Village, IL; Washington, DC: American Academy of Pediatrics; American College of Obstetricians and Gynecologists; 2007; American College of Obstetricians and Gynecologists. Barrier methods of contraception. Brochure (*available at* http://www.acog.org/publications/patient_education/bp022.cfm). Washington, DC: American College of Obstetricians and Gynecologists; 2008 July; World Health Organization, UNAIDS, UNFPA, *Position statement on condoms and HIV prevention*, UNICEF (2009), https://www.unicef.org/aids/files/2009_position_paper_condoms_en.pdf.
[98] Sajid Shahul et al., *Racial Disparities in Comorbidities, Complication, and Maternal and Fetal Outcomes in Women With Preeclampsia/eclampsia*, 34 HYPERTENSION PREGNANCY (Dec. 4, 2015), http://www.tandfonline.com/doi/abs/10.3109/10641955.2015.1090581?journalCode=ihip20.
[99] Richard Franki, *Preeclampsia/eclampsia rate highest in black women*, OB.GYN. NEWS (Apr. 29., 2017), http://www.mdedge.com/obgynnews/article/136887/obstetrics/preeclampsia/eclampsia-rate-highest-black-women.
[100] AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).
[101] Mary M. Canobbio et al., *Management of Pregnancy in Patients With Complex Congenital Heart Disease*, 135 CIRCULATION e1-e39 (2017); Debabrata Mukherjee, *Pregnancy in Patients With Complex Congenital Heart Disease*, AM. COLL. CARDIOLOGY (Jan. 24, 2017), http://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/01/24/14/40/management-of-pregnancy-in-patients-with-complex-chd.

cause significant fetal impairments, and therefore the U.S. Food and Drug Administration and professional medical associations recommend that women use contraceptives to ensure that they do not become pregnant while taking these medications.[102] In addition, some medical guidelines counsel patients to end a pregnancy if they are taking certain medications for thyroid disease.[103]

d. Emergency contraception

The proposed rule will magnify the harm in circumstances where women are already denied the standard of care. Catholic hospitals have a record of providing substandard care or refusing care altogether to women for a range of medical conditions and crises that implicate reproductive health. For example, in a 2005 study of Catholic hospital emergency rooms by Ibis Reproductive Health for Catholics for Choice, it was found that 55 percent would not dispense emergency contraception under any circumstances.[104] Twenty three percent of the hospitals limited EC to victims of sexual assault.[105]

These hospitals violated the standards of care established by medical providers regarding treatment of sexual assault. Medical guidelines state that survivors of sexual assault should be provided emergency contraception subject to informed consent and that it should be immediately available where survivors are treated.[106] At the bare minimum, survivors should be given comprehensive information regarding emergency contraception.[107]

e. Artificial Reproductive Technology (ART)

Refusals to provide the standard of care to LGBTQ individuals because of their sexual orientation or gender identity can affect access to care across a broad spectrum of health concerns, which includes primary and specialty care settings. One example of refusals that affects LGBTQ patients, as well as non-LGBTQ patients, is refusals to educate about, provide, or cover ART procedures for religious reasons. For individuals with cancer, the

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[102] ELEANOR BIMLA SCHWARZ M.D. M.S., et al., *Documentation of Contraception and Pregnancy When Prescribing Potentially Teratogenic Medications for Reproductive-Age Women*, 147 Annals of Internal Medicine. (Sept. 18, 2007).

[103] For example, the American College of Obstetricians and Gynecologists specifically recommends that if a woman taking Iodine 131 becomes pregnant, her physician should caution her to consider the serious risks to the fetus, and consider termination. American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 37: Thyroid disease in pregnancy* 100 OBSTETRICS & GYNECOLOGY 387-96 (2002).

[104] Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 ANNALS EMERGENCY MED. 105-10 (Aug. 2005), http://www.annemergmed.com/article/S0196-0644(05)00083-1/pdf

[105] *Id.* at 105.

[106] *Committee Opinion 592: Sexual Assault*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Apr. 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co592.pdf?dmc=1&ts=20170213T2116487879; *Management of the Patient with the Complaint of Sexual Assault*, AM. COLL. EMERGENCY MED. (Apr. 2014), https://www.acep.org/Clinical---Practice-Management/Management-of-the-Patient-with-the-Complaint-of-Sexual-Assault/#sm.00000bexmo6ofmepmultb97nfbh3r.

[107] *Access to Emergency Contraception H-75.985*, AMA (2014), https://policysearch.ama-assn.org/policyfinder/detail/emergency%20contraception%20sexual%20assault?uri=%2FAMADoc%2FHOD.xml-0-5214.xml.

standard of care includes education and informed consent around fertility preservation, according to the American Society for Clinical Oncology and the Oncology Nursing Society.[108] Refusals to educate patients about or to provide ART occur for two reasons: refusals based on religious beliefs about ART itself and refusals to provide ART to LGBTQ individuals because of their LGBTQ identity. In both situations, refusals to educate patients about ART and fertility preservation, and to facilitate ART when requested, are against the standard of care.

The lack of clarity in the rule could lead a hospital or an individual provider to refuse to provide ART to same-sex couples based on religious belief. For some couples, this discrimination would increase the cost and emotional toll of family building. In some parts of the country, however, these refusals would be a complete barrier to parenthood. More broadly, these refusals deny patients the human right and dignity to be able to decide to have children, and cause psychological harm to patients who are already vulnerable because of their health status or their experience of health disparities.

f. HIV Health

For HIV, in addition to consistent condom use, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are an important part of prevention for those at high risk for contracting HIV. ACOG recommends that PrEP be considered for individuals at high risk of contracting HIV.[109] Under the proposed rule, an insurance company could refuse to cover PrEP or PEP because of a religious belief. Refusals to promote and facilitate condom use because of religious beliefs and refusals to prescribe PrEP or PEP because of a patient's perceived or actual sexual orientation, gender identity, or perceived or actual sexual behaviors is in violation of the standards of care and harms patients already at risk for experiencing health disparities. Both PrEP and PEP have been shown to be highly effective in preventing HIV infection. Denying access to this treatment would adversely affect vulnerable, highest risk populations including gay and bisexual men.

VI. The proposed rule misinterprets statutory language governing Medicaid managed care organizations

The proposed rule misinterprets narrowly tailored language governing Medicaid managed care organizations (MCOs), and instead creates a freestanding religious exemption.[110]

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[108] Alison W. Loren et al., *Fertility Preservation for Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500-10 (July 1, 2013); Ethics Committee of the American Society for Reproductive Medicine, *Fertility preservation and reproduction in patients facing gonadotoxic therapies: a committee opinion*, 100 AM. SOC'Y REPROD. MED. 1224-31 (Nov. 2013), http://www.allianceforfertilitypreservation.org/_assets/pdf/ASRMGuidelines2014.pdf; Joanne Frankel Kelvin, *Fertility Preservation Before Cancer Treatment: Options, Strategies, and Resources*, 20 CLINICAL J. ONCOLOGY NURSING 44-51 (Feb. 2016).

[109] ACOG *Committee Opinion 595: Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (May 2014), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Preexposure-Prophylaxis-for-the-Prevention-of-Human-Immunodeficiency-Virus.

[110] 83 Fed. Reg. 3926.

Under current law, MCOs are prohibited from restricting a provider's ability to offer counseling and information regarding treatment and care that is within the lawful scope of the provider's practice regardless of whether these services are covered by the MCO.[111] However, the MCO does not need to pay for counseling or referral related to a service to which they object on the basis of religious or moral beliefs.[112] The underlying religious exemption is intended only to qualify the statute's prohibition on interference with doctor-patient communications of Medicaid managed care enrollees. Because the underlying statutory exemption is a provision of statutory construction, Congress could not have intended this provision to be a blanket provision for Medicaid managed care organizations.[113] Moreover, the proposed rule omits enrollee protections required by the underlying statute when a Medicaid managed care organization declines to cover referral or counseling on the basis of religious of moral beliefs. Current and prospective enrollees must receive written notice and information on policies regarding counseling or referral or changes to such policies before and during enrollment and within 90 days after a change to policy has occurred.[114] The language of the proposed rule misinterprets and far exceeds the plain language of the statute and may discourage Medicaid managed care organizations from complying with notice requirements to the detriment of enrollees.

VII. The proposed rule does not take into account the law governing emergency health situations

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.[115] Under EMTALA, every hospital is required to comply – even those that are religiously affiliated.[116] Because the proposed rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may

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[111] 42 U.S.C. § 1396u-2(b)(3)(A).

[112] *Id.* § 1396u-2(b)(3)(B)(i).

[113] *See e.g.*, *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 376 n.5 (1986) (stating that statutes may provide their own rules of statutory construction to ensure that the statute is read correctly). Moreover, when a general statement of policy is qualified by an exception, the exception is read narrowly to preserve the primary operation of the provision. *C.I.R. v. Clark*, 489 U.S. 726, 739 (1989) (citing *Phillips, Inc. V. Walling*, 324 U.S. 490, 493 (1945) ("To extend an exemption to other than those plainly and unmistakably within its terms and spirit is to abuse the interpretative process and to frustrate the announced will of the people").

[114] 42 U.S.C. § 1396u-2(b)(3)(B)(ii).

[115] 42 U.S.C. § 1295dd(a)-(c) (2003).

[116] 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).

believe they are not required to comply with EMTALA's requirements. As a result, patients experiencing medical emergencies may not receive the care they need.

VIII. The proposed rule violates the Establishment Clause

The Establishment Clause of the First Amendment bars the government from granting religious and moral exemptions that would harm any third party.[117] It requires the Department to "take adequate account of the burdens" that an exemption "may impose on nonbeneficiaries" and must ensure that any exemption is "measured so that it does not override other significant interests."[118]

The Supreme Court acknowledged the limitations imposed by the Establishment Clause in *Burwell v. Hobby Lobby Stores, Inc.*, declaring the effect on employees of an accommodation provided to employers under the Religious Freedom Restoration Act (RFRA) "would be precisely zero."[119] Justice Kennedy emphasized that an accommodation must not "unduly restrict other persons, such as employees, in protecting their own interests."[120] The proposed exemptions clearly impose burdens on, and harm others, and thus, violate the clear mandate of the Establishment Clause.

IX. The regulations are overly broad, vague, and will cause confusion in the health care delivery system

The regulations dangerously expand the application of the underlying statutes by offering an extremely broad definition of who can refuse and what they can refuse to do. Under the proposed rule, any one engaged in the health care system could refuse services or care. The proposed rule defines workforce to include "volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity."[121] Under this definition, could any member of the health care workforce refuse to serve a patient in any way – could a nurse assistant refuse to serve lunch to a transgender patient, could a billing specialist refuse to help a patient who had sought contraceptive counseling?

a. *Discrimination*

The failure to define the term "discrimination" will cause confusion for providers, and as employers, expose them to liability. Title VII already requires that employers accommodate employees' religious beliefs to the extent there is no undue hardship on the employer.[122] The regulations make no reference to Title VII or current EEOC guidance, which prohibits discrimination against an employee based on that employee's race, color, religion, sex, and

[117] E.g., *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Cutter v. Wilkinson*, 544 U.S.709, 720, 726 (2005); *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 18 n.8 (1989).
[118] *Cutter*, 544 U.S. at 720, 722; see also *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709-10 (1985).
[119] *Hobby Lobby*, 134 S. Ct. 2751, 2760 (2014).
[120] *Id.* at 2786-87 (Kennedy, J., concurring).
[121] 83 Fed. Reg. 3894.
[122] 42 U.S.C. § 2000e-2.; *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

national origin.[123] The proposed rule should be read to ensure that the long-standing balance set in Title VII between the right of individuals to enjoy reasonable accommodation of their religious beliefs and the right of employers to conduct their businesses without undue interference is to be maintained.

If this balance is not maintained, the language in the proposed rule could force health care providers to hire people who intend to refuse to perform essential elements of a position. For example, the proposed rule lacks clarity about whether a Title X-funded health center's decision not to hire a counselor or clinician who objected to provide non-directive options counseling as an essential job function of their position would be deemed discrimination under the rule. Furthermore, the proposed rule does not provide guidance on whether it is impermissible "discrimination" for a Title X-funded state or local health department to transfer such a counselor or clinician to a unit where pregnancy counseling is not done. By failing to define "discrimination," supervisors in health care settings will be unable to proceed in the orderly delivery of health care services, putting women's health at risk. The proposed rule impermissibly muddies the interpretation of Title VII and current EEOC guidance. If implemented, health care entities may be forced to choose between complying with a fundamentally misguided proposed rule and long-standing interpretation of Title VII.

Finally, the proposed rule's lack of clarity regarding what constitutes discrimination, may undermine non-discrimination laws. Because of the potential harm to individuals if religious refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.[124] Instead, courts have held that the government has a compelling interest in ending discrimination and that anti-discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race," and are narrowly tailored to meet that "critical goal."[125] The uncertainty regarding how the proposed rule will interact with non-discrimination laws is extremely concerning.

b. *Assist in the performance*

The definition of "assist in the performance" greatly expands the types of services that can be refused beyond any reasonable stretch of the imagination. The proposed rule defines

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[123] *Id.*

[124] *See e.g.*, *Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government's interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that "the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family"); *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

[125] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, slip op. at 46 (2014).

"assistance" to include participation "in any activity with an *articulable connection* to a procedure, health service or health service program, or research activity."[126] In addition, the Department includes activities such as "making arrangements for the procedure."[127] If workers in very tangential positions, such as schedulers, are able to refuse to do their jobs based on personal beliefs, the ability of any health system or entity to plan, to properly staff, and to deliver quality care will be undermined. Employers and medical staff may be stymied in their ability to establish protocols, policies and procedures under these vague and broad definitions. The proposed rule creates the potential for a wide range of workers to interfere with and interrupt the delivery of health care in accordance with the standard of care.

The regulations also leave unclear whether a worker can assert his or her moral belief in refusing to treat patients based on their identity or deny care for reasons outside of religious or moral beliefs. Even though women living with disabilities report engaging in sexual activities at the same rate as women who do not live with disabilities, they often do not receive the reproductive health care they need for multiple reasons, including lack of accessible provider offices and misconceptions about their reproductive health needs.[128] Biased counseling can contribute to unwanted health outcomes and exacerbate health disparities.[129] The proposed rule is especially alarming, as it does not articulate a definition of moral beliefs. The prejudices of a health care professional could easily inform their beliefs and consequently, serve as the basis of denying care to an individual based on characteristics alone. The proposed rule will foster discriminatory health care settings and interactions between patients and providers that are informed by bias instead of medically accurate, evidence-based, patient-centered care.

Moreover, in the preamble, the proposed rule states that the exemptions that Weldon provides is not limited to refusals of abortion care on the basis of religious or moral beliefs.[130] Due to this, health care professionals may think they can deny abortion care and other health services just because they do not want to provide the service. The preamble uses language such as "those who choose not to provide" or "Would rather not" as justification for a refusal. This is more concerning because the proposed rule contains no mechanism to ensure that patients receive the care they need if their provider refuses to furnish a service. The onus will be on the patient to question whether her hospital, medical doctor, or health care professional has religious, moral, or other beliefs that would lead them to deny services or if services were denied, the basis for refusal. This is likely to occur, as the proposed rule does not have any provisions that stipulate that patients must

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[126] 83 Fed. Reg. 3892.
[127] *Id.*
[128] RM Haynes et al., *Contraceptive Use at Last Intercourse Among Reproductive-Aged Women with Disabilities: An Analysis of Population-Based Data from Seven States*, CONTRACEPTION (2017), https://www.ncbi.nlm.nih.gov/pubmed/29253580; *See generally* Alex Zielinski, *Why Reproductive Health Can Be A Special Struggle for Women with Disabilities*, THINKPROGRESS, Oct. 1, 2015, https://thinkprogress.org/why-reproductive-health-can-be-a-special-struggle-for-women-with-disabilities-73ececea23c4/.
[129] In one study in Massachusetts, women living with intellectual and developmental disabilities, including those who were Black and Latina, faced increased risks of preterm delivery and very low and low birth weight babies. M. Mitra et al., *Pregnancy Outcomes Among Women with Intellectual and Developmental Disabilities*, AM. J. PREV. MED. (2015), https://www.ncbi.nlm.nih.gov/pubmed/25547927.
[130] 83 Fed. Reg. 3890-91.

be given notice that they may be refused certain health care services on the basis of religious or moral beliefs.

c. Referral

The definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information based on which an individual could get the care they need. Any information distributed by any method, including online or print, regarding any service, procedure, or activity could be refused by an entity if the information given would lead to a service, activity, or procedure that the entity or health care entity objects. Under this definition, could a medical doctor refuse to provide a website describing the medical conditions which contraception treats? Or could an entity refuse to provide a list of LGBTQ-friendly providers? In addition, the Department states that the underlying statutes of the proposed rule permits entities to deny help to anyone who is likely to make a referral for an abortion or for other services.[131] The breadth and vagueness of this definition will possibly lead providers to refrain from providing information vital to patients out of anxiety and confusion of what the proposed rule permits them to do.

d. Health Care Entity

The proposed rule's definition of "health care entity" conflicts with federal religious refusal laws such as the Coats and Weldon Amendments, thus fostering confusion regarding which entities are required to comply with the proposed rule and existing federal religious refusals. Specifically, under the Coats and Weldon Amendments a "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in health care delivery. Under the proposed rule, a plan sponsor "not primarily engaged in the business of health care" would be deemed a "health care entity."[132] This definition would mean that an employer acting as a third party administrator or sponsor could count as a "health care entity" and deny coverage. In 2016, OCR found that religiously affiliated employers were not health care entities under the Weldon amendment.[133]

Moreover, the Department states that their definition of "health care entity" is "not an exhaustive list" for concern that the Department would "inadvertently omit[ting] certain types of health care professionals or health care personnel."[134] Additionally, the proposed rule incorporates entities as defined in 1 U.S.C. 1 which includes corporations, firms, societies, etc.[135] States and public agencies and institutions are also deemed to be entities.[136] The Department's inclusion of entities who are primarily not engaged in the health care delivery system highlights the true purpose of the proposed rule, to permit a greater number of entities to interfere in the provider-patient relationship and deter a patient from making the best decision based on their circumstances, preferences, and beliefs.

[131] *Id.* at 3895.
[132] *Id.* at 3893.
[133] Office for Civil Rights, Decision Re: OCR Transaction Numbers: 14-193604, 15-193782 & 15-195665, 4 (Jun. 21, 2016) (letter on file with NHeLP-DC office).
[134] 83 Fed. Reg. 3893.
[135] *Id.*
[136] *Id.*

X. The Department failed to follow procedural requirements

This proposed rule suffers from a number of additional inadequacies, including:

- The Department fails to provide "adequate reasons" or a "satisfactory explanation" for this rulemaking based on the underlying facts and data. Under the Administrative Procedures Act, an agency must provide "adequate reasons" for its rulemaking, in part by "examin[ing] the relevant data and articulat[ing] a satisfactory explanation for its action including a rational connection between the fact found and the choice made."[137] As stated in the proposed rule, between 2008 and November 2016, OCR received 10 complaints alleging violations of federal religious refusal laws; OCR received an additional 34 similar complaints between November 2016 and January 2018.[138] By comparison, during a similar time period from fall 2016 to fall 2017, OCR received *over 30,000 complaints* alleging either civil rights or HIPAA violations. These numbers demonstrate that rulemaking to enhance enforcement authority over religious refusal laws is not warranted.

- The Department fails to adequately assess the costs imposed by this proposed rule, including both underestimating quantifiable costs, and completely neglecting to address the costs that would result from delayed or denied care. Under Executive Order 13563, an agency must "tailor its regulations to impose the least burden on society" and choose "approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity)."[139] The Department completely neglects to address the costs that would result from delayed or denied care. This proposed rule completely fails to account for increased medical and social costs that come from delayed or denied care. Health care refusals without adequate safeguards may also have negative consequences on the long-term socioeconomic status of women. A recent study in the American Journal of Public Health found that women who were denied a wanted abortion were three times more likely to be unemployed than women who obtained abortions.[140] Thus, the health care refusals that may increase because of this rule could lead to delays or effective denials of care that would not only affect women's immediate health costs but also have fundamental negative consequences in the long term—factors that the Department completely fails to acknowledge or take into account in this proposed rule.

- The Department and Office of Management and Budget ("OMB") have failed to take the appropriate steps to ensure that the regulation does not conflict with the policies or actions of other agencies. Under Executive Order 12866, in order to ensure that each agency does not promulgate regulations that are "inconsistent, incompatible, or

[137] *Encino Motorcars, LLC v. Navarro*, 136 S.Ct. 2117, 2125 (June 20, 2016) (citing *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 103 (1983)).
[138] 83 Fed. Reg. 3886.
[139] Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Sec. 1 (b).
[140] Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AM. J. PUB. H. 407 (2018), http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304247.

duplicative with its other regulations of those of other Federal agencies," each agency must include any significant regulatory actions in the Unified Regulatory Agenda.[141] The Department failed to include any reference to this significant regulation in its regulatory plans, and therefore failed to put impacted entities, including other federal agencies, on notice of possible rulemaking in this area. In addition, prior to publication in the Federal Register, the proposed rule must be submitted to the Office of Information and Regulatory Affairs (OIRA), within the OMB, to provide "meaningful guidance and oversight so that each agency's regulatory actions are consistent with applicable law, the President's priorities, and the principles set forth in this Executive order [12866] and do not conflict with the policies or actions of another agency."[142] According to OIRA's website, the Department submitted the proposed rule to OIRA for review on January 12, 2018, one week prior to the proposed rule being issued in the Federal Register. Standard review time for OIRA is often between 45 and 90 days. One week was plainly insufficient time for OIRA to review the rule, including evaluating the paperwork burdens associated with implementing this proposed rule. In addition, it is extremely unlikely that within that one-week timeframe, OIRA could or would have conducted the interagency review necessary to ensure that this proposed rule does not conflict with other federal statutes or regulations.

Conclusion

The National Health Law Program opposes the proposed rule as it expands religious refusals to the detriment of patients' health and well-being. We are concerned that these regulations, if implemented, will interfere in the patient-provider relationship by undermining informed consent. The proposed rule will allow any one in the health care setting to refuse health care that is evidence-based and informed by the highest standards of medical care. The outcome of this regulation will harm communities who already lack access to care and endure discrimination.

Thank you for your attention to our comments. If you have any questions, please reach out to Susan Berke Fogel, Director of Reproductive Health, at fogel@healthlaw.org.

Sincerely,

Elizabeth G. Taylor
Executive Director

[141] Executive Order 12866, at § 4(b),(c).
[142] *Id.* at § 6(b).

NHeLP
NATIONAL HEALTH LAW PROGRAM

Exhibit 131

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VIA ELECTRONIC SUBMISSION AT REGULATIONS.GOV

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 209F
200 Independence Avenue SW
Washington, DC 20201

RE: RIN 0945-ZA03
Comments on DHHS Notice of Proposed Rulemaking Concerning "Protecting Statutory Conscience Rights" in Health Care; Delegations of Authority

Dear Director Severino:

The National Immigration Law Center ("NILC") submits the following 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 (83 Fed, Reg. 3880 (Jan. 26, 2018)).

NILC specializes in the intersection of health care and immigration laws and policies, providing technical assistance, training, and publications to government agencies, labor unions, non-profit organizations, and health care providers across the country. For over 30 years, NILC has worked to promote and ensure access to health services for low-income immigrants and their family members.

As an organization focused on defending and advancing the rights of low income immigrants, we are deeply concerned with the ways in which these regulations fail to account for the significant burden that will fall disproportionately on immigrants and all people of color. Immigrant women and immigrants who identify as Lesbian, Gay, Bisexual, Transgender, and Queer ("LGBTQ") already experience severe health disparities and discrimination, conditions that will be exacerbated by the proposed rule, resulting in in poorer health outcomes.

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We object to the proposal that OCR direct its limited resources toward the subject of this rule, and to the newly created "Conscience and Religious Freedom Division" 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. Immigrant communities rely on OCR to enforce regulations implementing the Title VI protection that individuals with Limited English Proficiency (LEP) are not subject to discrimination based on national origin.[1] According to the Pew Research Center 49 percent of foreign born individuals are not proficient English speakers (data from the 2010 Census and 2013-15 American Community Surveys).[2] Yet OCR's enforcement of the Title VI protection is inadequate, with the result that LEP patients have been consistently shown to receive lower quality health care than English-proficient patients on various measures: understanding of treatment plans and disease processes, satisfaction, and incidence of medical errors resulting in physical harm.[3] For these reasons, NILC calls on the Department and OCR to withdraw the proposed rule in its entirety.

I. The proposed regulation would divert OCR from its agency mission by shifting resources that should be used to address the rights of populations subject to acute discrimination and health disparities.

The proposed regulation would inappropriately favor the supposed protection of individuals with certain religious and moral convictions at the expense of protections against the kind of documented experiences of discrimination leading to health disparities which OCR is designed by statute to address, notably under Title VI and Section 1557 of the Patient Protection and Affordable Care Act ("ACA").[4] With its origin in protecting against this type of discrimination, the agency must look closely at how any changes would affect this mission before creating new regulations.

As many other commentators will likely note, discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[5] Numerous federal courts have found that

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[1] 42 U.S.C. §2000d (stating that "no person in the United States shall, on the grounds of race, color, or national origin" be subject to discrimination in federally funded program), § 200d-1 (authorizing the establishment of the regulations and offices for civil rights within federal agencies to enforce prohibitions on discrimination).

[2] Gustavo López and Kristen Bialik, *Key findings about U.S. immigrants*, PEW RESEARCH CENTER (May 3, 2017), http://www.pewresearch.org/fact-tank/2017/05/03/key-findings-about-u-s-immigrants.

[3] Alexander R. Green, MD, MPH, and Chijioke Nze, Language-Based Inequity in Health Care: Who Is the "Poor Historian"?, *AMA Journal of Ethics*. March 2017, Volume 19, Number 3: 263-271.

[4] 42 U.S.C. § 18116 (tasking HHS with enforcing a number of civil rights laws which ban discrimination on additional discriminations, such as gender).

[5] *See, e.g.*, *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018).

federal sex discrimination statutes reach these forms of gender-based discrimination.[6] In 2012, the Equal Employment Opportunity Commission ("EEOC") likewise held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[7] This is a serious civil rights violation that OCR, under Section 1557 of the ACA, should be addressing.

The agency must therefore consider the impact on these populations in considering whether the proposed regulation is an appropriate action for the agency. As national advocates focused on the health of immigrants, NILC urges OCR and the Department to consider how particular sectors of the immigrant population would be harmed by this rule. Immigrants are among the most disproportionately uninsured people in the United States, a harm which is compounded by disparities in health disparities among women and LGBTQ persons. The uninsured rates for citizens (9 percent) is nearly half of lawfully present immigrants (17 percent), even though many of the latter are eligible for health coverage programs but not enrolled. In fact, according to the Kaiser Family Foundation, a larger percentage of unenrolled citizens have a factor making them ineligible for coverage or financial assistance (38 percent) than lawfully present immigrants (31 percent).[8] This is compounded by dynamics of an individual's race and sexual orientation: among adult women, 15.2 percent of those who identified as lesbian or gay reported being unable to obtain medical care in the last year due to cost, as compared to 9.6 percent of straight individuals.[9] These are documented health disparities, which OCR can and should be doing more to investigate under Section 1557 of the ACA.

II. The proposed regulation would harm the health outcomes of immigrant women and women of color by allowing further divergence of access to certain services for these populations.

Among individuals with access to health care, women's race and immigration status play a role in how they receive health services, access which would be harmed further by this rule. According to a recent report, doctors often fail to inform black women of the full range of reproductive health options regarding labor or delivery possibly due to

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[6] *See, e.g.*, *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co*., 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

[7] *Macy v. Holder*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).

[8] *Health Coverage of Immigrants*, KAISER FAMILY FOUNDATION (Dec. 13, 2017), https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants.

[9] Brian P. Ward et al., *Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey*, NAT'L CTR. FOR HEALTH STATISTICS, 2013 9 (2014), https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf.

stereotypes about black women's sexuality and reproduction.[10] Young black women noted that they were shamed by providers when seeking sexual health information and contraceptive care in part, due to their age, and in some instances, sexual orientation.[11] Moreover, the Centers for Disease Control and Prevention reports that black mothers experience maternal mortality at three times the rate of whites.[12]

New research also shows that women of color in many states disproportionately receive their care at Catholic hospitals.[13] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs), which provide guidance on wide range of hospital matters, including reproductive health care. In practice, the ERDs prohibit the provision of emergency contraception, sterilization, abortion, fertility services, and some treatments for ectopic pregnancies. 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, risking their health.[14] The proposed rule will give health care providers, such as Catholic hospitals, a license to opt out of evidence-based care that the medical community endorses. If this rule were to be implemented, more women, particularly women of color, will be put in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services. For many, this choice does not exist.

This problem is particularly acute for immigrant, Latina women and their families who often face cultural and linguistic barriers to care, especially in rural areas.[15] These women often lack access to transportation and may have to travel great distances to get the care

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[10] CTR. FOR REPROD. RIGHTS, NAT'L LATINA INST. FOR REPROD. HEALTH & SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter *Reproductive Injustice*]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), *available at* http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

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

[12] Centers for Disease Control and Prevention, Trends in Pregnancy-Related Deaths, available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

[13] Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, Pub. Rights Private Conscience Project (2018), *available at* https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[14] Lori R. Freedman et al., *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/.

[15] Michelle M. Casey et al., *Providing Health Care to Latino Immigrants: Community-Based Efforts in the Rural Midwest,* AM. J. PUB. HEALTH (2011), *available at* http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1709.

they need.[16] In rural areas there may simply be no other sources of health and life-preserving medical care. When these women encounter health care refusals, they have nowhere else to go. This is the kind of discrimination OCR should be protecting against.

III. The proposed regulation would allow OCR to turn a blind eye to the rampant discrimination faced by LGBTQ individuals, which would cause particular harm to LGBTQ immigrants.

LGBTQ people continue to face discrimination in many areas of their lives, including health care, on the basis of their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[17] A survey conducted by Lambda Legal found that in 2009, lesbian, gay, and bisexual immigrants and immigrants living with HIV reported higher levels of discrimination than non-immigrant individuals, and the numbers were especially high for immigrants of color.[18] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.[19] They concluded that discrimination as well as insensitivity or disrespect on the part of health care providers were key barriers to health care access and that increasing efforts to provide culturally sensitive services would help close the gaps in health care access.[20]

There are documented outcomes of discrimination against LGBTQ people:

- Twenty-nine percent of transgender individuals experienced a health care provider's refusal to see them on the basis of their perceived or actual gender identity, and 29 percent experienced unwanted physical contact from a health care provider.[21]

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[16] NAT'L LATINA INST. FOR REPROD. HEALTH & CTR. FOR REPROD. RIGHTS, NUESTRA VOZ, NUESTRA SALUD, NUESTRO TEXAS: THE FIGHT FOR WOMEN'S REPRODUCTIVE HEALTH IN THE RIO GRANDE VALLEY, 7 (2013), *available at* http://www.nuestrotexas.org/pdf/NT-spread.pdf.

[17] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 8, 2018).

[18] *LGBT Immigrants and Immigrants living with HIV*, LAMBDA LEGAL, https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_lgbt-immigrants-and-immigrants-living-with-hiv.pdf.

[19] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.

[20] *Id.*

[21] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AMERICAN PROGRESS, (Jan. 18, 2018),

- 23 percent of respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[22]
- According to one survey, 8 percent of lesbian, gay, bisexual, and queer individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and 7 percent experienced unwanted physical contact and violence from a health care provider.[23]
- Almost ten percent of lesbian, gay, or bisexual respondents reported that they had been denied necessary health care expressly because of their sexual orientation.[24]

Many LGBTQ people lack insurance and providers are not competent in health care issues and obstacles that the LGBTQ community experiences.[25] LGBTQ people still face discrimination and often avoid care due to fear of discrimination. This discrimination based on lack of competent care is only furthered when the addition of language and cultural differences exist.

This is the kind of discrimination that OCR has been successful in opposing, and it must continue to do so. As data obtained by the Center for American Progress shows, when the agency was enforcing its regulation against these forms of discrimination from 2012-16, it was effective at identifying discrimination, including 30 percent of cases that were based on denial of care because of gender identity, not related to gender transition.[26] The proposed rule allowing providers to deny needed care would reverse recent gains in combatting discrimination and health care disparities for LGBTQ persons. Refusals also implicate standards of care that are vital to LGBTQ health. Medical professionals are expected to provide LGBTQ individuals with the same quality of care as they would anyone else, and OCR should ensure that this happens.

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

[22] NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf [hereinafter *2015 U.S. Transgender Survey*].

[23] Mirza, *supra* note 21.

[24] LAMBDA LEGAL, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 5 (2010), *available at* .http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

[25] Medical schools often do not provide instruction about LGBTQ health concerns that are not related to HIV/AIDS. Jen Kates et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S*, KAISER FAMILY FOUND.12 (2017), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US.

[26] Mirza, et al., note 21.

IV. The proposed rule is overly broad, vague, and will cause confusion

NILC supports the comments submitted by the National Health Law Program, particularly in their analysis of the ways in which the proposed rule is broad, vague, and will cause confusion in the health care delivery system. The regulations as proposed would introduce broad and poorly defined language to the existing law that already provides ample protection for the ability of health care providers to refuse to participate in a health care service to which they have moral or religious objections. The regulations dangerously expand the application of the underlying statutes by offering an extremely broad definition of who can refuse to provide health services and what they can refuse to do.

While the proposed regulations purport to provide clarity and guidance in implementing existing federal religious exemptions, in reality they are vague and confusing. This lack of clarity may make it more difficult for people experiencing discrimination to understand and enforce their rights. This concern is particularly relevant to immigrant populations who have limited English proficiency and may be unfamiliar with the U.S. health care system.

V. Conclusion

NILC opposes the proposed rule as it expands religious refusals in a way that fails to protect immigrant women and LGBTQ immigrants from discrimination, to the detriment of patients' health and well-being. The outcome of this regulation will harm communities who already lack access to care and endure discrimination. For these reasons, we urge the agency to withdraw the rule in its entirety.

Thank you for your attention to our comments. If you have any questions, reach out to Matthew Lopas at lopas@nilc.org or 202-609-9962.

Sincerely,

Matthew Lopas
Health Policy Attorney
National Immigration Law Center

Exhibit 132

National Indian
Health Board

Submitted via: www.regulations.gov

March 27, 2018

Office for Civil Rights
Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

Dear Office for Civil Rights:

I write on behalf of the National Indian Health Board to comment on the notice of proposed rulemaking to revise regulations previously promulgated to ensure that persons or entities are not subject to certain practices or policies that violate conscience, coerce, or discriminate, in violation of such federal laws.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self- Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

Through this rulemaking, the Department of Health and Human Services (HHS) proposes to grant overall responsibility to its Office for Civil Rights (OCR) for ensuring that the Department, its components, HHS programs and activities, and those who participate in HHS programs or activities comply with Federal laws protecting the rights of conscience and prohibiting associated discriminatory policies and practices in such programs and activities. In addition to conducting outreach and providing technical assistance, OCR will have the authority to initiate compliance reviews, conduct investigations, supervise and coordinate compliance by the Department and its components, and use enforcement tools otherwise available in civil rights law to address violations and resolve complaints. In order to ensure that recipients of Federal financial assistance and other

Department funds comply with their legal obligations, the Department will require certain recipients to maintain records; cooperate with OCR's investigations, reviews, or other enforcement actions; submit written assurances and certifications of compliance to the Department; and provide notice to individuals and entities about their conscience and associated anti-discrimination rights, as applicable.

The proposed rule proposes to exempt Tribes and Tribal Organizations that contract with IHS under ISDEAA with written certification of compliance but not compliance overall.

The Proposed Rule also requests specific comments on the following: "Comment on whether the proposed rule should apply to Tribes, which are recipients of Federal financial assistance through compact agreements or are awarded Federal contracts. Furthermore, the Department requests comment on exemptions for any Indian Tribes under the notice and certification requirements. Additionally, the Department solicits comment on the rule's impact on Tribal sovereignty."

We very much appreciate that the Department has requested Tribal comments on this proposed rule and appreciate the opportunity to provide comments. However, the rulemaking process is no substitute for Tribal Consultation. We respectfully request HHS OCR also comply with Executive Order 13175 and consult directly with Tribes on the proposed rule. It requires any agency "undertaking to formulate and implement policies" affecting Tribes to:

- Where possible, defer to Indian Tribes to establish standards; and
- In determining whether to establish Federal standards, consult with Tribal officials as to the need for Federal standards and any alternatives that would limit the scope of Federal standards or otherwise preserve the prerogatives and authority of Indian Tribes.

HHS OCR should accordingly ensure that the Tribal community be given further opportunity to consult, review, and respond in order to more comprehensively flesh out necessary recommendations and changes to the Proposed Rule.

We appreciate OCR's proposal to exempt Indian Tribes and Tribal organizations contracting under the Indian Self-Determination and Education Assistance Act from the assurance/certification requirements. While we are mindful of the protections for conscience objections, we are unaware of there ever being an issue with such objection with regard to Tribal health providers. We also appreciate ORC's request for comment on whether the rule should apply to Tribes. The United States has unique legal obligations to Indian Tribes, and the courts recognize that both Congress and the Executive Branch may make special accommodations for American Indians and Alaska Natives without running afoul of civil rights laws or the Equal Protection Clause. Like any other Executive Department Agency, the Department of Health and Human Services has a duty and responsibility to ensure that the laws it administers are implemented in a manner that respects Congress' authority to enact Indian-specific legislation that fulfills its unique trust responsibility to Indian Tribes and Indian people. As the Supreme Court has recognized, Congress' authority to authorize Indian-specific programs in furtherance of the trust relationship is subject to rational basis review, and will not be subject to claims of discrimination under strict scrutiny under Title VI of the Civil Rights Act or otherwise.

In implementing this regulation, OCR must maintain the government to government relationship with Tribes. We appreciate the Department's request for comment on this proposed rule and look forward to further Tribal consultation.

Sincerely,

Chairman, National Indian Health Board

cc: Stacey L. Ecoffey, Principal Advisor for Tribal Affairs, Office of Intergovernmental Affairs, Immediate Office of the Secretary, Department of Health and Human Services

Exhibit 133

March 23, 2018

VIA ELECTRONIC SUBMISSION

Secretary Alex Azar
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

Attention: Comments on RIN 0945-ZA03 – Proposed Rule Protecting Statutory Conscience Rights in Health Care; Delegations of Authority

Dear Secretary Azar,

The National Institute for Reproductive Health (NIRH) 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 the National Institute for Reproductive Health calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

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

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

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

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

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

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

Already existing refusal of care laws are used across the country to deny patients the care they need.[3] The Proposed Rule attempts to expand these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church 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,

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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.

individuals working under global health programs funded by the Department thereby allowing global health providers and entities to refuse individuals the care they need contrary to the very purpose of such programs.

Similarly, the Proposed Rule defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. For example, the definition of "assist in the performance" greatly expands the types of services that can be refused to include merely "making arrangements for the procedure" no matter how tangential.[6] This means individuals not "assisting in the performance" of a procedure within the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, can now assert a new right to refuse. The Proposed Rule's definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information, including location or funding, that could help an individual to get the care they need.[7]

Furthermore, the Proposed Rule's new and unwarranted expanded definitions often exceed, or are not in accordance with, existing definitions contained within the statutes the Proposed Rule seeks to enforce. Specifically, under the Coats and Weldon Amendments "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.[8] The Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term.[9] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but goes directly against congressional intent. By expressly 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

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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 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 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]

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[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.

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 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

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[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.

[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/.

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 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]

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[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/.
[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

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 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

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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).

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

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

[37] *See id.*

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 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,

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[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.
[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).

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 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,

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[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.").
[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.

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 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

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[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.*

[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.

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 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

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[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.*
[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.

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 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]

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

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 Institute for Reproductive Health calls on the Department to withdraw the Proposed Rule in its entirety. If you have any questions, please do not hesitate to contact Rose MacKenzie at rmackenzie@nirhealth.org or 646-520-3519.

Sincerely,

Andrea Miller
President
National Institute for Reproductive Health
& National Institute for Reproductive Health Action Fund

Exhibit 134

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

By electronic submission

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 National Latina Institute for Reproductive Health (NLIRH) in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. As a reproductive justice organization, NLIRH believes a health care provider's personal beliefs should never determine the care a patient receives. NLIRH strongly opposes 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]

NLIRH is the only national reproductive justice organization dedicated to building Latina power to advance health, dignity, and justice for 28 million Latinas, their families, and communities in the United States through leadership development, community mobilization, policy advocacy, and strategic communications. NLIRH works to ensure that all Latinas of all racial identities[2] are informed about all their options for safe, effective, and acceptable forms of contraception and family planning. NLIRH supports affordable, accessible, and quality health care for all persons regardless of their age, gender identity, or sexual orientation.

The Latinx[3] community faces several challenges to care and therefore, any ability for providers to discriminate against patients will only exacerbate these barriers. For example, twenty-four percent of Latinas do not have health insurance. Latinas have the highest uninsured rates when

[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] Racial and ethnic identity is multifaceted and in a recent study, 24 percent of U.S. Latinos identified themselves as afro-Latinos, while only 18 percent answered Black as their race. Pew Research Center. "Afro-Latino: A deeply rooted identity among U.S. Hispanics." March 1, 2016. http://www.pewresearch.org/fact-tank/2016/03/01/afro-latino-a-deeply-rooted-identity-among-u-s-hispanics.
[3] NLIRH, conscious of the importance of gender equity in the production of educational materials utilizes gender-neutral terms throughout this document. "Latinx" is a term that challenges the gender binary in the Spanish language and embraces the diversity of genders that often are actively erased from spaces. Due to the limitations of data collection, we use "Latina(s)" or "women" where research only shows findings for cisgender women, including Latinas.

compared to other groups in the U.S., making the act of accessing affordable health care services and finding a provider difficult for many. These challenges can be compounded by cultural and linguistic differences. A person's immigration status can negatively impact one's ability to access care; therefore, for many immigrant women getting in the door of a provider is hard enough, and further discrimination based on a medical professional's religious or moral beliefs can prevent someone from accessing lifesaving care.

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) Latinxs are subject to a number of intersecting barriers to quality health care and increased health disparities. Due to systematic barriers and discrimination, LGBTQ individuals face higher rates of depression, an increased risk of some cancers, HIV/AIDS, and are twice as likely as their heterosexual peers to have a substance use disorders.[4] Additionally, for transgender patients these inequities and challenges to care are especially pronounced. By giving a provider the ability to deny care on the basis of moral or religious beliefs, only prevents individuals from accessing critical health care services they need when they need it.

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. The Proposed Rule unlawfully attempts to create new refusals that further undermine access to care. 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 NLIRH calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

I. The Proposed Rule Carries Severe Consequences for the Latinx community and will Exacerbate Already Existing Inequities for Individuals Seeking Care

The Proposed Rule attempts to expand the reach of existing harmful refusal of care laws and create new refusals of care where none were intended. This Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion and gender affirming 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)."[5] 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.

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[4] Kellan Baker, "Open Doors for All" (Washington: Center for American Progress, 2015), available at https://www.americanprogress.org/issues/lgbt/reports/2015/04/30/112169/open-doors-for-all/.
[5] See Rule *supra* note 1, at 12.

Women, communities of color, individuals living with disabilities, LGBTQ individuals, and people living in rural communities face severe health and health care disparities, and these disparities are compounded for individuals who hold these multiple identities. For example, among adult women, 15.2 percent of those who identified as lesbian or gay reported being unable to obtain medical care in the last year due to cost, as compared to 9.6 percent of straight individuals.[6] Women of color experience health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.[7] Meanwhile, people of color in rural parts of the United States are more likely to live in an area with a shortage of health professionals, with 83 percent of majority-Black counties and 81 percent of majority-Latinx counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

Additionally, due to limited provider networks in some areas and to the important role that case managers and personal care attendants play in coordinating care, it may be more difficult for people with disabilities and older adults to find alternate providers who can help them. Furthermore, the religious and moral objections to the rule is not limited to providers, but also health care entities and institutions that want to bind the hands of providers and attempt to limit the types of care they can provide and this will only exacerbate these problems facing communities of color. By allowing providers, including hospitals and health care institutions, to refuse to provide patients with information, the Proposed Rule makes it impossible for individuals to have full information regarding their own health care decisions. While the Department claims the Proposed Rule improves communication between individuals and providers, in truth it will deter open and honest conversations that are vital to ensuring that a patient can control their medical circumstances.[8]

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

a. Refusals of Care are Especially Dangerous for Latinxs 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 health care provider's or hospital's religious beliefs. This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the

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[6] Brian P. Ward et al., Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, NAT'L CTR FOR HEALTH STATISTICS, 2013 9 (2014), https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf.

[7] In 2014, Latinas had the highest rates of contracting cervical cancer and Black women had the highest death rates. Cervical Cancer Rates By Rates and Ethnicity, CTRS. FOR DISEASE CONTROL & PREVENTION, (Jun. 19, 2017), https://www.cdc.gov/cancer/cervical/statistics/race.htm.;At the end of 2014, of the total number of women diagnosed with HIV, 60 percent were Black. HIV Among Women, CTRS. FOR DISEASE CONTROL & PREVENTION, Nov. 17, 2017, https://www.cdc.gov/hiv/group/gender/women/index.html.

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

care they need.[9] In rural areas there may be no other sources of health care[10] and when these individuals encounter refusals of care, they may have nowhere else to go.

Broadly-defined and widely-implemented refusal clauses undermine access to basic health services for all, but can particularly harm women with low-incomes. These burdens can be insurmountable when women and families are uninsured,[11] locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services nor travel to another location. This is particularly relevant for immigrant women. In comparison to their U.S. born peers, immigrant women are more likely to be uninsured.[12] Notably, immigrant, Latina women have far higher uninsured rates than Latina women born in the United States (48 percent versus 21 percent, respectively).[13]

According to a recent report, doctors often fail to inform Black women of the full range of reproductive health options regarding labor or delivery largely due to stereotypes about Black women's sexuality and reproduction.[14] Young Black women noted that they were shamed by providers when seeking sexual health information and contraceptive care in part, due to their age, and in some instances, sexual orientation.[15]

New research also shows that women of color in many states disproportionately receive their care at Catholic hospitals, subjecting them to treatment that does not comply with the standards of care.[16] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on wide range of hospital matters, including reproductive health care. In practice, the ERDs prohibit the provision of emergency contraception, sterilization, abortion, fertility services, and some treatments for ectopic pregnancies. Providers in one 2008 study disclosed that they could not provide the standard of

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[9] 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.

[10] 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/.

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

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

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

[14] Ctr. for Reprod. Rights, Nat'l Latina Inst. for Reprod. Health & Sistersong Women of Color Reprod. Justice Collective, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [*hereinafter* Reproductive Injustice]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), available at http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

[15] Reproductive Injustice, *supra* note 14, at 16-17.

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

care for managing miscarriages at Catholic hospitals and as a result, women were delayed care or transferred to other facilities, risking their health.[17]

In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[18] One example of this is New Jersey where women of color make up 50 percent of women of reproductive age in the state, yet have twice the number of births at Catholic hospitals compared to their white counterparts.[19] Specifically, despite the fact that white women had over 15,000 more births than Latinas overall, Latinas had over twice the number of births at Catholic hospitals than white women.[20] Another example are Catholic hospitals in Maryland where three-quarters (75 percent) of births are to women of color, as compared with non-Catholic hospitals, where less than half (48 percent) of births are to women of color, additionally, 31 percent of Latinas who give birth in Maryland did so in facilities operating under the ERDs.[21]

The proposed rule will give health care providers a license, such as Catholic hospitals, to opt out of evidence-based care that the medical community endorses. If this rule were to be implemented, more women, particularly women of color, will be put in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services. For many, this choice does not exist.

b. The Proposed Rule Will Negatively Impact Latinxs Living in Rural Communities

Immigrant and Latina women often face cultural and linguistic barriers to care, especially in rural areas.[22] These women often lack access to transportation and may have to travel great distances to get the care they need.[23] In rural areas there may simply be no other sources of health and life preserving medical care. When these women encounter health care refusals, they have nowhere else to go.

The ability to refuse care to patients will leave many individuals in rural communities with no health care options. Medically underserved areas already exist in every state,[24] with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[25] Many rural communities experience a wide array of mental health, dental health, and primary care health

[17] Lori R. Freedman et al., *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/.
[18] *Id.* at 12.
[19] *Id.* at 9.
[20] *Id.* at 14.
[21] *Id.* at 15.
[22] Michelle M. Casey et al., *Providing Health Care to Latino Immigrants: Community-Based Efforts in the Rural Midwest*, AM. J. PUB. HEALTH (2011), available at http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1709.
[23] Nat'l Latina Inst. for Reprod. Health & Ctr. for Reprod. Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight For Women's Reproductive Health In The Rio Grande Valley*, 7 (2013), available at http://www.nuestrotexas.org/pdf/NT-spread.pdf.
[24] Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA, (last visited Mar. 21, 2018).
[25] M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH (2010), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/.

professional shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.[26] Among the many geographic and spatial barriers that exist, individuals in rural areas often must have a driver's license and own a private car to access care, as they must travel further distances for regular checkups, often on poorer quality roads, and have less access to reliable public transportation.[27] For undocumented individuals seeking care, the cost of driving to a doctor appointment can mean interactions with law enforcement or deportation. Those putting everything on the line to get in the door of a health care provider, once they enter the door, they should not be discriminated against based on the provider's religious or moral beliefs.

Moreover, the Proposed Rule could also hinder transgender individuals living in rural areas from seeking health care. A transgender advocate in Texas noted, "I know of people who don't even try for fear of being rejected. Now that there are laws out there that say, yeah, it's okay to discriminate, a lot of people just say, yeah, I don't go shopping in Williamson County. And that's true of any of the rural counties in Texas."[28] The Proposed Rule could allow religiously affiliated hospitals to not only refuse gender affirming care, but also deny surgeons, who otherwise have admitting privileges, to provide gender affirming surgery in the hospital. Gender affirming care is not only medically necessary, but for many transgender people it is lifesaving. In addition to gender affirming services, basic health care need for the transgender community in rural areas can be difficult to meet when providers have the option to deny care based on religious or moral beliefs.

Accessing quality, culturally competent care and overcoming outright discrimination is an even greater challenge for those living in areas with already limited access to health providers.

c. *The Proposed Rule Will Negatively Impact Latinxs Living With Low-Incomes Who Rely On Title X Clinics For Access To Care*

The Proposed Rule would seemingly allow health care entities to receive grants and contracts under HHS-funded programs, while refusing to provide key services required by those programs, once example of this being Title X.[29] Title X Family Planning Centers provide access to contraception and related information and services to anyone who needs them, but priority is given to persons who are living with low-incomes.[30] Title X patients are disproportionately

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[26] Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations*, ECON. RESEARCH SERV. (2009), available at https://www.ers.usda.gov/publications/pub-details/?pubid=44427.

[27] Thomas A. Arcury et al., *The Effects of Geography and Spatial Behavior on Health Care Utilization Among the Residents of a Rural Region*, 40 HEALTH SERV. RESEARCH (2005) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361130/.

[28] Human Rights Watch, *All We Want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

[29] 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.

[30] National Family Planning and Reproductive Health Association, *Title X: An Introduction to the Nation's Family Planning Program*. February 2017. https://www.nationalfamilyplanning.org/file/Title-X-101-February-2017-final.pdf.

Black or Latinx, with thirty-two percent of Title X patients identifying as Latinx and attacks on Title X negatively impact the ability of many Latinxs to receive necessary care. As such the Proposed rule will have a disproportionate impact on communities of color and individuals living with low-incomes.

Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[31] and current regulations require that pregnant people receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[32] 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.[33] The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the sub-recipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs which are meant to provide access to basic health services and information for populations with low-incomes.[34]

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 with low-incomes, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[35]

II. Religious Refusals Make It Difficult for Latinxs to Access the Reproductive Health Care They Need

The Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. 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 communities harms them and impairs their ability to make the health care decision that is right for them.

a. Contraception Access

Contraception helps Latinxs plan their families and their futures, improving their health and well-being. Unfortunately, lack of access to affordable and available contraception further exacerbates the severe health inequities that Latinxs experience. These inequities include: unintended pregnancies,[36] lack of comprehensive sexuality education, and high rates of maternal

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[31] See, e.g., Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[32] See What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).
[33] See, e.g., Rule *supra* note 1, at 180-185.
[34] See NFPRHA *supra* note 34.
[35] See *id*.
[36] In 2014, Latina youth experienced pregnancies at about twice the rate of their white counterparts. Centers for Disease Control and Prevention. *Reproductive Health: Teen Pregnancy. Social Determinants and Eliminating Disparities in Teen Pregnancy*. https://www.cdc.gov/teenpregnancy/ about/social-determinants-disparities-teen-pregnancy.htm (last visited on September 7, 2016).

mortality.[37] Furthermore, there is some evidence showing that lesbian, gay, and bisexual youth may experience unintended pregnancies at even higher rates than their heterosexual peers, suggesting that LGBTQ Latinx youth also need access to contraception.[38]

Individuals who are struggling to make ends meet are disproportionately impacted by unintended pregnancy. In 2011, 45 percent of pregnancies in the U.S. were unintended – meaning that they were either unwanted or mistimed.[39] Women with low-incomes have higher rates of unintended pregnancy as they are least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy.[40] Furthermore, Latinas experience unintended pregnancy at twice the rate of their white peers.

Immigrant women face numerous roadblocks in accessing affordable contraception. These include: lack of transportation, geographically inaccessible providers, pharmacy refusals and point of sales barriers, and affordability. However, a pressing barrier in accessing contraception is a person's inability to gain insurance coverage due to their immigration status.

In light of the pervasive and severe health inequities that Latinxs face, resources and tools, such as contraception, which help decide when and whether to become pregnant are necessary to achieve positive health outcomes. According to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care[41] and Latinas are 1.7 times more likely than white adults to have been diagnosed with diabetes.[42] 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.[43] The ability of Latinxs to access contraception and to ensure health equity for the Latinx community is threatened by providers having the ability to deny care based on religious or moral beliefs.

Denying Latinxs access to contraceptive information and services violates medical standards that recommend pregnancy prevention for these medical conditions. The importance of the ability of

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[37] According to the Centers for Disease Control and Prevention, during 2011 to 2012, the pregnancy-related mortality ratios were 11.8 deaths per 100,000 live births for white women, 41.1 deaths per 100,000 live births for Black women, and 15.7 deaths per 100,000 live births for women of other races. Given these statistics, the Afro-Latinx community may disproportionately face maternal mortality and the underlying factors of maternal mortality. Centers for Disease Control and Prevention. Reproductive Health. Pregnancy Mortality Surveillance System. http://www.cdc. gov/reproductivehealth/maternalinfanthealth/pmss.html (last visited October 7, 2016).

[38] Lisa L. Lindley & Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High-School Students*, 105 AMERICAN JOURNAL OF PUBLIC HEALTH 1379 (2015).

[39] Unintended Pregnancy in the United States, Guttmacher Inst. (Sept. 2016), available at https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.

[40] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in rates of unintended pregnancy in the United States*, 1994 and 2001, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90-6 (2006).

[41] Am. Diabetes Ass'n, *Standards Of Medical Care In Diabetes-2017*, 40 DIABETES CARE S115, S117 (2017), available at http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf.

[42] Office of Minority Health. *Diabetes and Hispanic Americans*. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63.

[43] *Id.*

individuals to make decisions for themselves to prevent or postpone pregnancy is well-established within the medical guidelines across a range of practice areas. Ninety-nine percent of all sexually active women have used contraception at some point in their lives — including 98 percent of Latinas and 99 percent of Catholics. Additionally, numerous studies have demonstrated that access to birth control strengthens families, increases women's earning power, and narrows the gender pay gap. A person knows what is best for them and their family and a medical professional should not be able to prevent a person from accessing critical contraception based on a religious or moral objection. Communities of color, women, and LGBTQ individuals must have the tools they need, including contraception, to make the best decisions for themselves and their families, and access to doctors that will not discriminate based on religious or moral objections.

b. Emergency Contraception

The proposed rule will magnify the harm in circumstances where individuals are already denied the standard of care. For Latinxs in particular, expanded access to emergency contraception is essential. Latinxs face a number of barriers to care, including poverty, language, immigration status, and lack of insurance, that prevent them from accessing contraception. Data shows young Latinas are the most likely group to skip taking prescription birth control because they cannot afford it. Current restrictions on accessing emergency contraception over-the-counter keep this birth control method out of reach for younger Latinxs and any woman who does not have a photo ID, so for those who are relying on a provider to access emergency contraception, it is critical that the only doctor they may have access to, does not deny them care.

Additionally, Catholic hospitals have a record of providing substandard care or refusing care altogether for a range of medical conditions and crises that implicate reproductive health. For example, in a 2005 study of Catholic hospital emergency rooms by Ibis Reproductive Health for Catholics for Choice, it was found that 55 percent would not dispense emergency contraception under any circumstances.[44] Twenty three percent of the hospitals limited emergency contraception to victims of sexual assault.[45] These hospitals violated the standards of care established by medical providers regarding treatment of sexual assault. Medical guidelines state that survivors of sexual assault should be provided emergency contraception subject to informed consent and that it should be immediately available where survivors are treated.[46] At the bare minimum, survivors should be given comprehensive information regarding emergency contraception.[47]

[44] Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 ANNALS EMERGENCY MED. 105-10 (Aug. 2005), http://www.annemergmed.com/article/S0196-0644(05)00083-1/pdf.
[45] *Id.* at 105.
[46] Committee Opinion 592: Sexual Assault, Am. Coll. Obstetricians & Gynecologists (Apr. 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co592.pdf?dmc=1&ts=20170213T2116487879; Management of the Patient with the Complaint of Sexual Assault, Am. Coll. Emergency Med. (Apr. 2014), https://www.acep.org/Clinical---Practice-Management/Management-of-the-Patient-with-the-Complaint-of-Sexual-Assault/#sm.00000bexmo6ofmepmultb97nfbh3r.
[47] Access to Emergency Contraception H-75.985, AMA (2014), https://policysearch.ama-assn.org/policyfinder/detail/emergency%20contraception%20sexual%20assault?uri=%2FAMADoc%2FHOD.xml-0-5214.xml.

c. Abortion Care

This Proposed Rule will only create more barriers for those seeking abortion care. Obstacles including cultural and linguistic differences, as well as restrictions based on age, economic status, immigration status, and geographic location already prohibit many, especially Latinxs, from obtaining safe abortion services.

For the Latinx communities, making multiple trips to doctors delays access to care or prevents an individual from seeking services altogether. Religious refusals will only exacerbate a distrust of the medical community and keep people from the care they desperately need. In the Latinx community, many forgo medical care because they fear that ICE, rather than a doctor, will be waiting for them at a health care provider or hospital. To couple this culture of fear with the fear that a doctor will turn someone away based on their religious or moral beliefs is unconscionable.

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 individual's 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.[48] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[49] 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 ignores the many providers with deeply held moral convictions that affirmatively motivate them to provide abortion services. 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.[50] No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion.

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[48] 42 U.S.C. § 1295dd(a)-(c) (2003).

[49] 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).

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

III. Expanding Religious Refusals Can Exacerbate The Barriers To Care That LGBTQ Latinxs Already Face

Given the broadly-written and unclear language of the Proposed Rule, if implemented, some providers may misuse this Rule to deny LGBTQ individuals services on the basis of perceived or actual gender identity or sexual orientation. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care impairs the ability of a person to make a health decision that expresses their self-determination. LGBTQ people around the country already face enormous barriers to getting the care they need.[51] In fact, many physicians are not trained to provide culturally competent care for LGBTQ patients and self-report a lack of knowledge regarding the concerns of the community.[52] The Proposed Rule will compound the barriers to care that LGBTQ individuals face, particularly the effects of ongoing and pervasive discrimination, by potentially allowing health care professionals to refuse to provide services and information that is critical to LGBTQ health.

LGBTQ people face discrimination in many areas of their lives, including health care, on the basis of their gender identity and sexual orientation. The Department's Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[53] LGTBQ people face discrimination in a wide variety of services, affecting access to health care, including reproductive services, adoption and foster care services, child care, as well as physical and mental healthcare services.[54] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in healthcare access.[55] They concluded that discrimination as well as insensitivity or disrespect on the part of health care providers were key barriers to health care access and that increasing efforts to provide culturally sensitive services would help close the gaps in health care access.[56]

The Proposed Rule allowing providers to deny needed care would reverse recent gains in combatting discrimination and health care disparities for LGBTQ individuals. Refusals also

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[51] 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.

[52] IOM (Institute of Medicine). 2011: 65. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academies Press.

[53] Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 24, 2018).

[54] HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

[55] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.

[56] *Id.*

implicate standards of care that are vital to LGBTQ health. Under the Affordable Care Act, medical professionals are expected to provide everyone, regardless of gender identity or sexual orientation, with the same quality of care. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and competency with LGBTQ issues as they pertain to any health services provided.[57]

LGBTQ individuals already experience significant health inequities. For example, LGBTQ adults are still more likely than non-LGBTQ adults to lack insurance. Denying medically necessary care on the basis of sexual orientation or gender identity exacerbates barriers to obtaining health care services. Expanding religious refusals will further put needed care, including reproductive health care, out of reach for many.

a. The Proposed Rule Can Further Discrimination Against the Latinx Transgender Community

The transgender community already experience high rates of discrimination, harassment, and violence when seeking health care services. Transgender individuals are less likely to have health insurance than heterosexual or lesbian, gay, or bisexual (LGB) individuals. A study conducted by the National Center for Transgender Equality and the TransLatin@ Coalition found that 17 percent of transgender Latinxs did not have health insurance, compared to 12 percent of their white counterparts.[58]

Transgender individuals already face many barriers when seeking health care services simply because of their gender identity. The Proposed Rule could embolden some providers to continue to act in a discriminatory manner against transgender individuals. According to a 2011 national survey of transgender people conducted by the National Gay and Lesbian Task Force and National Center for Transgender Equality, one in three Latinx respondents reported unequal treatment by a doctor or hospital.[59] Undocumented transgender respondents were found to be particularly vulnerable to physical attack in doctors' offices, hospitals, and emergency rooms.[60] Additionally, transgender persons have been denied care even for medically necessary treatment, and this discrimination has sometimes resulted in death.[61] For example, transgender and gender

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[57] *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, GAY LESBIAN BISEXUAL & TRANSGENDER HEALTH ACCESS PROJECT, http://www.glbthealth.org/CommunityStandardsofPractice.htm (last visited Jan. 26, 2018, 12:59 PM); *Creating an LGBTQ-friendly Practice*, A.M.A., https://www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice#Meet a Standard of Practice (last visited Jan. 26, 2018).

[58] James, S. E. & Salcedo, B. (2017). *2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents*. Washington, DC and Los Angeles, CA: National Center for Transgender Equality and TransLatin@ Coalition.

[59] Grant JM et al. National Gay and Lesbian Taskforce; National Center for Transgender Equality. *Injustice at every turn: A report of the National Transgender Discrimination Survey*, 73-74, 2011, available at http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.

[60] *Id.*

[61] Ravishankar M. *The story about Robert Eads*. THE JOURNAL OF GLOBAL HEALTH. January 18, 2013. http://www.ghjournal.org/jgh-online/the-story-about-robert-eads/.

non-conforming Latinxs with cervixes may disproportionately experience cervical cancer given that Latinas overall experience high rates of cervical cancer incidence.[62]

One fourth of transgender individuals experienced a problem in the past year with their insurance related to being transgender, such as being denied coverage for gender affirming care or being denied other types of health care because they were transgender.[63] Thirty-two percent, about one-third, of transgender individuals who saw a health care provider in the past year reported having at least one negative experience related to being transgender.[64] The reported negative experiences included being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.[65] The 2015 U.S. Transgender Survey showed that over a fourth of transgender individuals did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 37 percent, more than a third, did not see a doctor when needed because they could not afford it.[66]

The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.[67] The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.[68] Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity and 29 percent experienced unwanted physical contact from a health care provider.[69]

The 2015 U.S. Transgender Survey found that 23 percent of transgender respondents avoided seeking medical care when they needed it because of fear of being mistreated.[70] Additionally,

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[62] National Latina Institute for Reproductive Health, *Cervical Cancer & Latinxs: The Fight for Prevention and Health Equity*, January 2018, available at http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf.
[63] James, S. E. & Salcedo, B. (2017). *2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents*. Washington, DC and Los Angeles, CA: National Center for Transgender Equality and TransLatin@ Coalition.
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, World Prof. Ass'n for Transgender Health (2011), https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf.
[68] Committee Opinion 512: Health Care for Transgender Individuals, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Dec. 2011), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals.
[69] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for American Progress, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.
[70] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. *The Report of the 2015 U.S. Transgender Survey*, 2016, Washington, DC: National Center for Transgender Equality, available at https://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf.

the survey found that, just in the past year, 33 percent of those who saw a health care provider face some form of mistreatment or discrimination because of being transgender, such as being refused care, harassed, or physically or sexually assaulted, and more than one in five respondents reported that a health care provider used abusive or harsh language when treating them.[71]
The Proposed Rule, while cloaked in the language of non-discrimination, is designed to deny care and exclude vulnerable populations. The adverse consequences of health care refusals and other forms of discrimination are well documented. As the Department stated in its proposed rulemaking for Section 1557 of the Affordable Care Act (ACA),

> "[e]qual access for all individuals without discrimination is essential to achieving the ACA's aim to expand access to health care and health coverage for all, as discrimination in the health care context can often…exacerbate existing health disparities in underserved communities."[72]

Data obtained by Center for American Progress (CAP) under a FOIA request indicates the Department's enforcement was effective in resolving issues of anti-LGBTQ discrimination. CAP received information on closed complaints of discrimination based on sexual orientation, sexual orientation-related sex stereotyping, and gender identity that were filed with the Department under Section 1557 of the ACA from 2012 through 2016. CAP found that "[i]n approximately 30% of these claims, patients alleged denial of care or insurance coverage simply because of their gender identity – not related to gender transition."[73] Additionally, "[a]pproximately 20% of the claims were for misgendering or other derogatory language."[74] Individuals who were "denied care due to their gender identity or transgender status included a transgender woman denied a mammogram and a transgender man refused a screening for a urinary tract infection."[75]

b. The Proposed Rule Will Worsen Discrimination Based on Sexual Orientation

Many lesbian, gay, bisexual, and queer (LGBQ) people lack insurance.[76] Moreover, providers are not competent in health care issues and obstacles that the LGBQ community experiences.[77] For example, lesbian and bisexual individuals are less likely to get routine health care and

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[71] *Id.*
[72] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,194 (Sept. 8, 2015) (codified at 45 C.F.R. pt. 2).
[73] Sharita Gruberg & Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress, (March 7, 2018), available at https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.
[74] *Id.*
[75] *Id.*
[76] Medical schools often do not provide instruction about LGBTQ health concerns that are not related to HIV/AIDS. Jen Kates et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S*, KAISER FAMILY FOUND. 12 (2017), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US.
[77] *Id.*

cervical cancer screenings than their heterosexual counterparts.[78] Additionally, adolescent and young lesbians and bisexuals are less likely to receive the preventative HPV vaccine.[79] Barriers and inequities already exist among LGBQ individuals, and this Proposed Rule would further exacerbate such inequities.

Fear of discrimination causes many LGB people to avoid seeking health care, and, when they do seek care, lesbian, gay, and bisexual (LGB) people are frequently not treated with the respect that all individuals deserve. According to one survey, 8 percent of lesbian, gay, bisexual, and queer individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and 7 percent experienced unwanted physical contact and violence from a health care provider.[80] The study "When Health Care Isn't Caring" found that 56 percent of LGB people reported experiencing discrimination from health care providers – including refusals of care, harsh language, or even physical abuse – because of their sexual orientation.[81] Almost ten percent of LGB respondents reported that they had been denied necessary health care expressly because of their sexual orientation.[82] Delay and avoidance of care due to fear of discrimination compound the significant health disparities that affect the lesbian, gay, and bisexual population.

For example, queer Latinxs are more likely to disproportionately experience cervical cancer because of racial, ethnic, sexual orientation, and gender identity health disparities.[83] Health inequities already exist, and this Proposed Rule threatens to make access to healthcare information and services even harder and, for some people, nearly impossible.

III. The Department is Abdicating its Responsibility to Individuals Seeking Health Care

The Proposed Rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.[84] Instead, the Proposed Rule appropriates

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[78] National Latina Institute for Reproductive Health, *Cervical Cancer & Latinxs: The Fight for Prevention and Health Equity* January 2018, available at http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf.
[79] National Latina Institute for Reproductive Health, *Cervical Cancer & Latinxs: The Fight for Prevention and Health Equity* January 2018, available at http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf.
[80] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for American Progress, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.
[81] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 5 (2010), *available at* http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.
[82] *Id.*
[83] National Latina Institute for Reproductive Health, *Cervical Cancer & Latinxs: The Fight for Prevention and Health Equity* January 2018, available at http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf
[84] 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

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.[85] 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 inequities. 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.[86] 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.[87]

Nevertheless, there is still work to be done, and the Proposed Rule seeks to divert limited resources away from ending discrimination. Health disparities based on race and ethnicity do not occur in isolation. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. Black women, for example, are three to four times more likely than white women to die during or after childbirth.[88] While Black women are dying at much higher rates than their Latinx and white counterparts, some studies indicate that in certain

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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.").

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

[86] 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.

[87] 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.

[88] 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.

parts of the country (the Rio Grande and areas of California) maternal death rates are higher for Latinas. According to a recent study, Hispanic women in Texas make up 31 percent of maternal deaths and account for nearly half of all births in Texas (Black women account for 30 percent). Another recent study showed that Mexican-born women in California are more likely to die from birthing related complications than their white counterparts. Further, the disparity in maternal mortality is growing rather than decreasing,[89] 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.[90]

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.[91]

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

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."[92] 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.[93]

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.[94] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[95]

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[89] See *id.*
[90] 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).
[91] See *supra* note 83.
[92] 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.
[93] See Rule *supra* note 1, at 94-177
[94] 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).
[95] 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

Conclusion

The inability of providers to give comprehensive, medically accurate information and options that will help Latinxs make the best health decisions violates respect for autonomy, and justice. This rule, which allows misinformation and personal feelings to get in the way of science and lifesaving treatment, will not help achieve the goals of the administration; it will instead prevent critical care.

The expansion of religious refusals as envisioned in the Proposed Rule may compel medical professionals to provide care and information that harms the health, well-being, and goals of communities of color.

The Proposed Rule goes far beyond established law and will allow religious beliefs to dictate health care by unlawfully expanding already harmful refusals. 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. Most importantly, this Proposed Rule puts the lives of our community at risk. For all of these reasons National Latina Institute for Reproductive Health calls on the Department to withdraw the Proposed Rule in its entirety.

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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.

Exhibit 135

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March 27, 2018

VIA ELECTRONIC SUBMISSION

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM
RIN 0945-ZA03
Hubert H. Humphrey Building, Room 209F
200 Independence Avenue SW
Washington, DC 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:

The National LGBTQ Task Force is the oldest national organization advocating for the rights of lesbian, gay, bisexual, transgender, and queer (LGBTQ) people and their families. The Task Force builds power, takes action, and creates change to achieve freedom and justice for LGBTQ people and their families.

We are writing in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care," published on January 26, 2018. Every day too many LGBTQ people, women, people with disabilities, people of color and people living with HIV, face discrimination and other barriers to accessing lifesaving care. These barriers are especially pronounced for transgender patients.

The proposed rule ignores the prevalence of discrimination and the damage it causes. It 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. We deserve better.

The rule as proposed would introduce broad and poorly defined language to the existing law that already provides ample protection for the ability of health care providers to refuse to participate in a healthcare service to which they have moral or religious objections. While the proposed rule purports to provide clarity and guidance in implementing existing federal religious exemptions, they are vague and confusing. The proposed rule creates the potential for exposing patients to medical care that fails to comply with established medical practice guidelines, including the long-standing principles of informed consent, and undermines the ability of health facilities to provide care in an orderly and efficient manner.

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By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the U.S. Department of Health and Human Services (Department) seeks to use the Office of Civil Rights' (OCR's) limited resources 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, the National LGBTQ Task Force calls on the Department and OCR to withdraw the proposed rule in its entirety.

I. Expanding religious refusals can exacerbate the barriers to care that LGBTQ, women, people of color, and those living with HIV 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 an even greater challenge for those living in areas with already limited access to health providers. The proposed rule 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. 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 compared to other kinds of care.[3]

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[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.

[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

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This means that 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.

II. The proposed rule permits health care professionals to opt out of providing medical care that the public expects by allowing them to disregard evidence-based standards of care

Medical practice guidelines and standards of care establish the boundaries of medical care that patients can expect to receive and that providers should be expected to deliver. The health services impacted by refusals are often related to reproductive and sexual health, which are implicated in a wide range of common health treatment and prevention strategies. Information, counseling, referral and provisions 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. Many of these conditions disproportionately affect women of color.[5] The expansion of these refusals as outlined in the proposed rule will put women, particularly women of color, who experience these medical conditions at greater risk for harm.

[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.

[5] For example, Black women are three times more likely to be diagnosed with lupus than white women. Latinas and Asian, Native American, and Alaskan Native women also are likely to be diagnosed with lupus. Office on Women's Health, *Lupus and women*, U.S. DEP'T HEALTH & HUM. SERV. (May 25, 2017), https://www.womenshealth.gov/lupus/lupus-and-women. Black and Latina women are more likely to experience higher rates of diabetes than their white peers. Office of Minority Health, *Diabetes and African Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Jul. 13, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18; Office of Minority Health, *Diabetes and Hispanic Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (May 11, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63. Filipino adults are more likely to be obese in comparison to the overall Asian population in the United States. Office of Minority Health, *Obesity and Asian Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Aug. 25, 2017), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=55. Native American and Alaskan Native women are more likely to be diagnosed with liver and kidney/renal pelvis cancer in comparison to non-Hispanic white women. Office of Minority Health, *Cancer and American Indians/Alaska Natives*, U.S. DEP'T OF HEALTH & HUM. SERV. (Nov. 3, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=31.

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a. Ending a Pregnancy

While there are numerous reasons for why a person would seek to end a pregnancy, there are many medical conditions in which ending a pregnancy is recommended as treatment. These conditions include: preeclampsia and eclampsia, certain forms of cardiovascular disease, and complications for chronic conditions. Significant racial disparities exist in rates of and complications associated with preeclampsia.[6] For example, the rate of preeclampsia is 61% higher for Black women than it is for white women, and 50% higher than the rate for women overall.[7] 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.[8] ACOG and American Heart Association recommend that a pregnancy be avoided or ended for certain conditions such as severe pulmonary hypertension.[9] Many medications can cause significant fetal impairments, and therefore the Federal Food and Drug Administration and professional medical associations recommend that women use contraceptives to ensure that they do not become pregnant while taking these medications.[10] In addition, some medical guidelines counsel patients to end a pregnancy if they are taking certain medications for thyroid disease.[11]

b. Artificial Reproductive Technology (ART)

Refusals to provide the standard of care to LGBTQ individuals because of their sexual orientation or gender identity can impact access to care across a broad spectrum of health concerns. One example of refusals that impacts LGBTQ patients, as well as non-LGBTQ patients, is refusals to educate about, provide, or cover ART procedures for religious reasons. According to the American Society for Clinical Oncology and the Oncology Nursing Society, the

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[6] Sajid Shahul et al., *Racial Disparities in Comorbidities, Complication, and Maternal and Fetal Outcomes in Women With Preeclampsia/eclampsia*, 34 HYPERTENSION PREGNANCY (Dec. 4, 2015), http://www.tandfonline.com/doi/abs/10.3109/10641955.2015.1090581?journalCode=ihip20.
[7] Richard Franki, *Preeclampsia/eclampsia rate highest in black women*, OB.GYN. NEWS (Apr. 29., 2017), http://www.mdedge.com/obgynnews/article/136887/obstetrics/preeclampsia/eclampsia-rate-highest-black-women.
[8] AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).
[9] Mary M. Canobbio et al., *Management of Pregnancy in Patients With Complex Congenital Heart Disease*, 135 CIRCULATION e1-e39 (2017); Debabrata Mukherjee, *Pregnancy in Patients With Complex Congenital Heart Disease*, AM. COLL. CARDIOLOGY (Jan. 24, 2017), http://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/01/24/14/40/management-of-pregnancy-in-patients-with-complex-chd.
[10] ELEANOR BIMLA SCHWARZ M.D. M.S., et al., *Documentation of Contraception and Pregnancy When Prescribing Potentially Teratogenic Medications for Reproductive-Age Women*, 147 Annals of Internal Medicine. (Sept. 18, 2007).
[11] For example, the American College of Obstetricians and Gynecologists specifically recommends that if a woman taking Iodine 131 becomes pregnant, her physician should caution her to consider the serious risks to the fetus, and consider termination. American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 37: Thyroid disease in pregnancy* 100 OBSTETRICS & GYNECOLOGY 387-96 (2002).

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standard of care for individuals with cancer includes education and informed consent around fertility preservation.[12] Refusals to educate patients about or to provide ART occur for two reasons: refusal based on religious beliefs about ART itself and refusals to provide ART to LGBTQ individuals because of their LGBTQ identity. In both situations, refusals to educate patients about ART and fertility preservation and to facilitate ART when requested are against the standard of care.

The lack of clarity in the proposed rule could lead a hospital or an individual provider to refuse to provide ART to same-sex couples based on religious belief. For some couples, this discrimination would increase the cost and emotional toll of family building. In some parts of the country, however, these refusals would be a complete barrier to parenthood. More broadly, these refusals deny patients the human right and dignity to be able to decide to have children, and cause psychological harm to patients who are already vulnerable because of their health status or their experience of health disparities.

c. HIV Health

In addition to consistent condom use, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are an important part of HIV prevention for those at high risk for contracting HIV. ACOG recommends that PrEP be considered for individuals at high risk of contracting HIV.[13] Under the proposed rule, an insurance company could refuse to cover PrEP or PEP because of a religious belief. Refusals to promote and facilitate condom use because of religious beliefs and refusals to prescribe PrEP or PEP because of a patient's perceived or actual sexual orientation, gender identity, or perceived or actual sexual behaviors is in violation of the standard of care and harms patients already at risk of experiencing health disparities. Both PrEP and PEP have been shown to be highly effective in preventing HIV infection. Denying access to this treatment would adversely impact vulnerable, highest-risk populations, including gay and bisexual men.

The National LGBTQ Task Force opposes the proposed rule as it expands religious refusals to the detriment of patients' health and well-being. We are concerned that these regulations, if implemented, will interfere in the patient-provider relationship by undermining informed

[12] Alison W. Loren et al., *Fertility Preservation for Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500-10 (July 1, 2013); Ethics Committee of the American Society for Reproductive Medicine, *Fertility preservation and reproduction in patients facing gonadotoxic therapies: a committee opinion*, 100 AM. SOC'Y REPROD. MED. 1224-31 (Nov. 2013), http://www.allianceforfertilitypreservation.org/_assets/pdf/ASRMGuidelines2014.pdf; Joanne Frankel Kelvin, *Fertility Preservation Before Cancer Treatment: Options, Strategies, and Resources*, 20 CLINICAL J. ONCOLOGY NURSING 44-51 (Feb. 2016).
[13] ACOG *Committee Opinion 595: Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (May 2014), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Preexposure-Prophylaxis-for-the-Prevention-of-Human-Immunodeficiency-Virus.

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consent. The outcome of this regulation will harm communities who already lack access to care and endure discrimination.

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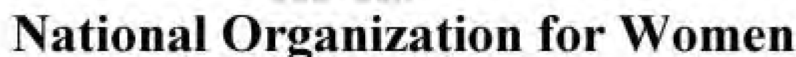
Thank you for your consideration of our comments. If you have any questions regarding these comments, please contact Candace Bond-Theriault, Policy Counsel, Reproductive Rights/Health/Justice (202-639-6315, cbond@thetaskforce.org).

Sincerely,

National LGBTQ Task Force

Exhibit 136



National Organization for Women

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, D.C. 20201

ATTN: Conscience NPRM RIN 0945-ZA03

To Whom It May Concern:

The National Organization for Women (NOW) strongly believes that a health care provider's personal beliefs cannot be allowed to impede or alter the treatment of patients. For this reason, we oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule") and the establishment of the "Conscience and Religious Freedom Division" within the Office of Civil Rights (OCR). This Rule and this Division legalize discrimination in health care via the expansion of refusal procedures, including religious and moral convictions as reasonable bases for refusal of care.[1] Such an act undermines the separation of church and state, allowing any individuals and health care entities receiving federal funding to refuse *any* part of a health service or program to an individual based on subjective convictions, which additionally may be used to mask bigotry and prejudice. In this manner, the Department plans to utilize OCR resources to allow institutions, insurance companies, and anyone involved in patient care, including "volunteers, trainees, contractors…and providers holding admitting privileges" to use their personal beliefs to deny treatment to those desperately needing it. This opens the door to widespread discrimination based on a patient's race, gender identity, and/or sexual orientation. **For these reasons, NOW calls on the Department and OCR to withdraw the Proposed Rule.**

The Department and OCR specifically attempt to require a broad swath of entities to permit individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[2] Read alongside the rest of the Proposed Rule, it is clear this allows 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. Consequently, it is not only patient interactions with immediate providers that will be affected, but with any personnel involved, directly or indirectly, in their care.

By expanding the reach of existing refusal of care laws, which already harm those seeking care, and creating a right to new refusals, this Rule will exacerbate health inequities in the denial of critical services, such as abortion and transition-related care. Already, the Ethical and Religious Directives (ERDs) followed by Catholic and Catholic-affiliated hospitals allow providers to deny reproductive

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[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.

health services to patients, with providers in one 2008 study disclosing that they could not provide the standard of care for managing miscarriages at Catholic hospitals.[3] As a result, women were delayed care or transferred to other facilities at great risk to their health [4]. One patient in Arkansas endured several pregnancy complications and, knowing she could not risk another pregnancy, requested a sterilization procedure at her Cesarean delivery which was refused by her Catholic hospital provider.[5] Under this proposed rule, similar denials of care, along with resulting emotional and physical distress, will become commonplace.

The Proposed Rule also broadens the Church Amendments, which in their current form, allow 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 related to the service or research activity to which they object.[6] The Proposed Rule expands this provision by allowing individuals to refuse to perform aspects of their jobs based on reference to religious or moral belief, whether or not the refusal relates to the specific biomedical, behavioral service, or research activity they are working on.[7] This expansion goes beyond the statute enacted by Congress.

Such overstepping, however, is a consistent theme with regards to this Proposed Rule. In addition to expanding the breadth of existing refusal laws, the Proposed Rule redefines phrases and words used in existing refusals of care laws and civil rights laws to further stretch and expand their intended meaning. For example, the definition of "assist in the performance" in the Proposed Rule indicates that the types of services which may be refused include "making arrangements for the procedure" no matter how tangential such arrangements are to the procedure.[8] As such, individuals not "assisting in the performance" of a procedure in the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, now possess a new "right" to refuse. The Proposed Rule's definition of "referral" also goes beyond any recognized understanding, allowing providers and personnel to refuse to provide any additional information, including location or funding, that could help an individual to get the care they need, denying patients knowledge concerning their full and complete options for care.[9] Furthermore, the Proposed Rule's newly expanded definitions often exceed, or are not in accordance with, existing definitions within the statutes the Proposed Rule seeks to enforce. 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.[10] The Proposed Rule, however, attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad

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[3] 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/.
[4] Id.
[5] *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.
[6] The Church Amendments, 42 U.S.C. § 300a-7 (2018).
[7] *See* Rule *supra* note 1, at 185.
[8] *Id.* at 180.
[9] *Id.* at 183.
[10] 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).

term.[11] This attempt to expand the meaning of a statutory term already defined by Congress fosters confusion and goes against congressional intent. By defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert into the definition.[12]

When these broad definitions are combined with expansive interpretations of the underlying statutes, they expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, another way the Weldon Amendment is expanded under the Proposed Rule is through the definition of "discrimination."[13] The Proposed Rule defines "discrimination" against a health care entity broadly, including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[14] In a Rule that seeks to protect those who want to discriminate, such a broad definition is inappropriate. Furthermore, the definition itself is so vague that it provides no functional guidance on how to comply with its requirements, fostering confusion.

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have potentially harmful consequences for those denied care. When women and families are uninsured, locked into managed care plans that do not meet their needs, or cannot afford to pay out of pocket and/or travel to another location, refusals bar access to care.[15] This is especially true for immigrants, who often lack transportation and may have to travel great distances to get required care.[16] In rural areas there may be no other sources of health and life preserving medical care.[17] When these individuals encounter refusals of care, they may have nowhere else to go. The same holds true for members of the LGBTQ+ community, who have often faced discrimination with regards to healthcare. This is evidenced by the fact that 8% of lesbian, gay, bisexual and queer respondents to a survey by the Center for American Progress indicated that a provider had refused to see them based on their sexual orientation, 16% reporting that they had experienced verbal, physical and/or sexual abuse at the hands of their providers[18]. For trans individuals, the statistics are still more alarming. 29% of trans people surveyed indicated that a healthcare provider had refused to see them and 50% stated that their providers

[11] *See* Rule *supra* note 1, at 182.

[12] 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.

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

[14] *Id.*

[15] 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.

[16] 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.

[17] 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/.

[18] Percentages of those experiencing verbal, physical and/or sexual abuse are the result of the addition of percentages reporting verbal abuse and percentages reporting unwanted sexual/physical contact. For a summary of survey results, see: Shabab Ahmed Mirza and Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care, Center for American Progress* (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/

had verbally, physically or sexually abused them as they sought care [19]. With such reported instances of discrimination and harm done while seeking treatment, it is sadly unsurprisingly that, according to the 2015 U.S. Transgender Survey, nearly 1 in 4 trans people avoided seeking necessary health care in the year prior due to a fear of discrimination, a fear, which given reported instances thereof, cannot be considered unreasonable [20]. And yet, like immigrant populations, the LGBTQ+ community often has nowhere else to go, those surveyed indicating in high amounts that it would be "very difficult" or "not possible" for them to find the services needed either at a different hospital, pharmacy or clinic, trans people once again reporting higher rates of difficulty as compared to cisgender LGBTQ+ individuals[21]. LGBTQ+ people living in non-metropolitan areas also report high rates of difficulty finding a new provider, a situation that is likely the result of increased transportation costs and distance[22].

The Proposed Rule and the Division become still more troubling when one considers that individuals who face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, research shows that women of color disproportionately receive their care at Catholic hospitals and that, (in) nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[23] This puts them at greater risk of being denied appropriate reproductive healthcare, such as miscarriage management and treatment for pregnancy complications, relative to white women, simply due to the supposed religious preferences of these institutions.

In this manner, by expanding and creating new methods by which providers and personnel associated with healthcare services – however tangentially – may refuse to perform services for any patient, the Proposed Rule opens the doors to federally-sanctioned, legalized discrimination in healthcare, something that will cost lives and endanger the health and safety of many, especially those whose identities mark them as part of one or more marginalized populations. **For this reason, NOW reiterates, this Proposed Rule cannot be permitted to stand, and must be withdrawn, so as not to cause irreparable harm to prospective patients, all of whom are owed treatment in keeping with the recognized full and complete standard of care**.

Regards,

Toni Van Pelt, President
National Organization for Women
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[19] Id.
[20] Id.
[21] Id.
[22] Id.
[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.

Exhibit 137

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 209F
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via regulations.gov

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

The National Partnership for Women & Families is dedicated to expanding opportunities for women and improving the well-being and economic security of our nation's families. For more than 45 years, we have promoted access to quality, affordable health care, reproductive health and rights, policies that help women and men meet the dual demands of work and family, and fairness in the workplace.

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 programs like Title X, interfere with the patient-provider 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, the National Partnership for

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[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].

Women & Families 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 of existing harmful refusal of care laws and 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 health care services. 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."[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 Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research 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

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[2] *See id.* at 12 (emphasis added).
[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.

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 Proposed Rule's 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 who would not otherwise be considered to be "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 medical instruments and other hospital employees, can now assert a new right to refuse. The Proposed Rule's definition of "referral" similarly goes beyond any reasonable understanding of the term, allowing individuals to refuse 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 defined not only fosters confusion, but goes directly against congressional intent. By expressly defining the term "health care entity," Congress 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 so-called "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 against patients, this broad definition is nonsensical and inappropriate. Further, such a vague and inappropriate definition provides no functional

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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.*

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 Women 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] For example, one woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, only to be denied the miscarriage management she needed because the hospital objected to this care.[14] Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.[15] A 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.[16] Yet 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.[17]

b. Expanding Religious Refusals Can Exacerbate the Barriers to Care that LGBTQ Individuals Already Face

LGBTQ people and other vulnerable groups around the country already face enormous barriers to getting the care they need.[18] Accessing quality, culturally competent care and overcoming outright discrimination is an even greater challenge for those living in areas

[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 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.
[17] *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.
[18] *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.

with already limited access to health providers. The Proposed Rule 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 health care facility can be a significant barrier to getting care. 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 farther to seek care for gender dysphoria than for other kinds of care.[19]

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 percent 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 nonmetropolitan areas, with 41 percent reporting that it would be very difficult or impossible to find an alternative provider.[20] 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.

c. *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's personal beliefs or a hospital's religious affiliation. 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.[21] 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.[22] In rural areas, there may be no other sources of health and life preserving

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

[20] 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.

[21] 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.

[22] 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.

medical care.[23] In developing countries where many health systems are weak, health care options and supplies are often unavailable.[24] 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 19 states, women of color are more likely than white women to give birth in Catholic hospitals.[25] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives ("ERDs"), which provide guidance on a wide range of hospital matters, including reproductive health care, and can prevent providers from offering the standard of care.[26] 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.[27] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious affiliation to discriminate and the number of religiously affiliated entities that provide health care and related services.[28] In communities that have experienced historic and ongoing coercion within the medical system, the Proposed Rule could further undermine the trust that is the foundation of the patient-provider relationship and deepen health disparities.

d. 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 increase the barriers to health care patients face. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing health care entities to prevent employees from providing needed care and individual providers to use their personal beliefs to dictate patient care. 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

[23] 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/.

[24] *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.

[25] *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.

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

[27] 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/.

[28] *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.

regulations are tailored "to impose the least burden on society."[29] 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.[30]

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.[31] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[32]

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 Department-funded programs or other federal health programs, such as Title X, the only dedicated domestic family planning program, while refusing to provide key services required by those programs.[33] For instance, Congress has specifically required that under the Title X program, providers must offer nondirective pregnancy options counseling[34] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption and/or pregnancy termination.[35] 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.[36] 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

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[29] 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.

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

[31] 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).

[32] 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.

[33] *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.

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

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

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

supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[37] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with preexisting legal requirements, but could also undermine the program's fundamental objectives. Every year, millions of low-income – including underinsured and uninsured – individuals rely on Title X clinics to access services they otherwise might not be able to afford.[38]

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

Existing refusals of care based on personal beliefs already undermine open communication between patients and providers, 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 prevent their employees from treating patients regardless of the professional, ethical or moral convictions of these providers.[39] 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 to their patients.

The Proposed Rule threatens informed consent, a foundational principle of patient-centered decision-making intended to help balance the power dynamics between health providers and patients and ensure patient-centered decision-making.[40] 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.[41] By allowing providers, including hospitals 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.[42]

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

[37] *See* NFPRHA *supra* note 34.
[38] *See id.*
[39] *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.
[40] *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).
[41] *See id.*
[42] *See* Rule *supra* note 1, at 150-151.

medical conditions, including heart disease, diabetes, epilepsy, lupus, obesity and cancer.[43] 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.[44] 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.[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 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, and especially 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

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

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 previously 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]

There is much work still 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, more than 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. 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 and queer people and 29 percent of transgender people reported that

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§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 Research Overview of Maternal Mortality and Morbidity in the United States,* BLACK MAMAS MATTER 2, https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_MH_TO_ResearchBrief_Final_5.16.pdf.

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

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 refusal of care laws beyond their statutory requirements and create new 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 would generate chaos through its failure to account for existing laws that conflict with the refusals of care it would create.

For example, the Proposed Rule makes no mention of Title VII,[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, co-workers, 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, it is unclear under the Proposed Rule whether a Title X-funded health center could decline to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide nondirective options counseling, even though the employer could do so under Title VII.[61] It

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

is not only illogical 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 emergent 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 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. As an advocate for quality, evidence-based medical care and the integrity of the patient-provider relationship, the National Partnership for Women & Families calls on the Department to withdraw the Proposed Rule in its entirety. If you have questions please contact Sarah

[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.*

Lipton-Lubet, vice president of reproductive health programs at slipton-lubet@nationalpartnership.org.

Sincerely,

National Partnership for Women & Families

Exhibit 138

March 27, 2018

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

Submitted Electronically

Attention: Comments in Response to Department of Health and Human Services, Office for Civil Rights, Conscience NPRM, RIN 0945-ZA03

Dear Secretary Azar,

The National Women's Law Center ("the Center") is writing to comment on the Department of Health and Human Services' ("the Department") and the Office for Civil Rights' ("OCR") proposed rule "Protecting Statutory Rights in Health Care" ("Proposed Rule").[1] Since 1972, the Center has worked to protect and advance the progress of women and their families in core aspects of their lives, including income security, employment, education, and reproductive rights and health, with an emphasis on the needs of low-income women and those who face multiple and intersecting forms of discrimination. To that end, the Center has long worked to end sex discrimination and to ensure all people have equal access to the full range of health care, including abortion and birth control, regardless of income, age, race, sex, sexual orientation, gender identity, ethnicity, geographic location, or type of insurance coverage.

Despite the Department's claims, the Proposed Rule is unnecessary. It is also illegal. The Proposed Rule attempts to create new rights for individuals and entities to refuse to provide patient care by expanding existing, harmful religious exemption laws in ways that exceed and conflict with both the plain language of the statutes and Congressional intent. The Proposed Rule also asserts authority over other federal laws, attempting to create new refusals to provide care. In creating these new rights and expanding its reach, the Proposed Rule conflicts with federal law thereby fostering confusion and chaos.

The Proposed Rule emboldens discrimination. By making it easier for institutions and individuals to refuse to provide comprehensive health care, the Proposed Rule endangers the health and lives of women and lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people across the country. While the Center's comments focus in particular on the harm to women and access to reproductive health care, it is clear that the Proposed Rule will undermine the provision of health care and exacerbate health disparities for many patient populations, as other commentators will discuss. And yet the Department fails to take this harm into account. Contrary

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[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*].

to the Department's claims, the Proposed Rule harms rather than helps the provider-patient relationship and burdens providers who want to provide comprehensive care.

For all of these reasons, explained in more detail below, the Center is strongly opposed to the Proposed Rule and calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

I. Despite the Department's Claims, the Proposed Rule is Unnecessary, Emboldens Discrimination in Health Care, and Goes Far Beyond the 2008 Rule.

The Department claims that the Proposed Rule is necessary to protect individuals and health care providers from "discrimination, coercion, and intolerance."[2] But there is no need to address the so-called discrimination the Department purports to protect against. There are already ample religious exemptions in federal law, including in Title VII,[3] the Americans with Disabilities Act,[4] and the "ministerial exception" courts have read into the U.S. Constitution.[5] In addition, there are already a number of existing federal religious exemption laws that unfortunately allow individuals and entities to opt of providing critical health care services, in particular abortion and sterilization.[6] The Proposed Rule claims that more authority and enforcement of the religious exemption laws is needed, but the Notice of Proposed Rulemaking cites only forty-four complaints in ten years, which OCR is capable of handling without additional resources or authority.[7] Moreover, OCR already has authority to investigate complaints and, where appropriate, either collect funds wrongfully given while the entity was not in compliance or terminate funding altogether, and already educates providers about their rights under these laws.[8]

The reality is that the Department is seeking not to enforce existing laws but to expand them and create new rights under these laws. As explained below, this is unlawful and creates conflicts with other federal laws. Further, the Proposed Rule does not merely expand rights under existing refusal of care laws. Instead, it pulls in a host of new laws over which OCR has never before had authority, creating new rights and enforcement powers under these laws as well.

In so doing, the Proposed Rule does not address discrimination in health care, it emboldens it. The Proposed Rule intends to change existing law in order to allow any individual or entity involved in a patient's care – from a hospital's board of directors, to an insurance company, to the receptionist that schedules procedures – to use their personal beliefs to determine a patient's access to care. The Proposed Rule would further entrench discrimination against women and

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[2] *Id.* at 3903.
[3] 42 U.S.C. § 2000e-2 (1964).
[4] 42 U.S.C. § 12101 (1990).
[5] *See* Hosanna-Tabor Evangelical Lutheran Church v. Equal Emp't. Opportunity Comm'n, 132 S. Ct. 694, 704 (2012) (holding for the first time that the First Amendment requires a "ministerial exception").
[6] "Weldon Amendment", Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018); "Church Amendments" 42 U.S.C. § 300a-7 (2018); "Coats Amendment" 42 U.S.C. § 238n (2017).
[7] *Rule, supra* note 1, at 3886.
[8] *See* Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 45 C.F.R. pt. 88 (2011).

LGBTQ patients who already face high rates of discrimination in health care, including as a result of providers' religious beliefs. As explained in more detail below, this not only harms individuals and subjects them to discrimination, it is unlawful.

The Department tries to hide how far-reaching and dramatic this Proposed Rule is by claiming it is merely a reinstatement of the rule promulgated by the Bush Administration in 2008 and later rescinded by the Obama Administration in 2011.[9] Even if this was the case, the Proposed Rule would be dangerous. The 2008 rule was the subject of widespread opposition, including from 28 U.S. Senators and 131 Members of the U.S. House of Representatives, 14 state attorneys general, 27 state medical societies, the American Medical Association (AMA), American Hospital Association, National Association of Community Health Centers, American College of Emergency Physicians, and commissioners on the Equal Employment Opportunity Commission.[10] In fact, the AMA and several leading medical organizations argued the 2008 Rule would "seriously undermine patients' access to necessary health services and information, negatively impact federally-funded biomedical research activities, and create confusion and uncertainty among physicians, other health care professionals, and health care institutions."[11] But, the Proposed Rule reaches much further than the 2008 Rule. When compared to the 2008 Rule, the Proposed Rule seeks to allow more individuals and more entities to refuse care to patients and allow more services, or even information, to be refused, forces more entities to allow their employees to refuse care, imposes additional, unnecessary notice and compliance requirements, and invites states to further expand refusal laws.

II. The Proposed Rule Unlawfully Creates and Expands Rights to Refuse to Provide Care.

Under the Proposed Rule the Department intends to extend the reach of already harmful religious exemption laws so that any individual or entity, no matter how attenuated their involvement, can refuse to provide, participate in, or give information about any part of any health care service based on the assertion of a religious or moral belief. Furthermore, the Proposed Rule hamstrings the ability of an enormous range of entities to ensure that patients get the care they need. These expansions represent unlawful overreach by the Department and contradict the plain language of underlying federal law and Congressional intent.

a. The Proposed Rule Expands Existing Harmful Religious Exemption Laws

Although the Proposed Rule purports to merely interpret existing harmful federal laws that allow health care providers to refuse to treat an individual seeking an abortion and/or sterilization –

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[9] *Rule, supra* note 1, at 3885. *See also* Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law 73 Fed. Reg. 78,071(Dec. 19, 2009) (2008 Rule) (rescinded in large part by 76 Fed. Reg. 9,968 (Feb. 23, 2011)(codified at 45 C.F.R. pt. 88)).
[10] Comment Letters on Proposed Rule Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law 73 Fed. Reg. 50,274 (Aug. 26, 2008) (on file with National Women's Law Center).
[11] American Medical Assoc. et al. Comment Letter on Proposed Rule 73. Fed. Reg. 50,274 (Aug. 26, 2008)(on file with National Women's Law Center).

namely the so-called Church, Coats, and Weldon Amendments – in fact it creates new rights that are not specifically and currently enumerated in those laws.

It does this in part by redefining words in harmful, expansive ways that belie common understandings of the terms in order to create new rights. For example:

- The Proposed Rule's definition of "assist in the performance" greatly expands not only the types of services that can be refused, but also the individuals who can refuse. It includes those merely making "arrangements for the procedure" no matter how tangential and could be read to include individuals such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees. In fact, the definition includes participation "in any program or activity with an *articulable connection* to a procedure…" (emphasis added).[12] While what is meant by "articulable connection" is not clear, the use of the term in case law indicates an intention for it to be interpreted broadly – a mere connection that one can articulate may suffice.[13]
- Through a broad definition of "entity" the Proposed Rule attempts to expand the individuals and types of entities covered by religious exemption laws and allow an even broader swath of individuals within those entities to refuse to do their jobs.[14] For example, under the Proposed Rule a Department grantee that provides health care transportation services for individuals with disabilities could attempt to claim a right to refuse to provide that service to a person who needs a sterilization procedure. Or an employee at a research and development laboratory could claim the right to refuse to accept the delivery of biomedical waste donated from a hospital with an obstetrics and gynecology practice that performs abortions.
- The Proposed Rule's definition of "referral" goes beyond any common understanding of the term, allowing refusals to provide any information that could help an individual to get the care they need. [15] The Proposed Rule does not even require that patients be informed of the individual's or entity's refusal to provide care, information, referrals, or other services, leaving patients unaware that their health care providers is not providing the care or information they need.
- The Proposed Rule's definition of "workforce" attempts to expand refusals of care to an even broader range of people and would allow almost all staff levels within an entity, including volunteers or trainees, to assert a new right to refuse to do their job.[16] For example, a volunteer at a hospital could claim a right to refuse to deliver medicine to a patient's room or even deliver meals to a patient who is recovering from a surgery to which the volunteer objects.

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[12] *Rule, supra* note 1, at 3923.
[13] *Cf.* Jamerson v. Runnels, 713 F.3d 1218, 1229 (9th Cir. 2013) (describing the standard for evaluating whether a peremptory challenge was impermissibly based on race as "require[ing] only that the prosecutor express a believable and *articulable connection* between the race-neutral characteristic identified and the desirability of a prospective juror…"(emphasis added)).
[14] *Rule, supra* note 1, at 3924.
[15] *Id.*
[16] *Id.*

b. These New Rights are Contrary to Existing Law and Congressional Intent

The expansions and new and unwarranted definitions exceed and conflict with the existing federal laws the Proposed Rule seeks to enforce. For example, the Proposed Rule expands the definition of "health care entity" under existing law to include plan sponsors and third-party administrators.[17] Adding plan sponsors to the definition of "health care entity" under the Weldon Amendment is a blatant attempt to add words that plainly do not exist in the underlying federal law.[18] Indeed, just two years ago, OCR determined that the Weldon Amendment – according to its plain text – does not apply to plan sponsors.[19] This also holds true for the other ways in which the Proposed Rule attempts to expand the definition of "health care entity." Under the Coats and Weldon Amendments, "health care entity" is defined to encompass a limited and specific range of individuals and entities.[20] The Proposed Rule attempts to create a new definition of this term by combining statutory definitions of "health care entity" found in different statutes and applicable in different circumstances. Such an attempt to expand the meaning of a statutory term Congress already took the time to define goes directly against Congressional intent.[21]

The legislative history of the existing federal refusal of care laws reinforces that the Proposed Rule violates Congressional intent. For example, Congress adopted the Coats Amendment in response to a decision by the accrediting body for graduate medical education to rightfully require obstetrics and gynecology residency programs to provide abortion training. The legislative history of Coats states, "[p]roviders will continue to train the management of complications of induced abortion as well as train to handle [a] situation involving miscarriage and still birth or a threat to the life of the mother. The amendment requires no change in the practice of good obstetrics and gynecology."[22] The attempted expansion under the Proposed Rule to allow anyone to refuse to provide abortion regardless of the circumstances was clearly not intended. Similarly, proponents of the Weldon Amendment made "modest" claims about the Amendment, suggesting that the additional language was necessary only to clarify existing "conscience protections" not for it to be the sweeping license to refuse the Proposed Rule attempts to create.[23]

The Proposed Rule's expanded use of sections (c)(2) and (d) of the Church Amendments also violates Congressional Intent. These two sections were passed under Title II of the National Research Services Act in 1974, which specifically dealt with biomedical and behavioral research.[24] This Act was designed to ensure that research projects involving human subjects are

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[17] *Id.*
[18] *See* Weldon Amendment, *supra* note 6.
[19] *See* Letter from Jocelyn Samuels, Director of Office for Civil Rights, to Catherine W. Short, Esq. et al. (June 21, 2016), *available at* http://www.adfmedia.org/files/CDMHCInvestigationClosureLetter.pdf.
[20] Weldon Amendment, *supra* note 6; Coats Amendment, *supra* note 6.
[21] The doctrine of *expressio 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.
[22] 141CONG. REC. S17293 (June 27, 1995) (statement of Rep. Coats).
[23] 150 CONG. REC. H10090 (Nov. 20, 2004) (statement of Rep. Weldon).
[24] National Research Services Act of 1974, Pub. L. No, 93-348, 88 Stat. 348 § 214.

performed in an ethical manner.[25] Congress did not intend, as the Proposed Rule implies, to allow health care personnel to refuse to participate in any health care service. Such an expansion of the meaning of the Church Amendment was clearly not intended by Congress in the passage of the statute and would turn Congress' intent to protect patients on its head.

In other words, in greatly expanding the existing federal refusal laws relating to treating an individual seeking abortion or sterilization or refusing in the biomedical or behavioral research context, the Proposed Rule exceeds the scope of federal law and conflicts with congressional intent. It is therefore unlawful.

c. The Proposed Rule Overreaches Into Other Federal Laws, Undermining Congressional Intent

However, the Department does not limit its overreach to the aforementioned laws. Instead, under the Proposed Rule, the Department has unlawfully asserted authority over a greater number of federal statutes in an attempt to create new refusal provisions and to give the Department authority it previously did not have. For example, the Proposed Rule would prohibit a State agency that administers a Medicaid managed care program from requiring an organization "to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization objects."[26] However, the underlying Medicaid statute merely provides a rule of statutory construction which states that nothing in the statute should be construed to require a state agency that administers a Medicaid managed care program to use its funds for such purposes.[27] By misrepresenting the limited scope of this provision in order to create a new refusal provision, the Proposed Rule directly contradicts Congressional intent.

By attempting to create new refusal provisions, the Department also seeks to give OCR unlawful enforcement authority over these provisions. For many of these, Congress already established an enforcement scheme in the statute at issue. The Department should be reminded that "regardless of how serious the problem an administrative agency seeks to address … it may not exercise its authority 'in a manner that is inconsistent with the administrative structure that Congress enacted into law.'"[28] Not only is it unlawful for the Department to alter the enforcement mechanisms contemplated by the statute, in many cases it would be nonsensical. For example, the Proposed Rule is attempting to re-delegate oversight of youth suicide early intervention and prevention strategies to OCR, despite the specific existing authority held by the Center for Substance Abuse Treatment.[29] Congress specifically created a "Center for Substance Abuse Treatment," the director of which is already charged with administering block grants and ensuring compliance with applicable law for development of youth suicide early intervention and prevention strategies.[30] The Department's attempt to alter this statutory scheme by attempting to give OCR

[25] *See, e.g.*, Todd W. Rice, *The Historical, Ethical, and Legal Background of Human-Subjects Research*, 53 RESPIRATORY CARE 2325 (2008), http://rc.rcjournal.com/content/respcare/53/10/1325.full.pdf.
[26] *Rule, supra* note 1, at 3926.
[27] *See* 42 U.S.C. § 1395w-22 (2010).
[28] *See* Food and Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 125-26 (2000).
[29] *See Rule, supra* note 1, at 3927.
[30] *See* Center for Substance Abuse Treatment, 42 U.S.C. § 290bb (2016); Youth Suicide Early Intervention and Prevention Strategies, 42 U.S.C. § 290bb-36 (2004).

authority to enforce certain provisions of the block grant is unlawful. Moreover, this change is nonsensical, given that the provision of statutory construction found within the statute outlining the program's requirement was never intended to be used to create a right to refuse.[31]

III. The Proposed Rule Conflicts with Federal Laws.

The Proposed Rule generates conflict and confusion, creating chaos with existing federal laws. It appropriates language from landmark civil rights laws while entirely failing to even mention important laws that protect patients from discrimination and unreasonable barriers to health care access, that already govern employment discrimination based on religious belief, and that ensure patients get the care they need, particularly in emergency situations. By unilaterally attempting to broaden existing refusal of care laws, the Department jettisons the careful balance present in existing federal law. The Department attempts to upset this existing federal balance without legitimate statutory authority or even a reasoned explanation.

a. The Proposed Rule Would Subvert Civil Rights Statutes by Attempting to Appropriate their Language

The Department has exceeded its authority by appropriating language from civil rights statutes and regulations that were intended to improve access to health care and applying 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 unlawful, but is nonsensical and 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. They will place a significant and burdensome requirement on health care providers, taking resources away from patient care without adding any benefit.

Moreover, the Proposed Rule defines "discrimination" for the first time[32] and does so in a way that subverts the language of landmark civil rights statutes to shield those who would discriminate rather than to protect against discrimination. In this context, this broad definition is 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.

b. The Proposed Rule Conflicts with Sections 1554 and 1557 of the Affordable Care Act

The Proposed Rule conflicts with two provisions of the Affordable Care Act.

Section 1554 of the Affordable Care Act prohibits the Secretary of Health and Human Services from promulgating any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care."[33] As discussed in more detail below, religious refusals have been used to discriminate and deny patients the care they need based on the assertion of a religious or personal belief. By expanding the reach of refusals and permitting

[31] *See* 42 U.S.C. § 290bb-36 (2004).
[32] *Id.* at 3923-924.
[33] 42 U.S.C. § 18114(1) (2010).

objecting individuals and health care entities to deny patients needed health care services, the Proposed Rule erects unreasonable barriers to medical care and impedes access to health care services such as abortion and sterilization.[34]

Section 1557 of the Affordable Care Act prohibits discrimination in health care programs or activities on the basis of race, color, national origin, sex, age, or disability.[35] Prior to Section 1557, no broad federal protections against sex discrimination in health care existed. The ACA was intended to remedy this, as evidenced not only by the robust protection provided by Section 1557 itself, but also by the ACA's particular focus on addressing the obstacles women faced in obtaining health insurance and accessing health care.[36] As discussed in more detail below, by emboldening refusals for services that women and LGBTQ patients disproportionately or exclusively need, the Proposed Rule entrenches sex discrimination in health care and undermines the express purpose of Section 1557.

c. The Proposed Rule Conflicts with Title VII

The Proposed Rule makes no mention of Title VII, the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[37] 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.[38] 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

[34] The Proposed Rule therefore also violates § 706(2) of the APA, which instructs a reviewing court under arbitrary and capricious standard of review to consider and hold unlawful agency action found to be (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (D) without observance of procedure required by law; (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

[35] 42 U.S.C. § 18116 (2010).

[36] *See* 42 U.S.C. § 300gg(a) (2015) (allowing rating based only on family size, tobacco use, geographic area, and age, but not sex); 45 C.F.R. § 147.104(e) (2015) (prohibiting discrimination in marketing and benefit design, including on the basis of sex); *see also, e.g.*, 156 CONG. REC. H1632-04 (daily ed. March 18, 2010) (statement of Rep. Lee) ("While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children."); 156 CONG. REC. H1891-01 (daily ed. March 21, 2010) (statement of Rep. Pelosi) ("It's personal for women. After we pass this bill, being a woman will no longer be a preexisting medical condition."); 155 CONG. REC. S12026 (daily ed. Oct. 8, 2009) (statements of Sen. Mikulski) ("[H]ealth care is a women's issue, health care reform is a must-do women's issue, and health insurance reform is a must-change women's issue because . . . when it comes to health insurance, we women pay more and get less."); 155 CONG. REC. S10262-01 (daily ed. Oct. 8, 2009) (statement of Sen. Boxer) ("Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform."); 156 CONG. REC. H1854-02 (daily ed. March 21, 2010) (statement of Rep. Maloney) ("Finally, these reforms will do more for women's health . . . than any other legislation in my career.").

[37] *See* 42 U.S.C. § 2000e-2 (1964); 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.

[38] *Id.*

obligations.[39] 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 the Proposed Rule and Title VII. Indeed, when similar regulations were proposed in 2008, EEOC commissioners and the Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[40]

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 who refuses to provide non-directive options counseling to women with positive pregnancy tests even though it is an essential job function. The employer would not be required to do so under Title VII. 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.

d. The Proposed Rule Conflicts with Federal Law on Treatment of Patients Facing Emergency Situations

The Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion. 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.[41]

Because the Proposed Rule does not contain an explicit exception for situations in which an abortion – or other health service the Proposed Rule may empower individuals or entities to refuse – is needed to protect the health or life of a patient, the Proposed Rule is confusing to institutions regarding their obligations under the Proposed Rule as they relate to EMTALA. Every hospital is required to comply with EMTALA; even a religiously-affiliated hospital with an institutional objection to abortion must provide the care required in emergency situations.[42]

e. The Proposed Rule Violates the Establishment Clause

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[39] *Id.*

[40] Equal Emp't. Opportunity Comm'n. Legal Counsel Comment Letter on Proposed Rule 73 Fed. Reg. 50,274 (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html; Equal Emp't Opportunity Commissioners Christine Griffiin, Stuart Ishimaru Comment Letter on Proposed Rule 73 Fed. Reg. 50,274 (on file with National Women's Law Center).

[41] *See* 42 U.S.C. § 1395dd(a)-(c) (2003).

[42] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, Shelton v. University of Medicine and Dentistry of New Jersey, 223 F.3d 220, 228 (3rd Cir. 2000); *In re* Baby K, 16 F.3d 590, 597 (4th Cir. 1994); Nonsen v. Medical Staffing Network, Inc. 2006 WL 1529664 (W.D. Wis.); Grant v. Fairview Hosp. & Healthcare Servs., No. Civ. 02–4232JNEJGL, 2004 WL 326694, at *2 (D. Minn. 2006); Brownfield v. Daniel Freeman Marina Hosp., 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); Barris v. County of Los Angeles, 972 P.2d 966, 972 (Cal. 1999).

The Proposed Rule unlawfully establishes and adopts one subset of religious views while denying health care to those with differing views. In fact, staff within the Department have indicated that the Department intends to support evangelical beliefs over others.[43] These statements are consistent with the Department's actions.[44] The Department cannot promulgate proposed rules in reliance on unconstitutional preferences such as religious beliefs. Such actions are unlawful and out of line with the Department's historical mission.[45]

IV. The Proposed Rule Will Harm Patients, and the Department Has Failed to Take This Into Account.

The Proposed Rule is contrary to the Department's stated mission: "to enhance and protect the health and well-being of all Americans." In order to achieve that mission, one of the Department's primary goals is to "eliminate[ ] disparities in health, as well as [to increase] health care access and quality."[46] In its singular focus on what the Department claims is discrimination on the basis of religious or moral beliefs, it abdicates its mission. The Department ignores the pervasive discrimination in health programs and activities that individuals face, particularly those who seek reproductive health care, or because of their sex, gender identity, or sexual orientation. The Department unlawfully ignores how this discrimination is compounded by refusals of care based on personal beliefs and how the Proposed Rule will amplify that harm.

a. Certain Groups of Patients Routinely Face Discrimination in Health Care

Women have long been the subject of discrimination in health care.[47] Despite the historic achievements of the Affordable Care Act, women are still more likely to forego care because of cost,[48] and women – particularly Black women – are far more likely to be harassed by a

[43] Dan Diamond, *The Religious Activists on the Rise Inside Trump's Health Department*, POLITICO (Jan. 22, 2018), https://www.politico.com/story/2018/01/22/trump-religious-activists-hhs-351735.
[44] *See, e.g.*, Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding, 82 Fed. Reg. 49,300 (proposed Oct. 25, 2017); Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47, 792 (proposed Oct. 13, 2017).
[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 HHS Action Plan to Reduce Racial and Ethnic Health Disparities,* DEP'T OF HEALTH AND HUMAN SERVS., at 7, https://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.
[47] Prior to the Affordable Care Act (ACA), women were charged more for health care on the basis of sex and were continually denied health insurance coverage for services that only ciswomen, transgender, and gender non-conforming patients need. *See Turning to Fairness*, NAT'L WOMEN'S L. CTR. 1, 3-4 (2012), https://nwlc.org/wp-content/uploads/2015/08/nwlc_2012_turningtofairness_report.pdf (noting that while the ACA changed the health care landscape for women in significant ways, women still face additional hurdles).
[48] *See* Shartzer, et al., *Health Reform Monitoring Survey*, URBAN INST. HEALTH POLICY CTR. (Jan. 2015), http://hrms.urban.org/briefs/Health-Care-Costs-Are-a-Barrier-to-Care-for-Many-Women.html.

provider.[49] These barriers mean women are more likely not to receive routine and preventive care than men. Moreover, when women are able to see a provider, women's pain is routinely undertreated and often dismissed.[50] And due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[51]

LGBTQ individuals encounter high rates of discrimination in health care. According to one survey, eight percent of lesbian, gay, bisexual, and queer individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and seven percent experienced unwanted physical contact and violence from a health care provider.[52] Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity in the previous year.[53] Additionally, the 2015 U.S. Transgender Survey found that 23 percent of respondents did not see a provider for needed health care in the previous year because of fears of mistreatment or discrimination.[54]

And these barriers disproportionately impact those facing multiple and intersecting forms of discrimination, including women of color, LGBTQ persons of color, and individuals living with disabilities and those struggling to make ends meet. In one report, Black women disclosed that their doctors failed to inform them of the full range of reproductive health options regarding labor or delivery possibly due to stereotypes about Black women's sexuality.[55] Even though women living with disabilities report engaging in sexual activities at the same rate as women who do not live with disabilities, they often do not receive the reproductive health care they need for multiple reasons, including lack of accessible provider offices and misconceptions about their reproductive health needs.[56] These barriers also are often made worse by the complex web of

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[49] *See Discrimination in America: Experiences and Views of American Women*. NPR & HARVARD T.H. CHAN SCH. OF PUB. HEALTH (Dec. 2017), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2017/12/NPR-RWJF-HSPH-Discrimination-Women-Final-Report.pdf.

[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).

[52] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AMERICAN PROGRESS, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

[53] *Id.*

[54] *The Report of the 2015 U.S. Transgender Survey*, NAT'L CTR. FOR TRANSGENDER EQUALITY 5 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[55] *See The State of Black Women & Reproductive Justice*, IN OUR OWN VOICE (2017), http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

[56] RM Haynes et al., *Contraceptive Use at Last Intercourse Among Reproductive-Aged Women with Disabilities: An Analysis of Population-Based Data from Seven States*, CONTRACEPTION (2017), https://www.ncbi.nlm.nih.gov/pubmed/29253580; *see generally* Alex Zielinski, *Why Reproductive Health Can Be A Special Struggle for Women with Disabilities*, THINK PROGRESS, Oct. 1, 2015, https://thinkprogress.org/why-reproductive-health-can-be-a-special-struggle-for-women-with-disabilities-73ececea23c4/.

federal and state laws and policies that restrict access to care, particularly around certain health services like abortion.

b. Refusals of Care Based on Personal Beliefs Compound the Harm to Patients

This discrimination in health care against women, LGBTQ persons, and those facing multiple and intersecting forms of discrimination is exacerbated by providers invoking personal beliefs to deny access to health insurance and an increasingly broad range of health care services, including birth control, sterilization, certain infertility treatments, abortion, transition-related care, and end of life care.[57] For example, one woman experiencing pregnancy complications was 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.[58] A transgender man was denied gender affirming surgery at a religiously-affiliated hospital that refused to provide him a hysterectomy.[59] A woman called an ambulance after experiencing abdominal pain, but the ambulance driver refused to take her to get the care she needed.[60]

When refusals of care happen, many patients are forced to delay or forego necessary care, which can pose a threat not only to their health, but their lives. This is particularly true for patients with limited resources and options. For many patients, such refusals do not merely represent an inconvenience but can result in necessary or even emergent care being delayed or denied outright. These refusals are particularly dangerous in situations where individuals have limited options, such as in emergencies, when needing specialized services, in rural areas, or in areas where religiously-affiliated hospitals are the primary or sole hospital serving a community. The reach of these types of refusals to provide care continues to grow 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.[61]

c. The Proposed Rule Will Further Harm Patients, Yet the Department Unlawfully Ignores that Harm

[57] Directive 24 denies respect for advance medical directives. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. Moreover, religiously-affiliated individuals have challenged key provisions of the federal law and implementing regulations that prohibit discrimination on the basis of sex, gender identity, or sexual orientation in health care. *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care*, NAT'L WOMEN'S LAW CTR. (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf.; *see also Health Care Denied*, AM. CIVIL LIBERTIES UNION (May 2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[58] *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.

[59] *See id.* at 29.

[60] *Put Patient Health First,* NAT'L WOMEN'S LAW CENTER 1 (August 2017), https://nwlc.org/resources/continued-efforts-to-undermine-womens-access-to-health-care/.

[61] *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.

By stretching refusals of care far beyond their current reach, the Proposed Rule leaves patients seeking reproductive or sexual health care services facing even greater threats to their health, life, and future fertility than they did before. In addition, the expansion of refusals of care under the Proposed Rule has far reaching implications for those providing or seeking services and information in a wide range of areas including HIV, drug addiction, infertility, vaccinations, psychology, sexually transmitted infections and end-of-life care, among others. This means that the Proposed Rule will compound harm to patients in multiple new ways, imposing additional hurdles patients must overcome to get the care they need. For example, young people in federal custody, including foster youth and unaccompanied immigrant children, already face enormous hurdles to accessing health care. Yet, the Proposed Rule seeks to allow foster parents, social service agencies, and shelters that provide services to young people to refuse even minor assistance to a young person in their care who needs health services, including STI testing or treatment and abortion care.

The reach of the Proposed Rule will create a vicious cycle where those already subject to multiple forms of discrimination in the health care system may be the most likely to find themselves seeking care from a health care professional who refuses to provide it. For example, in many states women of color are more likely than white women to give birth at a Catholic hospital.[62] By expanding refusals of care, the Proposed Rule will exacerbate the barriers to health care services patients need.

Yet despite the overwhelming evidence of discrimination against patients seeking health care services and the harm of refusals of care that are based on personal beliefs, the Department issued this Proposed Rule. The Department fails entirely to consider the impact of the Proposed Rule on patients, particularly individuals seeking reproductive health care, patients of color, and LGBTQ individuals. At no point does the Proposed Rule acknowledge the many ways it will harm patients. This consideration is required by law and by the U.S. Constitution, and the Department's failure to account for these requirements renders the Proposed Rule invalid and unlawful.

III. The Proposed Rule Erodes the Core Tenants of the Medical System.

The Proposed Rule undermines the trust in the provider-patient relationship and unduly burdens those health care providers who want to fulfill their obligations to provide patients with the care they need.

a. The Proposed Rule Undermines the Provider-Patient Relationship

A strong provider-patient relationship is the foundation of our medical system. Patients rely on their providers to give full information about their treatment options and to provide medical advice and treatment in line with the standards of care established by the medical community. Yet, the Proposed Rule allows providers to do the opposite, threatening informed consent,

[62] *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.

undermining standards of care, and eroding patient trust in their providers and ultimately the medical system.

Informed consent is intended to help address the knowledge and power imbalance between providers and their patients, so patients can make their own competent and meaningful decisions about their treatment options.[63] The Proposed Rule acknowledges the importance of open, honest conversations in health care, stating "open communication in the doctor-patient relationship will foster better over-all care for patients."[64] Yet, it would allow providers, including hospitals and health care institutions, to ignore the patient's right to receive information and refuse to disclose relevant and medically accurate information about treatment options and alternatives. To make matters worse, the Proposed Rule includes provisions that specifically remove statutory requirements that health care entities at least notify patients they may be refused health care services or information. For example, it omits requirements enumerated in the counseling and referral provisions of the Medicaid managed care statute. These provisions require organizations that decline to cover certain treatments to notify enrollees of the policy.[65] The Department's attempts to affirmatively remove notice requirements underscore how little it cares about patients receiving full information. Allowing refusals to provide information and then barring patients from receiving any notice that they may not be given full information makes open communication impossible.

In addition to receiving non-biased information from their providers, patients also expect to receive treatment in line with medical practice guidelines and standards of care. Yet, the Proposed Rule seeks to allow providers, including hospitals and other health care institutions, to ignore the standards of care, particularly surrounding reproductive and sexual health. This completely undermines the provider-patient relationship and will create uncertainty and doubt where there should be trust and respect.

b. The Proposed Rule Burdens Providers that Want to Uphold the Hippocratic Oath and Provide Comprehensive Care

As the American Medical Association Code of Medical Ethics states, "the relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest."[66] Yet, the Proposed Rule flips this principle on its head – attempting to expand the ability of institutions to use personal beliefs to dictate patient care. In doing so, the Department allows institutions to block providers that want to provide patients with necessary or comprehensive care.

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[63] As the AMA Code of Ethics makes clear, "Informed Consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care." *Informed Consent*, AMERICAN MED. ASSOC., https://www.ama-assn.org/delivering-care/informed-consent (last visited Mar. 23, 2018).
[64] *Rule, supra* note 1, at 3917.
[65] The requirements of 42 U.S.C. § 1396u-2(b)(3)(B)(ii) excluded from the Proposed Rule's requirements surrounding Medicaid managed care organization. *See Rule, supra* note 1, at 3926.
[66] *Code of Medical Ethics: Patient-Physician Relationships*, AMERICAN MED. ASSOC., https://www.ama-assn.org/delivering-care/code-medical-ethics-patient-physician-relationships (last visited Mar. 23, 2018).

Most providers believe they should and must treat patients according to medical standards regardless of their personal beliefs. Moreover, many providers have deeply held moral convictions that affirmatively motivate them to provide patients with certain services, including abortion, transition-related care, and end-of-life care. Existing refusal of care laws already burden these providers. 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. The Proposed Rule would exacerbate these problems by expanding the number and types of institutions that can bind the hands of providers and limit the types of care, or even information, they can provide.

The Proposed Rule egregiously misuses research to falsely claim that a majority of obstetrician-gynecologists are unwilling to provide abortion.[67] In fact, the survey underlying the cited study found that over 80% of obstetrician-gynecologists are willing to help a patient obtain an abortion in the vast majority of cases. The survey also found that even where providers had a moral objection to providing abortion in a particular situation, a majority would still help the patient obtain an abortion.[68] Hospitals already discriminate against health care providers by preventing them from providing certain health care services, particularly abortion, even in life-threatening situations.[69] In fact, researchers have found that over a third of obstetrician-gynecologists experience conflict with their employers over religiously based patient care policies, with a majority of obstetrician-gynecologists at Catholic institutions reporting such conflicts.[70]

The Proposed Rule's expansion of entities that can constrain their employees not only ignores the barriers facing health care professionals who are committed to providing patients with comprehensive care regardless of personal beliefs, but it also ignores the Department's duty to enforce federal law that protects those who support abortion or sterilization. The Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services. No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion. But instead of acting to protect health care providers who put patients first, the Proposed Rule allows more institutions to interfere and prevent employees from providing care.

IV. The Proposed Rule Burdens States that Want to Protect Patient Access to Care.

As the Department recognized in the preamble of the Proposed Rule, forty-seven states have laws that allow health care providers and/or institutions to refuse health care to individuals based on personal beliefs.[71] These harmful existing state laws have already undoubtedly resulted in the

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[67] *Rule, supra* note 1, at 3916.

[68] Lisa Harris et al., *Obstetrician-Gynecologists' Objections to and Willingness to Help Patients Obtain an Abortion*, 118 OBSTETRICS & GYNECOLOGY 905 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4185126/.

[69] *Discrimination Against Health Care Professionals Who Provide or Support Abortion* NAT'L WOMEN'S LAW CENTER (August 2017), https://nwlc.org/resources/discrimination-against-health-care-professionals-who-provide-or-support-abortion/.

[70] Stulberg et al., *Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient Care Policies*, 73 AM. J. OF OBSTETRICS AND GYNECOLOGY e1 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3383370/

[71] *Rule, supra* note 1, at 3931; *see also Refusing to Provide Health Services*, GUTTMACHER INSTITUTE (Feb. 2018), https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services.

denial of health care, and in particular have endangered women's health. Now, the Proposed Rule is inviting states to enact even more sweeping laws.[72] The Proposed Rule encourages states to pass laws that go even further than the Proposed Rule does in allowing for refusals of health care. While it is clear that federal laws generally provide a minimum level of protection and allow states to enact more substantial protections, those protections are usually for the purpose of protecting individuals from discrimination and/or ensuring access to important services or benefits. As discussed above, the Proposed Rule subverts this entirely, entrenching discrimination and taking away access to health care services and benefits.

The Proposed Rule also creates a chilling effect on the enforcement of and passage of state laws that protect patient access to health care. The Department argues that the Proposed Rule is needed in order to clarify how federal religious exemption laws interact with state and local laws. To illustrate this purported need, the preamble cites several state laws intended to protect access to care. These include laws that require anti-abortion counseling centers to provide information about the full range of reproductive health care options and inform patients if the facility employs medical providers as well as state laws that ensure that individuals have comprehensive health insurance that includes abortion coverage. The discussion implies these and other laws that protect patient access to care conflict with the Proposed Rule, particularly when read in conjunction with several of the leading questions regarding state law posed in the preamble. This puts states in the untenable position of choosing between passing laws that protect their people and potentially losing millions of dollars in critical federal funding, likely resulting in a chilling effect on states attempting to pass or enforce laws intended to protect patients.

Conclusion

The Proposed Rule is illegal and harmful. It attempts to 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 Center unequivocally calls on the Department to withdraw the Proposed Rule.

Sincerely,

Fatima Goss Graves
President and CEO, National Women's Law Center

[72] *See e.g.*, *Rule*, *supra* note 1, at 3888-89.

Exhibit 139

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:

New Voices for Reproductive Justice is a Human Rights and Reproductive Justice advocacy organization with a mission to build a social change movement dedicated to the full health and well-being of Black women, femmes, and girls in Pennsylvania and Ohio. Since 2004 the organization has served over 75,000 women of color and LGBTQ+ people of color through community organizing, grassroots activism, civic engagement, youth mentorship, leadership development, culture change, public policy advocacy and political education.

New Voices defines Reproductive Justice as the human right of all people to have full agency over their bodies, gender identity and expression, sexuality, work, reproduction and the ability to form families. New Voices for Reproductive Justice opposes efforts by the Federal Administration and the U.S. Department of Health and Human Services to make it easier for a wide range of institutions and entities, including hospitals, pharmacies, doctors, nurses, even receptionists, to deny patients the critical care they need via the proposed rule entitled "Protecting Statutory Conscience Rights in Health Care" published January 26.[1]

In allowing unprecedented discretion of providers on religious, ethical, or moral grounds, the proposed conscience and religious freedom provisions make it easier for patients to be denied crucial healthcare and to encounter harmful provider bias. Women of color and LGBTQ+ people of color, in particular, already face disproportionate and systemic barriers to accessing care. Under these newly proposed rules, blatant racism, homophobia, transphobia, and gender discrimination are given the opportunity to run rampant in the health care system without consequence.

This proposed regulation would exacerbate the challenges that many patients -- especially women, LGBTQ people, people of color, immigrants and low-income people -- already face in getting the health care they need in a timely manner and at an affordable cost. The rule would expose vulnerable patients to increased discrimination and denials of medically indicated care by broadening religious health care provider exemptions beyond the existing limited circumstances allowed by law. Moreover, while

[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].

protecting health providers who deny care, the rule would provide *no protections for patients who are being denied care – even in emergencies*. As drafted, the rule would not even require that patients be informed of all their potential treatment options and referred to alternative providers of needed care.

We urge the administration to put patients first, and withdraw the proposed regulation because of the serious problems enumerated below.

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

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

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

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

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

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

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[2] *See, e.g., Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Utley, L., et al, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), https://www.aclu.org/report/miscarriage-medicine.
[3] *See* Rule *supra* note 1, at 12.
[4] Hardaway, Lisa, *Settlement Reached in Case of Lambda Legal Lesbian Client Denied Infertility Treatment by Christian Fundamentalist Doctors*, Lambda Legal, September 29, 2009, accessed at https://www.lambdalegal.org/news/ca_20090929_settlement-reached.
[5] Erdely, Sabrina, *Doctors' beliefs can hinder patient care*, SELF magazine, June 22, 2007, accessed at http://www.nbcnews.com/id/19190916/print/1/displaymode/1098/

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

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

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

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

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

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

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

[8] Stein, Rob, *Religious hospitals' restrictions sparking conflicts, scrutiny*, The Washington Post, January 3, 2011, accessed at https://www.washingtonpost.com/health-environment-science/religious-hospitals-restrictions-sparking-conflicts-scrutiny/2011/01/03/ABVVxmD_story.html?utm_term=.ec34abcbb928

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

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

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

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

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

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

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

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

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

Across the country, refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[16] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage

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

management she needed because the hospital objected to this care.[17] Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.[18] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital, which refused to provide him a hysterectomy.[19] 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.[20] 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.[21]

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.[22] 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.[23] In rural areas there may be no other sources of health and life preserving medical care.[24] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that In 19 states, women of color are more likely than white women to give birth in Catholic hospitals.[25] Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provide guidance on a wide range of hospital matters, including reproductive health care, and can keep providers from offering the standard of care.[26] The reach of this type of religious refusal of care is growing with the proliferation

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[17] *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.
[18] *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.
[19] *See* Kira Shepherd, et al., *supra* note 19, at 29.
[20] *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.
[21] *See* Kira Shepherd, et al., *supra* note 19, at 27.
[22] 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.
[23] 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.
[24] 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/.
[25] *See* Kira Shepherd, et al., *supra* note 19, at 12.
[26] *See id.* at 10-13.

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.[27]

7. The Department is abdicating its responsibility to patients

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

The proposed rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. For example, Black women are three to four times more likely than white women to die during or after childbirth.[28] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[29] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[30] OCR must work to address these disparities, yet the proposed rule is antithetical to OCR's mission.

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

The proposed rule will have a chilling effect on the enforcement and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. Moreover, the proposed rule invites states to further expand refusals of care by making clear that this expansive rule is a floor, and not a ceiling, for religious exemption laws.[31]

Conclusion

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

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[27] *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.
[28] *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.
[29] *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.
[30] *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.
[31] *See, e.g.*, Rule, *Supra* note 1, at 3888-89.

Exhibit 140

March 27, 2018

Via electronic submission

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (Docket No.: HHS-OCR-2018-0002)

To Whom It May Concern:

The New York City Commission on Human Rights, the New York City Department of Health and Mental Hygiene, the New York City Department of Social Services, and NYC Health + Hospitals write to express our opposition to the United States Department of Health and Human Services' (HHS) proposed regulations entitled, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.

HHS' proposed rule will cause serious harm to the health and well-being of New Yorkers. It will erect barriers to the delivery and receipt of timely, high quality health care. It will foster a new standard of selective and discriminatory treatment for many of our most vulnerable populations. It will also multiply the administrative burdens that health care organizations shoulder to address time-sensitive health conditions. Finally, it will infringe on the ability of state and local governments to enforce their laws and policies. In the face of these significant harms, we urge HHS to rescind this rule.

The Proposed Rule Will Harm Patients

The proposed rule elevates healthcare providers' personal beliefs over patient health. It gives providers wide latitude in opting out of treating patients. Undoubtedly, providers will deny care to patients who need it. At a minimum, a denial will mean that patients who are turned away will experience delays and increased expenses in receiving care. But in many cases, delay will effectively mean denial, particularly where time is of the essence or locating a suitable alternate provider is not feasible. The denial of care will be the end of the road in many patients' search for treatment.

Indeed, finding an alternate provider is no simple task. Health plans have limited provider networks, caps on the number of specialty visits, and steep cost-sharing obligations. Workers have limited or no sick leave, and forcing them to visit a second provider to accommodate the first provider's beliefs means that many patients will have to decide between taking care of their health and making a living. That is no choice at all, and many patients will forego care that they otherwise would have received.

Similarly, many people live in areas with a limited number of primary care doctors, specialists, and specialty care facilities. They may be forced to travel great distances to find a provider willing to treat them. Patients who are elderly, patients with disabilities, and patients under the age of majority may be completely unable to access an alternate healthcare provider if refused

care. During an emergency such as a national disaster, there may be only one accessible provider.

The denials of care that will result if the proposed rule is adopted will have severe and often irreversible consequences: unintended pregnancies, disease transmission, medical complications and anguish in the last days of life, and death. For example:

- Post-exposure prophylaxis for HIV should be initiated within 36 hours, but not beyond 72 hours after potential exposure.
- Emergency contraception is most effective at preventing pregnancy if taken as soon as possible after sexual intercourse.
- Contraceptives and pre-exposure prophylaxis for HIV are effective only if accessed prior to a sexual encounter.
- There is a window for a safe, legal abortion, and a narrower window for medication abortion. In the case of ectopic pregnancy or other life-threatening complication, an abortion may need to be performed immediately.
- Opiate users denied methadone or buprenorphine remain at increased risk of overdose, and naloxone must be administered quickly to reverse drug overdose.
- Persons with suicidal ideation need immediate care to prevent self-harm.
- Refusing to honor a person's end-of-life wishes prolongs suffering.

In short, the proposed rule will cause long-lasting and irreparable harm to patients.

The breadth of the proposed rule is extraordinary, all but guaranteeing that patients will be denied essential health care. Extending protections to health plans, plan sponsors, and third-party administrators that receive federal funds may prompt health plans to cease coverage for abortion, contraceptives, health care related to gender transition, and other services. Allowing anyone "with an articulable connection to a procedure, health service, health program or research activity" to raise an alleged conscience objection, means that the myriad of participants in a healthcare encounter—from intake and billing staff to pharmacists, translators, radiology technicians, and phlebotomists—can refuse to participate in service delivery. This will cause untold disruptions and delays for patients. And the expansive definitions of "assist in the performance" and "referral" mean that healthcare providers – after refusing to care for a patient – will not even need to provide a referral or other necessary information for a patient to seek care elsewhere.

The negative health impact of denied care is profound. In the case of infectious disease, there is societal impact: delays in diagnosis, prophylaxis and treatment increase the likelihood of individual disease progression and transmission to others. The consequences of untreated substance use disorders are likewise far-reaching. Compounding matters, the harmful effects of the proposed rules will be felt most acutely by individuals and communities that already face great challenges accessing the care that they need: people of color, low-income persons, women, children, people with substance use disorders, and lesbian, gay, bisexual, transgender, queer, intersex and gender nonconforming ("LGBTQI") persons.

The Proposed Rule Will Lead to Discrimination Against Already Vulnerable Populations

The rule gives healthcare providers a free pass to discriminate based on a patient's identity and against any patient whose actions or decisions conflict with the provider's alleged conscience objection.

Discrimination by health care providers marginalizes and stigmatizes patients, driving them away from care systems. It has long-term destructive consequences for the health and well-being of patients and communities that already bear the brunt of discrimination. Women and LGBTQI people will find themselves denied care at alarming rates. Providers may refuse to prescribe contraceptives to women who are not married, fertility treatment to same-sex couples, pre-exposure prophylaxis to gay men, or counseling to LGBTQI survivors of hate or intimate partner violence. Transgender patients are likely to be refused medically necessary care like hormone therapy, and substance users may be denied medications to treat addiction or reverse drug overdose.

The impact of such discrimination extends far beyond the individual patient encounter. For example, LGBTQI youth that are denied services and psychosocial support show a lasting distrust of systems of care.[i] Concerns regarding stigma may also make patients reluctant to reach out to loved ones for support, as has been shown with women who have had abortions.[ii]

This never-before-seen license to pick and choose the type of patient and nature of care that a clinician or organization will provide runs counter to principles of comprehensiveness and inclusion that have long guided the federal government's oversight of key health care programs and the operation of the country's health care delivery system.

The Proposed Rule Creates New Administrative Burdens for a Strained Health Care System

The extraordinary breadth of the proposed rule will result in significant and costly administrative burdens on an already-strained healthcare system. The proposed rule places healthcare entities in the precarious position of having to accommodate various ethical beliefs held by thousands of staff, regardless of how tenuous those staffs' connection to the clinical encounter. Also, by prohibiting employers from withholding or restricting any title, position or status from staff that refuse to participate in care, healthcare entities are limited in being able to move staff into positions where they will not disrupt care and harm patients. Thus, doctors in private practice will be prohibited from firing any staff who refuses to assist, and thereby stigmatizes and harms, LGBTQI patients. Emergency departments, ambulance corps, mental health hotlines, and other urgent care settings may need to increase the number of shift staff to ensure sufficient coverage in case of a refusal to work with a patient. This will have a very real financial impact on healthcare facilities, including government-run and subsidized clinics and hospital systems. This is a costly proposition that flies in the face of the federal government's stated goal of reducing administrative burdens within the health care system.

The Proposed Rule Infringes on State and Local Governments' Ability to Enforce Their Laws and Policies and Conflicts with Patient Protections

The proposed rule may impact the ability of State and local governments to enforce the full scope of their health- and insurance-related laws and policies by conditioning the receipt of federal funding on compliance with the rule. Similarly, it may leave providers caught between conflicting mandates. The New York City Human Rights Law ("City Human Rights Law"), for example, like many state and local nondiscrimination laws, protects patients from discrimination based on sexual orientation, gender (including gender identity), marital status, and disability.

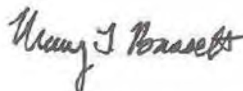
Protecting vulnerable populations from discrimination and misinformation is of paramount importance to New York City. The City Human Rights Law is one of the most comprehensive civil rights laws in the nation, prohibiting discrimination in health care settings based on, among other things, a patient's race, age, citizenship status, and religion. A provider's refusal to serve a patient pursuant to the proposed rule may be a violation of state and local laws, some of which are enforced through the imposition of injunctive relief and substantial financial penalties. Violations of the City Human Rights Law, for example, can lead to the imposition of penalties of up to $250,000 per violation.

We oppose regulations that allow personal beliefs to trump science at the expense of vulnerable populations' access to health care. We oppose systems that compromise our duty to protect and improve the health of City residents. We oppose actions that sanction discrimination against patients based on who they are or what health conditions they have.

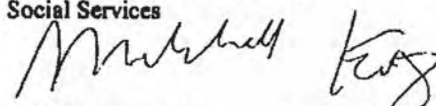
We urge HHS to rescind the proposed rule.

Sincerely,

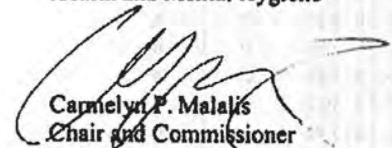
Steven Banks
Commissioner
New York City Department of
Social Services



Mary T. Bassett, MD, MPH
Commissioner
New York City Department of
Health and Mental Hygiene



Mitchell Katz, MD
President and Chief Executive Officer
New York City Health and Hospitals



Carmelyn P. Malalis
Chair and Commissioner
New York City Commission on
Human Rights

[1] Substance Abuse and Mental Health Services Administration. Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[x] Shellenberg KM, Tsui AO. Correlates of perceived and internalized stigma among abortion patients in the USA: an exploration by race and Hispanic ethnicity. *Int J Gynaecol Obstet*. 2012;118(2):60015-60010.

Exhibit 141

March 27, 2018

Submitted electronically

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

Attn: Conscience NPRM, RIN 0945-ZA03

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

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

The New York Civil Liberties Union (NYCLU), a nonprofit, nonpartisan organization with eight chapters, regional offices, and more than 200,000 members and supporters across the state, works to defend and promote the fundamental principles, rights and constitutional values embodied in the Bill of Rights of the U.S. Constitution and the Constitution of the State of New York. The NYCLU has a long history of vigorously defending religious liberty. We are equally vigilant in our efforts to safeguard reproductive rights and to end discrimination against those who have historically been excluded or diminished by more powerful actors in society, including in health care settings. The Proposed Rule implicates a host of health care services, including reproductive health services, end-of-life care, HIV/AIDS counseling and treatment, reproductive technology and fertility treatments, and post-sexual assault care. The NYCLU is particularly well-positioned to comment on the Proposed Rule and the serious concerns it raises about access to reproductive and other health care, based on the religious or other beliefs of institutions or individual providers. We steadfastly protect the right to religious freedom. But that right does not include a right to harm others as this Proposed Rule contemplates.

The NYCLU strongly advocates solutions that balance the protection of public health, patient autonomy, and gender equality with the protection of individual religious belief and institutional religious worship. To achieve this balance, we believe it is often possible to

accommodate an individual health care professional's religiously-based refusal to provide a particular health service so long as the professional takes steps to ensure that the patient can receive that service elsewhere. However, because health care providers serve patients and customers of all faiths and backgrounds, a provider's wholesale refusal to provide services poses a much greater risk of harm to those who do not share in those religious beliefs and should not be allowed to trump all other important societal interests.

The proposed regulation threatens to upset the careful balance between the religious freedom of health care providers and patients' ability to access health care services—a balance that has been carefully struck in both New York State and federal law. Since the founding of our Nation, freedom of religion has been one of our most highly prized liberties, and protections for that freedom are enshrined in both the United States and New York State Constitutions. Congress, as well as the state legislatures, have enacted numerous laws to add force to those protections. Both Title VII of the 1964 Civil Rights Act and the New York State Human Rights Law currently protect against discrimination on the basis of religion and in employment.[1] However, in codifying and applying these laws, courts and legislatures have been careful to ensure that in protecting religious liberty, other fundamental rights and freedoms are not unduly burdened. The proposed regulation fails to take the same precautions. New York State, in particular, has a history of balancing these sometimes competing interests to ensure seamless delivery of health care and protect individuals' religious liberty rights. Indeed, the New York Civil Rights Law prevents discrimination against individuals who refuse to perform abortions as against their religious beliefs.[2] Even in the insurance context, New York has created explicit carve outs for religious employers who wish to exclude contraception or abortion from their employees' health plan.[3] These laws represent important steps toward ending gender discrimination, ensuring access to health care that meets the standard of care, as well as ensuring religious objectors have the opportunity to honor their private beliefs.

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

[1] 42 U.S.C. § 2000e *et seq.* (2008); N.Y. Executive Law § 296.
[2] N.Y. Civil Rights Law 79-i.
[3] *E.g.*, N.Y. Ins. Law § 3221(l)(16), 4303(cc) (the New York Women's Health and Wellness Act contains an exemption from a contraceptive insurance coverage requirement for religious employers).

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

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

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

The Proposed Rule seeks to immunize refusals of health care, yet utterly fails to consider the harmful impact it would have on patients' health. But this failure to address the obvious consequences of giving federally subsidized providers *carte blanche* to decide whom to treat or not treat based on religious or moral convictions—or indeed, based on any reasoning or none at all[4]—does not mean the harm does not exist. In fact, the harms would be substantial. For example, the Proposed Rule:

- Appears to provide immunities for health care institutions that receive federal funding and professionals who work in federally funded programs to refuse to provide complete information to patients about their condition and treatment options;

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

- Causes confusion about whether hospitals can prevent staff from providing emergency care to pregnant women who are suffering miscarriages or otherwise need emergency abortion care; and

- Invites health care providers to discriminate against individuals based on who they are, for example, by refusing to provide otherwise available services to a patient for the sole reason that the patient is transgender or by refusing to provide medical services to the children of a same sex couple or by refusing care for patients living with HIV, including the option of pre-exposure prophylaxis (PrEP) for those people who are in a sexual relationship with an HIV-positive partner.

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

- Permits health care providers to refuse to honor the advance health care directives of patients who choose a DNR/DNI order or who refuse artificial nutrition or other life-sustaining medical treatment.

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

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

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

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

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

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

A. Assist in the Performance

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

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

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

B. Referral or Refer for

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

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

C. <u>Discriminate or Discrimination</u>

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

D. <u>Other Expansions of the Scope of the Refusal Statutes</u>

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

For example, Congress enacted Subsection (d) of the Church Amendment in 1974 as part of Public Law 93-348, a law that addressed biomedical and behavioral research, and appended that new Subsection (d) to the pre-existing subsections of Church from 1973, which all are codified within 42 U.S.C. § 300a-7: the "Sterilization or Abortion" section within the code subchapter that relates to "Population Research and Voluntary Family Planning Programs." Despite this explicit context for Subsection (d), and Congress' intent that it apply narrowly, however, the Proposed Rule attempts to import into this Subsection an unduly broad definition of "health service program," along with the expansive definitions discussed above, to purportedly transform it into a much more general prohibition that would apply to any programs or services administered by the Department, and that would assertedly prevent any entity that receives

federal funding through those programs or services from requiring individuals to perform or assist in the performance of actions contrary to their religious beliefs or moral convictions. *See* 83 FR 3894, 3906, 3925. This erroneous expansion of Church (d), as described in this attempted rule-making, could prevent health care institutions from ensuring that their employees provide appropriate care and information. It would purportedly prevent institutions taking action against members of their workforce who refuse to provide any information or care that they "sincerely understand" may have an "articulable connection" to some eventual procedure to which they object—no matter what medical ethics, their job requirements, Title VII or laws directly protecting patient access to care may require.

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

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

The Department should withdraw the Rule to prevent it from impeding health care and harming patients. But if it does not do so, each of the definitions must be clarified and revert to

the terms' proper meaning, and each of the substantive requirements should track only those provisions actually found in the Refusal Statutes themselves.

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

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

New York State Public Health Law requires physicians to obtain informed consent before provision of any procedure, and defines informed consent as including advice as to the foreseeable risks and benefits of a proposed treatment, as well as any alternatives.[5] And, as the American Medical Association's Code of Medical Ethics ("AMA Code") explains, the relationship between patient and physician "gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest[.]" AMA Code § 1.1.1. Even in instances where a provider's beliefs are opposed to a particular course of action, the provider must "[u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects." *Id.* § 1.1.7(e).

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

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

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

[5] See N.Y. Public Health Law § 2805(d).

A. Title VII

The Proposed Rule is not only unauthorized and harmful to patients, it is also unnecessary to accommodate individual workers—federal law already amply protects individuals' religious freedom in the workplace. For more than four decades, Title VII has required employers to make reasonable accommodations for current and prospective employers' religious beliefs so long as doing so does not pose an "undue hardship" to the employer. 42 U.S.C. §§ 2000e(j), 2000e-(2)(a); *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 84 (1977); EEOC Guidelines, 29 C.F.R. § 1605.2(e)(1).[6] Thus, Title VII—while protecting freedom of religion—establishes an essential balance. It recognizes that an employer cannot subject an employee to less favorable treatment because of that individual's religion and that generally an employer must accommodate an employee's religious practices. However, it does not require accommodation when the employee objects to performing core job functions, particularly when those objections harm patients, depart from the standard of care, or otherwise constitute an undue hardship. *Id.* This careful balance between the needs of employees, patients, and employers is critical to ensuring that religious beliefs are respected while at the same time health care employers are able to provide quality health care to their patients.

The New York State Human Rights and Civil Rights laws similarly afford protection against religious discrimination by employers, including on the grounds that a health care provider refuses to provide abortion.[7] However, the New York courts have also applied a balancing test, and have stopped short of requiring employers to offer accommodations that would impede their mission or interfere with their ability to conduct business[8]. In the health care context, this has meant that employers whose mission is providing health care to the public have not been required to accommodate the religious beliefs of their employees if the accommodation sought would impede their ability to serve patients promptly and respectfully.[9]

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

[7] *See* N.Y. Executive Law § 296; N.Y. Civil Rights Law § 79-I; *Larson v. Albany Med. Ctr.*, 252 A.D.2d 936 (N.Y. App. Div., 3d Dep't 1998).

[8] *See Eastern Greyhound Lines v. New York State Div. of Human Rights*, 27 N.Y.2d 279, 284 (1970) (holding uniformly applied policy requiring all employees to be clean-shaven was not an unlawful discriminatory practice as applied to a Muslim employee whose religion required him to have a beard); *Harmon v. General Electric Co.*, 72 A.D.2d 903, 904 (N.Y. App. Div., 3d Dep't 1979) (finding termination of employee who refused to continue working in employer's machinery apparatus operation based on pacifist views, which are part of his Catholic faith, was not an unlawful discriminatory practice). While the NYCLU may not agree with the outcome in each of these cases, we cite them merely to illustrate that the courts have adopted a balancing test that appears to be completely absent from the proposed regulation's terms.

[9] *See Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 228 (3d Cir. 2000) (finding hospital's offer to move nurse who objected to performance of abortions from labor and delivery to infant ICU constituted reasonable accommodation of religious beliefs); *Noesen v. Med. Staffing Network, Inc.*, 232 Fed. Appx. 581, 584, 2007 WL 1302118, at *3 (7th Cir. 2007) (finding that pharmacy was not required to offer accommodation to pharmacist who objected to provision of birth control removing him from all contact with patients because such accommodation would pose undue hardship on employer); *Grant v. Fairview Hosp. and Healthcare Servs.*, 2004 WL 326694, at *5 (D. Minn. 2004) (holding hospital had offered reasonable accommodation to ultrasound technician who disapproved of abortion by taking steps to avoid him coming into contact with patients contemplating abortion, but that it was not required to permit him to provide pastoral counseling to all pregnant patients receiving ultrasounds).

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

B. EMTALA

The Proposed Rule also puts patients at risk by ignoring the federal Emergency Medical Treatment and Labor Act ("EMTALA") and hospitals' obligations to care for patients in an emergency. As Congress has recognized, a refusal to treat patients facing an emergency puts their health and, in some cases, their lives at serious risk. Through EMTALA, Congress has required hospitals with an emergency room to provide stabilizing treatment to any individual experiencing an emergency medical condition or to provide a medically beneficial transfer. 42 U.S.C. § 1395dd(a)-(c). New York also has many protections in place to ensure medical care for patients in need, such as professional misconduct laws prohibiting abandonment of a patient in need of care,[10] and state laws requiring emergency treatment for patients at hospital emergency rooms.[11] The proposed rule casts doubt on the State's continued authority to enforce such provisions.

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

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

[10] *See* 8 NYCRR § 29.2 (2008) (including abandoning patient in need of care in definition of professional misconduct for medical professionals).
[11] *See* New York State Emergency Medical Services Reform Act (EMSRA), N.Y. Public Health Law §2805-b; 10 NYCRR Part 800.

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

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

C. Section 1557

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

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

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

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

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

Thus, the Proposed Regulation and its treatment of state and local laws puts at risk provisions of New York State and local laws that prohibit medical facilities and providers from discriminating against anyone on the basis of certain characteristics, such as race, sex, sexual orientation, marital status or disability.[12]

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

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

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

[12] *See e.g.* N.Y. Human Rights Law, N.Y. Executive Law Article 15, § 290 *et seq.* and N.Y.C. Human Rights Law, N.Y.C. Admin. Code Title 8, § 8-801 *et seq.*.

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

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

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

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

* * *

For all these reasons, the Department should withdraw the Proposed Rule. If it fails to do

so, it must substantially modify the Proposed Rule so as, at a minimum, not to exceed the terms of and congressional intent behind the underlying statutes.

Sincerely,

Katharine Bodde
Senior Policy Counsel

Beth Haroules
Senior Staff Attorney

Exhibit 142

March 27, 2018

SUBMITTED VIA THE FEDERAL E-RULEMAKING PORTAL

Roger Severino
Director
Office for Civil Rights
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 209F
200 Independence Avenue SW
Washington, DC 20201

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (RIN 0945-ZA0; Docket No.: HHS-OCR-2018-0002)

To Whom It May Concern:

NMAC (formerly, the National Minority AIDS Council) submits these comments to the U.S. Department of Health and Human Services ("Department") and its Office for Civil Rights ("OCR") to urge the Department to uphold its duty to "enhance the health and well-being of all Americans" by withdrawing the proposed rule entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority. "

NMAC, a 501(c) 3 organization, develops leadership in communities of color to end the HIV epidemic. NMAC leads with race to urgently fight for health equity and racial justice to end the HIV epidemic in America. Since 1987, NMAC has advanced this mission through a variety of programs and services, including a public policy education program, national and regional training conferences, treatment and research programs, numerous electronic and materials and a website: http://www.nmac.org/. NMAC also serves as an association of HIV service organizations providing valuable information to community-based organizations, hospitals, clinics and other groups assisting individuals and families affected by the HIV epidemic.

The regulations fail to account for the significant burden that will be imposed on patients, a burden that will fall disproportionately and most harshly on women, people of color, people living with disabilities, and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals. These communities already experience severe health disparities and discrimination, conditions that will be exacerbated by the proposed rule, possibly ending in in poorer health outcomes. By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the Department seeks to use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. The regulations as proposed would introduce broad and poorly defined language to the existing law that already provides ample protection for the ability of health care providers to refuse to participate in a health care service to which they have moral or religious objections.

For the following reasons, the NMAC calls on the Department and OCR to withdraw the proposed rule in its entirety:

I. The expansion of religious refusals under the proposed rule will disproportionately harm communities who already lack access to care

Women, individuals living with disabilities, LGBTQ persons, people living in rural communities, people living with HIV (PLWH) and people of color face severe health and health care disparities, and these disparities are compounded for individuals who hold these multiple identities. For example, among adult women, 15.2 percent of those who identified as lesbian or gay reported being unable to obtain medical care in the last year due to cost, as compared to 9.6 percent of straight individuals.[1] Women of color experience health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.[2] Meanwhile, people of color in rural America are more likely to live in an area with a shortage of health professionals, with 83% of majority-Black counties and 81% of majority-Latino/a counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

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

a. The proposed rule will block access to care for low-income women, including immigrant women and African American women

Broadly-defined and widely-implemented refusal clauses undermine access to basic health services for all, but can particularly harm low-income women of color. The burdens on low-income women can be insurmountable when women and families are uninsured,[3] underinsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services nor travel to another location. This is especially true for immigrant women. In comparison to their U.S. born peers, immigrant women are more likely to be

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[1] Brian P. Ward et al., *Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey*, NAT'L CTR. FOR HEALTH STATISTICS, 2013 9 (2014), https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf.

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

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

uninsured.[4] Notably, immigrant, Latina women have far higher rates of uninsurance than Latina women born in the United States (48 percent versus 21 percent, respectively).[5]

According to a recent report, doctors often fail to inform Black women of the full range of reproductive health options regarding labor or delivery possibly due to stereotypes about Black women's sexuality and reproduction.[6] Young Black women noted that they were shamed by providers when seeking sexual health information and contraceptive care in part, due to their age, and in some instances, sexual orientation.[7]

New research also shows that women of color in many states disproportionately receive their care at Catholic hospitals, subjecting them to treatment that does not comply with the standards of care.[8] In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[9] In New Jersey, for example, women of color make up 50 percent of women of reproductive age in the state, yet have twice the number of births at Catholic hospitals compared to their white counterparts.[10] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on wide range of hospital matters, including reproductive health care. In practice, the ERDs prohibit the provision of emergency contraception, sterilization, abortion, fertility services, and some treatments for ectopic pregnancies. 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, risking their health.[11] The proposed rule will give health care providers a license, such as Catholic hospitals, to opt out of evidence-based care that the medical community endorses. If this rule were to be implemented, more women, particularly women of color, will be put in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services. For many, this choice does not exist.

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[4] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf.
[5] *Id.* at 8, 16.
[6] CTR. FOR REPROD. RIGHTS, NAT'L LATINA INST. FOR REPROD. HEALTH & SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter *Reproductive Injustice*]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), *available at* http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.
[7] *Reproductive Injustice*, *supra* note 10, at 16-17.
[8] Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT (2018), *available at* https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[9] *Id* at 12.
[10] *Id* at 9.
[11] Lori R. Freedman et al., *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/.

b. The proposed rule will negatively impact rural communities

The ability to refuse care to patients will leave many individuals in rural communities with no health care options. Medically underserved areas already exist in every state,[12] with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[13] Many rural communities experience a wide array of mental health, dental health, and primary care health professional shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.[14] Among the many geographic and spatial barriers that exist, individuals in rural areas often must have a driver's license and own a private car to access care, as they must travel further distances for regular checkups, often on poorer quality roads, and have less access to reliable public transportation.[15] This scarcity of accessible services leaves survivors of intimate partner violence (IPV) in rural areas with fewer shelter beds close to their homes, with an average of just 3.3 IPV shelter beds per rural county as compared to 13.8 in urban counties.[16] Among respondents of one survey, more than 25 percent of survivors of IPV in rural areas have to travel over 40 miles to the nearest support service, compared to less than one percent of women in urban areas.[17]

Other individuals in rural areas, such as people with disabilities, people with Hepatitis C, and people of color, have intersecting identities that further exacerbate existing barriers to care in rural areas. Racial and ethnic minority communities often live in concentrated parts of rural America, in communities experiencing rural poverty, lack of insurance, and health professional shortage areas.[18] People with disabilities experience difficulties finding competent physicians in rural areas who can provide experienced and specialized care for their specific needs, in buildings that are barrier free.[19] Individuals with Hepatitis C infection find few providers in rural areas with the specialized knowledge to manage the emerging treatment options, drug toxicities and side effects.[20] All of these barriers will worsen if providers are allowed to refuse care to particular patients.

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[12] Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA, (last visited Mar. 21, 2018).

[13] M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH (2010), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/.

[14] Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations*, ECON. RESEARCH SERV. (2009), *available at* https://www.ers.usda.gov/publications/pub-details/?pubid=44427.

[15] Thomas A. Arcury et al., *The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region*, 40 HEALTH SERV. RESEARCH (2005) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361130/.

[16] Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources*, 20 J. OF WOMEN'S HEALTH (Nov. 2011) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216064/.

[17] *Id.*

[18] Janice C. Probst et al., *Person and Place: The Compounding Effects of Race/Ethnicity and Rurality on Health*, AM. J. PUB. HEALTH (2011), *available at* http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1695.

[19] Lisa I. Iezzoni et al., *Rural Residents with Disabilities Confront Substantial Barriers to Obtaining Primary Care*, 41 HEALTH SERV. RESEARCH (2006), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1797079/.

[20] Sanjeev Arora et al., *Expanding access to hepatitis C virus treatment – Extension for Community Healthcare Outcomes (ECHO) Project: Disruptive Innovation in Specialty Care*, 52 HEPATOLOGY (2010), *available at* http://onlinelibrary.wiley.com/doi/10.1002/hep.23802/full.

Meanwhile, immigrant, Latina women and their families often face cultural and linguistic barriers to care, especially in rural areas.[21] These women often lack access to transportation and may have to travel great distances to get the care they need.[22] In rural areas there may simply be no other sources of health and life preserving medical care. When these women encounter health care refusals, they have nowhere else to go.

c. *The proposed rule would harm LGBTQ Communities who continue to face rampant discrimination and health disparities*

The proposed rule will compound the barriers to care that LGBTQ individuals face, particularly the effects of ongoing and pervasive discrimination by potentially allowing providers to refuse to provide services and information vital to LGBTQ health.

LGBTQ people continue to face discrimination in many areas of their lives, including health care, on the basis of their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[23] LGBTQ people still face discrimination in a wide variety of services affecting access to health care, including reproductive services, adoption and foster care services, child care, homeless shelters, and transportation services – as well as physical and mental health care services.[24] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.[25] They concluded that discrimination as well as insensitivity or disrespect on the part of health care providers were key barriers to health care access and that increasing efforts to provide culturally sensitive services would help close the gaps in health care access.[26]

i. <u>Discrimination against the transgender community</u>

Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[27] Numerous federal courts

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[21] Michelle M. Casey et al., *Providing Health Care to Latino Immigrants: Community-Based Efforts in the Rural Midwest*, AM. J. PUB. HEALTH (2011), *available at* http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1709.

[22] NAT'L LATINA INST. FOR REPROD. HEALTH & CTR. FOR REPROD. RIGHTS, NUESTRA VOZ, NUESTRA SALUD, NUESTRO TEXAS: THE FIGHT FOR WOMEN'S REPRODUCTIVE HEALTH IN THE RIO GRANDE VALLEY, 7 (2013), *available at* http://www.nuestrotexas.org/pdf/NT-spread.pdf.

[23] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 8, 2018).

[24] HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

[25] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.

[26] *Id.*

[27] *See, e.g.*, *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018); *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (Title IX and Equal Protection Clause); Doddsv. U.S. Dep't of Educ., 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004)

have found that federal sex discrimination statutes reach these forms of gender-based discrimination.[28] In 2012, the Equal Employment Opportunity Commission (EEOC) likewise held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII."[29]

Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity and 29 percent experienced unwanted physical contact from a health care provider.[30] Additionally, the 2015 U.S. Transgender Survey found that 23 percent respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[31]
Data obtained by Center for American Progress (CAP) under a FOIA request indicates the Department's enforcement was effective in resolving issues of anti-LGBTQ discrimination. CAP received information on closed complaints of discrimination based on sexual orientation, sexual orientation-related sex stereotyping, and gender identity that were filed with the Department under Section 1557 of the ACA from 2012 through 2016.

(Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *A.H. ex rel. Handling v. Minersville Area School District*, 3:17-CV-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and Equal Protection Clause); *Stone v. Trump*, ---F.Supp.3d ---, No. 17–2459 (D. Md. Nov. 21, 2017) (Equal Protection Clause); Doe v. Trump, ---F.Supp.3d ---, 2017 WL 4873042 (D.D.C. Oct. 30, 2017) (Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, ---F.Supp.3d ---, 2017 WL 4310756 (S.D. Cal. Sept. 27, 2017) (Section 1557); *E.E.O.C. v. Rent-a-Center East, Inc.*, ---F.Supp.3d ---, 2017 WL 4021130 (C.D. Ill. Sept. 8, 2017) (Title VII); *Brown v. Dept. of Health and Hum. Serv.*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017) (Equal Protection Clause); *Smith v. Avanti*, 249 F.Supp.3d 1194 (D. Colo. 2017) (Fair Housing Act); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); *Mickens v. Gen. Elec. Co.* No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hosp. of Cent. Conn.*, 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016) (Section 1557); *Doe v. State of Ariz.*, No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016) (Title VII); *Dawson v. H&H Elec., Inc.*, No. 4:14CV00583 SWW, 2015 WL 5437101 (E.D. Ark. Sept. 15, 2015) (Title VII); *U.S. v. S.E. Okla. State Univ.*, No. CIV–15–324–C, 2015 WL 4606079 (W.D. Okla. 2015) (Title VII); *Rumble v. Fairview Health Serv.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557); *Finkle v. Howard Cty.*, 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Lopez v. River Oaks Imaging & Diagnostic Grp.*, Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); *Mitchell v. Axcan Scandipharm*, Inc., No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); *Tronettiv. Healthnet Lakeshore Hosp.*, No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII).

[28] *See, e.g.*, *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

[29] *Macy v. Holder*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).

[30] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AMERICAN PROGRESS, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

[31] NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf [hereinafter *2015 U.S. Transgender Survey*].

- "In approximately 30% of these claims, patients alleged denial of care or insurance coverage simply because of their gender identity – not related to gender transition."
- "Approximately 20% of the claims were for misgendering or other derogatory language."
- "Patients denied care due to their gender identity or transgender status included a transgender woman denied a mammogram and a transgender man refused a screening for a urinary tract infection."[32]

As proposed, the rule could allow religiously affiliated hospitals to not only refuse to provide transition related treatment for transgender people, but to also deny surgeons who otherwise have admitting privileges to provide transition related surgery in the hospital. Transition-related care is not only medically necessary, but for many transgender people it is lifesaving.

ii. Discrimination Based Upon Sexual Orientation

Many LGBTQ people lack insurance and providers are not competent in health care issues and obstacles that the LGBTQ community experiences.[33] LGBTQ people still face discrimination. According to one survey, 8 percent of lesbian, gay, bisexual, and queer individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and 7 percent experienced unwanted physical contact and violence from a health care provider.[34]

Fear of discrimination causes many LGB people to avoid seeking health care, and, when they do seek care, LGB people are frequently not treated with the respect that all patients deserve. The study "When Health Care Isn't Caring" found that 56 percent of LGB people reported experiencing discrimination from health care providers – including refusals of care, harsh language, or even physical abuse – because of their sexual orientation.[35] Almost ten percent of LGB respondents reported that they had been denied necessary health care expressly because of their sexual orientation.[36] Delay and avoidance of care due to fear of discrimination compound the significant health disparities that affect the lesbian, gay, and bisexual population. These disparities include:

[32] Sharita Gruberg & Frank J. Bewkes, Center for American Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (March 7, 2018), *available at* https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.

[33] Medical schools often do not provide instruction about LGBTQ health concerns that are not related to HIV/AIDS. Jen Kates et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S*, KAISER FAMILY FOUND.12 (2017), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US.

[34] Mirza, *supra* note 34.

[35] LAMBDA LEGAL, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 5 (2010), *available at* .http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

[36] *Id.*

- LGB individuals are more likely than heterosexuals to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities.[37]
- Lesbian and bisexual women report poorer overall physical health than heterosexual women.[38]
- Gay and bisexual men report more cancer diagnoses and lower survival rates, higher rates of cardiovascular disease and risk factors, as well as higher total numbers of acute and chronic health conditions.[39]
- Gay and bisexual men and other men who have sex with men (MSM) accounted for more than half (56 percent) of all people living with HIV in the United States, and more than two-thirds (70 percent) of new HIV infections.[40]
- Bisexual people face significant health disparities, including increased risk of mental health issues and some types of cancer.[41]

This discrimination affects not only the mental health and physical health of LGBTQ people, but that of their families as well. One pediatrician in Alabama reported that "we often see kids who haven't seen a pediatrician in 5, 6, 7 years, because of fear of being judged, on the part of either their immediate family or them [identifying as LGBTQ]".[42] It is therefore crucial that LGBTQ individuals who have found unbiased and affirming providers, be allowed to remain with them. If turned away by a health care provider, 17 percent of all LGBTQ people, and 31 percent of LGBTQ people living outside of a metropolitan area, reported that it would be "very difficult" or "not possible" to find the same quality of service at a different community health center or clinic.[43]

The proposed rule allowing providers to deny needed care would reverse recent gains in combatting discrimination and health care disparities for LGBT persons. Refusals also implicate standards of care that are vital to LGBTQ health. Medical professionals are expected to provide LGBTQ individuals with the same quality of care as they would anyone else. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and competency with LGBTQ issues as they pertain to any health services provided.[44] The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary

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[37] David J. Lick, Laura E. Durso & Kerri L. Johnson, *Minority Stress and Physical Health Among Sexual Minorities*, 8 PERS. ON PSYCHOL. SCI. 521 (2013), *available at* http://williamsinstitute.law.ucla.edu/research/health-and-hiv-aids/minority-stress-and-physical-health-among-sexual-minorities/.
[38] *Id.*
[39] *Id.*
[40] CTRS FOR DISEASE CONTROL & PREVENTION, *CDC Fact Sheet: HIV Among Gay and Bisexual Men* 1(Feb. 2017), https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf.
[41] HUMAN RIGHTS CAMPAIGN ET AL., *Health Disparities Among Bisexual People* (2015) *available at* http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/HRC-BiHealthBrief.pdf.
[42] HUMAN RIGHTS WATCH, *supra* note 28.
[43] Mirza, *supra* note 34.
[44] *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, GAY LESBIAN BISEXUAL & TRANSGENDER HEALTH ACCESS PROJECT, http://www.glbthealth.org/CommunityStandardsofPractice.htm (last visited Jan. 26, 2018, 12:59 PM); *Creating an LGBTQ-friendly Practice*, A.M.A., https://www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice#Meet a Standard of Practice (last visited Jan. 26, 2018, 12:56 PM).

and part of the standard of care.[45] The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.[46] LGBTQ individuals already experience significant health disparities, and denying medically necessary care on the basis of sexual orientation or gender identity exacerbates these disparities.

In addition, LGBTQ individuals face disparities in medical conditions that may implicate the need for reproductive health services. For example, lesbian and bisexual women report heightened risk for and diagnosis of some cancers and higher rates of cardiovascular disease.[47] The LGBTQ community is significantly at risk for sexual violence.[48] Eighteen percent of lesbian, gay, bisexual students have reported being forced to have sex.[49] Transgender women, particularly women of color, face high rates of HIV.[50]

Refusals to treat individuals according to medical standards of care put patients' health at risk, particularly for women and LGBTQ individuals. Expanding religious refusals will further put needed care, including reproductive health care, out of reach for many. Given the broadly-written and unclear language of the proposed rule, if implemented, some providers may misuse this rule to deny services to LGBTQ individuals on the basis of perceived or actual sexual orientation and gender identity. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care impairs the ability of patients to make a health decision that expresses their self-determination.

Finally, the proposed rule threatens to turn back the clock to the darkest days of the AIDS pandemic when same-sex partners were routinely denied hospital visitation and health care providers scorned sick and dying patients.

d. The proposed rule will hurt people living with disabilities

Many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously-affiliated providers. Historically, people with disabilities who rely on these services have sometimes faced discrimination, exclusion, and a loss of autonomy due to provider objections. Group homes have, for example, refused to allow

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[45] *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, WORLD PROF. ASS'N FOR TRANSGENDER HEALTH (2011), https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf.
[46] *Committee Opinion 512: Health Care for Transgender Individuals*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Dec. 2011), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals.
[47] Kates, *supra* note 37, at 4.
[48] Forty-six percent of bisexual women have been raped and 47 percent of transgender people are sexually assaulted at some point in their lifetime. This rate is particularly higher for transgender people of color. Kates, *supra* note 37, at 8.; *2015 U.S. Transgender Survey*, *supra* note 35, at 5.
[49] *Health Risks Among Sexual Minority Youth*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/healthyyouth/disparities/smy.htm (last updated May 24, 2017).
[50] More than 1 in 4 transgender women are HIV positive. Kates, *supra* note 37, at 6.

residents with intellectual disabilities who were married to live together in the group home.[51] Individuals with HIV – a recognized disability under the ADA – have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. One man with HIV was refused care by six nursing homes before his family was finally forced to relocate him to a nursing home 80 miles away.[52] Given these and other experiences, the extremely broad proposed language at 45 C.F.R. § 88.3(a)(2)(vi) that would allow any individual or entity with an "articulable connection" to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a moral or religious objection is extremely alarming and could seriously compromise the health, autonomy, and well-being of people with disabilities.

Many people with disabilities live or spend much of their day in provider-controlled settings where they often receive supports and services. They may rely on a case manager to coordinate necessary services, a transportation provider to get them to community appointments, or a personal care attendant to help them take medications and manage their daily activities. Under this broad new proposed language, any of these providers could believe they are entitled to object to providing a service covered under the regulation and not even tell the individual where they could obtain that service, how to find an alternative provider, or even whether the service is available to them. A case manager might refuse to set up a routine appointment with a gynecologist because contraceptives might be discussed. A personal home health aide could refuse to help someone take a contraceptive. An interpreter for a deaf individual could refuse to mediate a conversation with a doctor about abortion. In these cases, a denial based on someone's personal moral objection can potentially impact every facet of life for a person with disabilities – including visitation rights, autonomy, and access to the community.

Finally, due to limited provider networks in some areas and to the important role that case managers and personal care attendants play in coordinating care, it may be more difficult for people with disabilities and older adults to find an alternate providers who can help them. For example, home care agencies and home-based hospice agencies in rural areas are facing significant financial difficulties staying open. Seven percent of all zip codes in the United States to not have any hospice services available to them.[53] Finding providers competent to treat people with certain disabilities can increase the challenge. Add in the possibility of a case manager or personal care attendant who objects to helping and the barrier to accessing these services can be insurmountable. Moreover, people with disabilities who identify as LGBTQ or who belong to a historically disadvantaged racial or ethnic group may be both more likely to encounter service refusals and also face greater challenges to receive (or even know about) accommodations.

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

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

[53] Julie A. Nelson & Barbara Stover Gingerich, *Rural Health: Access to Care and Services*, 22 HOME HEALTH CARE MGMT. PRAC. (2010), *available at* http://globalag.igc.org/ruralaging/us/2010/access.pdf.

II. The regulations fail to consider the impact of refusals on persons suffering from substance use disorders (SUD)

The over breadth of this proposed rule could be devastating to people with Substance Use Disorder (SUD). Rather than promoting the evidence-based standard of care, the rule could allow anyone from practitioners to insurers to refuse to provide, or even recommend, Medication Assisted Treatment (MAT) and other evidence-based interventions due simply to a personal objection.

The growing opioid epidemic has and is likely to continue impacting HIV transmission. Sharing needles, syringes, or other injection equipment (works) to inject drugs puts people at risk for getting or transmitting HIV and other infections. According to the Centers for Disease Control and Prevention (CDC), nearly 1 in 10 new HIV diagnoses in the United States are attributed to injection drug use or male-to-male sexual contact *and* injection drug use.[54]

The opioid epidemic continues to claim too many lives. According to the CDC, over 63,000 people in the U.S. died from drug overdose in 2016.[55] The latest numbers show a 2017 increase in emergency department overdose admissions of 30% across the country, and up to 70% in some areas of the Midwest.[56]

The clear, evidence-based treatment standard for opioid use disorder (OUD) is medication-assisted treatment (MAT).[57] Buprenorphine, methadone, and naltrexone are the three FDA-approved drugs for treating patients with opioid use disorder. MAT is so valuable to treatment of addiction that the World Health Organization considers buprenorphine and methadone "Essential Medications."[58] Buprenorphine and methadone are, in fact, opioids. However, while they operate on the same receptors in the brain as other opioids, they do not produce the euphoric effect of other opioids but simply keep the user from experiencing withdrawal symptoms. They also keep patients from seeking opioids on the black market, where risk of death from accidental overdose increases. Patients on MAT are less likely to engage in dangerous or risky behaviors because their physical cravings are met by the medication, increasing their safety and the safety of their communities.[59] Naloxone is another medication key to saving the lives of people experiencing an opioid overdose. This medication reverses the effects of an opioid and can completely stop an overdose in its tracks.[60] Information about and access to these medications are crucial factors in

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[54] https://www.cdc.gov/hiv/risk/idu.html
[55] Holly Hedegaard M.D., et al. *Drug Overdose Deaths in the United States, 1999-2016*, NAT'L CTR. FOR HEALTH STATISTICS1-8 (2017).
[56] *Vital Signs*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/vitalsigns/opioid-overdoses/.
[57] U.S. DEP'T HEALTH & HUM. SERV., PUB NO. (SMA)12-4214, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS (2012), https://store.samhsa.gov/shin/content/SMA12-4214/SMA12-4214.pdf; National Institute on Drug Abuse, *Effective Treatments for Opioid Addiction*, https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction.
[58] World Health Organization, 19th WHO Model List of Essential Medicines (April 2015), http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf
[59] OPEN SOC'Y INST., BARRIERS TO ACCESS: MEDICATION-ASSISTED TREATMENT AND INJECTION-DRIVEN HIV EPIDEMICS 1 (2009), https://www.opensocietyfoundations.org [https://perma.cc/YF94-88AP].
[60] *See* James M. Chamberlain & Bruce L. Klein, *A Comprehensive Review of Naloxone for the Emergency Physician*, 12 AM. J. EMERGENCY MED. 650 (1994).

keeping patients suffering from SUD from losing their jobs, losing their families, and losing their lives.

However, stigma associated with drug use stands in the way of saving lives.[61] America's prevailing cultural consciousness, after decades of treating the disease of addiction as largely a criminal justice and not a public health issue, generally perceives drug use as a moral failing and drug users as less deserving of care. For example, a needle exchange program designed to protect injection drug users from contracting blood borne illnesses such as HIV, Hepatitis C, and bacterial endocarditis was shut down in October 2017 by the Lawrence County, Indiana County Commission due to their moral objection to drug use, despite overwhelming evidence that these programs are effective at reducing harm and do not increase drug use.[62] One commissioner even quoted the Bible as he voted to shut it down. Use of naloxone to reverse overdose has been decried as "enabling these people" to go on to overdose again.[63]

In this frame of mind, only total abstinence is seen as successful treatment for SUD, usually as a result of a 12-step or faith-based program. MAT is considered by many to be simply "substituting one drug for another drug."[64] This belief is so common that even the former Secretary of the Department is on the record as opposing MAT because he didn't believe it would "move the dial," since people on medication would be not "completely cured."[65] The scientific consensus is that SUD is a chronic disease, and yet many recoil from the idea of treating SUD with medication like any other illness such as diabetes or heart disease.[66] The White House's own opioid commission found that "negative attitudes regarding MAT appeared to be related to negative judgments about drug users in general and heroin users in particular."[67]

People with SUD already suffer due to stigma and have a difficult time finding appropriate care. For example, it can be difficult to find access to local methadone clinics in rural areas.[68] Other

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[61] Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL'Y 49, 56 (2010); German Lopez, *There's a highly successful treatment for opioid addiction. But stigma is holding it back.*, VOX, Nov. 15, 2017, https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone.

[62] German Lopez, *An Indiana county just halted a lifesaving needle exchange program, citing the Bible,* VOX, Oct. 20, 2017, https://www.vox.com/policy-and-politics/2017/10/20/16507902/indiana-lawrence-county-needle-exchange.

[63] Tim Craig & Nicole Lewis, *As opioid overdoses exact a higher price, communities ponder who should be saved*, WASH. POST, Jul. 15, 2017, https://www.washingtonpost.com/world/as-opioid-overdoses-exact-a-higher-price-communities-ponder-who-should-be-saved/2017/07/15/1ea91890-67f3-11e7-8eb5-cbccc2e7bfbf_story.html?utm_term=.4184c42f806c.

[64] Lopez, *supra* note 75.

[65] Eric Eyre, *Trump officials seek opioid solutions in WV*, CHARLESTON GAZETTE-MAIL, May 9, 2017, https://www.wvgazettemail.com/news/health/trump-officials-seek-opioid-solutions-in-wv/article_52c417d8-16a5-59d5-8928-13ab073bc02b.html.

[66] Nora D. Volkow et al., *Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic*, 370 NEW ENG. J. MED. 2063, http://www.nejm.org/doi/full/10.1056/NEJMp1402780.

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

[68] Christine Vestal, *In Opioid Epidemic, Prejudice Persists Against Methadone*, STATELINE, Nov. 11, 2016, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/11/11/in-opioid-epidemic-prejudice-persists-against-methadone

roadblocks, such as artificial caps on the number of patients to whom doctors can prescribe buprenorphine, further prevent people with SUD from receiving appropriate care.[69] Only one-third of treatment programs across the country provide MAT, even though treatment with MAT can cut overdose mortality rates in half and is considered the gold standard of care.[70] The current Secretary of the Department has noted that expanding access to MAT is necessary to save lives and that it will be "impossible" to quell the opioid epidemic without increasing the number of providers offering the evidence-based standard of care.[71] This rule, which allows misinformation and personal feelings to get in the way of science and lifesaving treatment, will not help achieve the goals of the administration; it will instead trigger countless numbers of deaths.

III. The proposed rule permits health care professionals to opt out of providing medical care that the public expects by allowing them to disregard evidence-based standards of care

Medical practice guidelines and standards of care establish the boundaries of medical care that patients can expect to receive and that providers should be expected to deliver. The health services impacted by refusals are often related to reproductive and sexual health, which are implicated in a wide range of common health treatment and prevention strategies. Information, counseling, referral and provisions of contraceptive and abortion services are part of the standard of care for a range of common medical conditions such as HIV as well as common co-morbidities including heart disease, diabetes, epilepsy, lupus, obesity, and cancer. Many of these conditions disproportionately affect communities of color.[72] The expansion of these refusals as outlined in the proposed rule will put women, particularly women of color, who experience these medical conditions at greater risk for harm.

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[69] 42 C.F.R. §8.610.

[70] Matthais Pierce, et al., *Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England*, 111:2 ADDICTION 298 (Nov. 2015); Luis Sordo, et al., Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies, BMJ (2017), http://www.bmj.com/content/357/bmj.j1550.; Alex Azar, Secretary, U.S. Dep't of Health & Hum. Serv., Plenary Address to National Governors Association, (Feb. 24, 2018), https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/plenary-addres-to-national-governors-association.html.

[71] Azar, *supra* note 84.

[72] For example, Black women are three times more likely to be diagnosed with lupus than white women. Latinas and Asian, Native American, and Alaskan Native women also are likely to be diagnosed with lupus. Office on Women's Health, *Lupus and women*, U.S. DEP'T HEALTH & HUM. SERV. (May 25, 2017), https://www.womenshealth.gov/lupus/lupus-and-women. Black and Latina women are more likely to experience higher rates of diabetes than their white peers. Office of Minority Health, *Diabetes and African Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Jul. 13, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18; Office of Minority Health, *Diabetes and Hispanic Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (May 11, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63. Filipino adults are more likely to be obese in comparison to the overall Asian population in the United States. Office of Minority Health, *Obesity and Asian Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Aug. 25, 2017), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=55. Native American and Alaskan Native women are more likely to be diagnosed with liver and kidney/renal pelvis cancer in comparison to non-Hispanic white women. Office of Minority Health, *Cancer and American Indians/Alaska Natives*, U.S. DEP'T OF HEALTH & HUM. SERV. (Nov. 3, 2016), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=31.

Moreover, a 2007 survey of physicians working at religiously-affiliated hospitals found that nearly one in five (19 percent) experienced a clinical conflict with the religiously-based policies of the hospital.[73] While some of these physicians might refer their patients to another provider who could provide the necessary care, one 2007 survey found that as many as one-third of patients (nearly 100 million people) may be receiving care from physicians who do not believe they have any obligations to refer their patients to other providers.[74] Meanwhile, the number of Catholic hospitals in the United States has increased by 22 percent since 2001, and now own one in six hospital beds across the country.[75] The increase of Catholic hospitals poses a danger for women seeking reliable access to medical services, many of whom do not understand the full range of services that may be denied them. One public opinion survey found that, among the less than one-third of women who understood that a Catholic hospital might limit care, only 43 percent expected limited access to contraception, and a mere 6 percent expected limited access to the morning-after pill.[76]

a. HIV Health

For HIV, in addition to consistent condom use, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are an important part of prevention for those at high risk for contracting HIV. The American College of Obstetricians and Gynecologists recommends that PrEP be considered for individuals at high risk of contracting HIV.[77] Under the proposed rule, an insurance company could refuse to cover PrEP or PEP because of a religious belief. Refusals to promote and facilitate condom use because of religious beliefs and refusals to prescribe PrEP or PEP because of a patient's perceived or actual sexual orientation, gender identity, or perceived or actual sexual behaviors is in violation of the standards of care and harms patients already at risk for experiencing health disparities. Both PrEP and PEP have been shown to be highly effective in preventing HIV infection. Denying access to this treatment would adversely impact vulnerable, highest risk populations including gay and bisexual men.

b. Sexually transmitted infections (STIs)

Religious refusals also impact access to sexual health care more broadly. Contraceptives and access to preventative treatment for sexually transmitted infections are a critical aspect of health care. The CDC estimates that 20 million new sexually transmitted infections occur each year. Chlamydia remains the most commonly reported infectious disease in the U.S., while HIV/AIDS

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[73] Debra B. Stulberg M.D. M.A., et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, J. GEN. INTERN. MED. 725-30 (2010) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881970/.

[74] Farr A. Curlin M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, NEW ENG. J. MED. 593-600 (2007) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2867473/.

[75] Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, AM. CIVIL LIBERTIES UNION 22 (2017), *available at* https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[76] Nadia Sawicki, *Mandating Disclosure Of Conscience-Based Limitations On Medical Practice*, 42 AM. J. OF LAW & MED. 85-128 (2016) *available at* http://journals.sagepub.com/doi/pdf/10.1177/0098858816644717.

[77] ACOG *Committee Opinion 595: Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (May 2014), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Preexposure-Prophylaxis-for-the-Prevention-of-Human-Immunodeficiency-Virus.

remains the most life threatening. Women, especially young women, and Black women, are hit hardest by Chlamydia—with rates of Chlamydia 5.6 times higher for Black than for white Americans.[78] Consistent use of condoms results in an 80 percent reduction of HIV transmission, and the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the World Health Organization all recommend the condom use be promoted by providers.[79]

c. Pregnancy prevention

The importance of the ability of women to make decisions for themselves to prevent or postpone pregnancy is well-established within the medical guidelines across a range of practice areas. Millions of women live with chronic conditions such as cardiovascular disease, diabetes, lupus, and epilepsy, which if not properly controlled, can lead to health risks to the pregnant woman or even death during pregnancy. Denying these women access to contraceptive information and services violates medical standards that recommend pregnancy prevention for these medical conditions. For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care.[80] 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.[81]

Moreover, women who are struggling to make ends meet are disproportionately impacted by unintended pregnancy. In 2011, 45% of pregnancies in the U.S. were unintended – meaning that they were either unwanted or mistimed.[82] Low-income women have higher rates of unintended pregnancy as they are least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy.[83] The Institute of Medicine has documented negative health effects of unwanted pregnancy for mothers

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[78] *Sexually Transmitted Disease Surveillance 2016*, CTR. FOR DISEASE CONTROL & PREVENTION (Sept. 2017), https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf.
[79] American Academy of Pediatrics Committee on Adolescence, *Condom Use by Adolescents*, 132 PEDIATRICS (Nov. 2013), http://pediatrics.aappublications.org/content/132/5/973; American Academy of Pediatrics, American College of Obstetricians and Gynecologists, March of Dimes Birth Defects Foundation. Guidelines for perinatal care. 6th ed. Elk Grove Village, IL; Washington, DC: American Academy of Pediatrics; American College of Obstetricians and Gynecologists; 2007; American College of Obstetricians and Gynecologists. Barrier methods of contraception. Brochure (available at http://www.acog.org/publications/patient_education/bp022.cfm). Washington, DC: American College of Obstetricians and Gynecologists; 2008 July; World Health Organization, UNAIDS, UNFPA, *Position statement on condoms and HIV prevention*, UNICEF (2009), https://www.unicef.org/aids/files/2009_position_paper_condoms_en.pdf.
[80] AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE S115, S117 (2017), available at: http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf
[81] *Id.* at S114.
[82] *Unintended Pregnancy in the United States*, Guttmacher Inst. (Sept. 2016), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.
[83] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in rates of unintended pregnancy in the United States, 1994 and 2001*, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90-6 (2006).

and children. Unwanted pregnancy is associated with maternal morbidity and risky health behaviors as well as low-birth weight babies and insufficient prenatal care.[84]

d. Ending a Pregnancy

While there are numerous reasons for why a person would seek to end a pregnancy, there are many medical conditions in which ending a pregnancy is recommended as treatment. These conditions include: preeclampsia and eclampsia, certain forms of cardiovascular disease, and complications for chronic conditions. Significant racial disparities exist in rates of and complications associated with preeclampsia.[85] For example, the rate of preeclampsia is 61% higher for Black women than for white women, and 50% higher than women overall.[86] 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.[87] ACOG and American Heart Association recommend that a pregnancy be avoided or ended for certain conditions such as severe pulmonary hypertension.[88] Many medications can cause significant fetal impairments, and therefore the Federal Food and Drug Administration and professional medical associations recommend that women use contraceptives to ensure that they do not become pregnant while taking these medications.[89] In addition, some medical guidelines counsel patients to end a pregnancy if they are taking certain medications for thyroid disease.[90]

e. Emergency contraception

The proposed rule will magnify the harm in circumstances where women are already denied the standard of care. Catholic hospitals have a record of providing substandard care or refusing care altogether to women for a range of medical conditions and crises that implicate reproductive health. For example, in a 2005 study of Catholic hospital emergency rooms by Ibis Reproductive Health for Catholics for Choice, it was found that 55 percent would not dispense emergency

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[84] INSTITUTE OF MEDICINE COMMITTEE ON UNINTENDED PREGNANCY, THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES (Sarah S. Brown & Leon Eisenberg eds.,1995).
[85] Sajid Shahul et al., *Racial Disparities in Comorbidities, Complication, and Maternal and Fetal Outcomes in Women With Preeclampsia/eclampsia*, 34 HYPERTENSION PREGNANCY (Dec. 4, 2015), http://www.tandfonline.com/doi/abs/10.3109/10641955.2015.1090581?journalCode=ihip20.
[86] Richard Franki, *Preeclampsia/eclampsia rate highest in black women*, OB.GYN. NEWS (Apr. 29., 2017), http://www.mdedge.com/obgynnews/article/136887/obstetrics/preeclampsia/eclampsia-rate-highest-black-women.
[87] AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).
[88] Mary M. Canobbio et al., *Management of Pregnancy in Patients With Complex Congenital Heart Disease*, 135 CIRCULATION e1-e39 (2017); Debabrata Mukherjee, *Pregnancy in Patients With Complex Congenital Heart Disease*, AM. COLL. CARDIOLOGY (Jan. 24, 2017), http://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/01/24/14/40/management-of-pregnancy-in-patients-with-complex-chd.
[89] ELEANOR BIMLA SCHWARZ M.D. M.S., et al., *Documentation of Contraception and Pregnancy When Prescribing Potentially Teratogenic Medications for Reproductive-Age Women*, 147 Annals of Internal Medicine. (Sept. 18, 2007).
[90] For example, the American College of Obstetricians and Gynecologists specifically recommends that if a woman taking Iodine 131 becomes pregnant, her physician should caution her to consider the serious risks to the fetus, and consider termination. American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 37: Thyroid disease in pregnancy* 100 OBSTETRICS & GYNECOLOGY 387-96 (2002).

contraception under any circumstances.[91] Twenty three percent of the hospitals limited EC to victims of sexual assault.[92]

These hospitals violated the standards of care established by medical providers regarding treatment of sexual assault. Medical guidelines state that survivors of sexual assault should be provided emergency contraception subject to informed consent and that it should be immediately available where survivors are treated.[93] At the bare minimum, survivors should be given comprehensive information regarding emergency contraception.[94]

f. Artificial Reproductive Technology (ART)

Refusals to provide the standard of care to LGBTQ individuals because of their sexual orientation or gender identity can impact access to care across a broad spectrum of health concerns, which includes primary and specialty care settings. One example of refusals that impacts LGBTQ patients, as well as non-LGBTQ patients, is refusals to educate about, provide, or cover ART procedures for religious reasons. For individuals with cancer, the standard of care includes education and informed consent around fertility preservation, according to the American Society for Clinical Oncology and the Oncology Nursing Society.[95] Refusals to educate patients about or to provide ART occur for two reasons: refusal based on religious beliefs about ART itself and refusals to provide ART to LGBTQ individuals because of their LGBTQ identity. In both situations, refusals to educate patients about ART and fertility preservation, and to facilitate ART when requested, are against the standard of care.

The lack of clarity in the rule could lead a hospital or an individual provider to refuse to provide ART to same-sex couples based on religious belief. For some couples, this discrimination would increase the cost and emotional toll of family building. In some parts of the country, however, these refusals would be a complete barrier to parenthood. More broadly, these refusals deny patients the human right and dignity to be able to decide to have children, and cause psychological harm to patients who are already vulnerable because of their health status or their experience of health disparities.

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[91] Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 ANNALS EMERGENCY MED. 105-10 (Aug. 2005), http://www.annemergmed.com/article/S0196-0644(05)00083-1/pdf
[92] *Id.* at 105.
[93] *Committee Opinion 592: Sexual Assault*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Apr. 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co592.pdf?dmc=1&ts=20170213T2116487879; *Management of the Patient with the Complaint of Sexual Assault*, AM. COLL. EMERGENCY MED. (Apr. 2014), https://www.acep.org/Clinical---Practice-Management/Management-of-the-Patient-with-the-Complaint-of-Sexual-Assault/#sm.00000bexmo6ofmepmultb97nfbh3r.
[94] *Access to Emergency Contraception H-75.985*, AMA (2014), https://policysearch.ama-assn.org/policyfinder/detail/emergency%20contraception%20sexual%20assault?uri=%2FAMADoc%2FHOD.xml-0-5214.xml.
[95] Alison W. Loren et al., *Fertility Preservation for Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500-10 (July 1, 2013); Ethics Committee of the American Society for Reproductive Medicine, *Fertility preservation and reproduction in patients facing gonadotoxic therapies: a committee opinion*, 100 AM. SOC'Y REPROD. MED. 1224-31 (Nov. 2013), http://www.allianceforfertilitypreservation.org/_assets/pdf/ASRMGuidelines2014.pdf; Joanne Frankel Kelvin, *Fertility Preservation Before Cancer Treatment: Options, Strategies, and Resources*, 20 CLINICAL J. ONCOLOGY NURSING 44-51 (Feb. 2016).

IV. The regulations are overly broad, vague, and will cause confusion in the health care delivery system

The regulations dangerously expand the application of the underlying statutes by offering an extremely broad definition who can refuse and what they can refuse to do. Under the proposed rule, any one engaged in the health care system could refuse services or care. The proposed rule defines workforce to include "volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity."[96] Under this definition, could any member of the health care workforce refuse to serve a patient in any way – could a nurse assistant refuse to serve lunch to a transgender patient, could a billing specialist refuse to help a patient who had sought contraceptive counseling?

a. Discrimination

The failure to define the term "discrimination" will cause confusion for providers, and as employers, expose them to liability. Title VII already requires that employers accommodate employees' religious beliefs to the extent there is no undue hardship on the employer.[97] The regulations make no reference to Title VII or current EEOC guidance, which prohibits discrimination against an employee based on that employee's race, color, religion, sex, and national origin.[98] The proposed rule should be read to ensure that the long-standing balance set in Title VII between the right of individuals to enjoy reasonable accommodation of their religious beliefs and the right of employers to conduct their businesses without undue interference is to be maintained.

If this balance is not maintained, the language in the proposed rule could force health care providers to hire people who intend to refuse to perform essential elements of a position. For example, the proposed rule lacks clarity about whether a Title X-funded health center's decision not to hire a counselor or clinician who objected to provide non-directive options counseling as an essential job function of their position would be deemed discrimination under the rule. Furthermore, the proposed rule does not provide guidance on whether it is impermissible "discrimination" for a Title X-funded state or local health department to transfer such a counselor or clinician to a unit where pregnancy counseling is not done.

By failing to define "discrimination," supervisors in health care settings will be unable to proceed in the orderly delivery of health care services, putting women's health at risk. The proposed rule impermissibly muddies the interpretation of Title VII and current EEOC guidance. If implemented, health care entities may be forced to choose between complying with a fundamentally misguided proposed rule and long-standing interpretation of Title VII.

Finally, the proposed rule's lack of clarity regarding what constitutes discrimination, may undermine non-discrimination laws. Because of the potential harm to individuals if religious

[96] 83 Fed. Reg. 3894.
[97] 42 U.S.C. § 2000e-2.; *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.
[98] *Id.*

refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.[99] Instead, courts have held that the government has a compelling interest in ending discrimination and that anti-discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race," and are narrowly tailored to meet that "critical goal."[100] The uncertainty regarding how the proposed rule will interact with non-discrimination laws is extremely concerning.

b. Assist in the performance

The definition of "assist in the performance" greatly expands the types of services that can be refused beyond any reasonable stretch of the imagination. The proposed rule defines "assistance" to include participation "in any activity with an *articulable connection* to a procedure, health service or health service program, or research activity."[101] In addition, the Department includes activities such as "making arrangements for the procedure."[102] If workers in very tangential positions, such as schedulers, are able to refuse to do their jobs based on personal beliefs, the ability of any health system or entity to plan, to properly staff, and to deliver quality care will be undermined. Employers and medical staff may be stymied in their ability to establish protocols, policies and procedures under these vague and broad definitions. The proposed rule creates the potential for a wide range of workers to interfere with and interrupt the delivery of health care in accordance with the standard of care.

The regulations also leave unclear whether a worker can assert his or her moral belief in refusing to treat patients on the basis of their identity or deny care for reasons outside of religious or moral beliefs. Even though women living with disabilities report engaging in sexual activities at the same rate as women who do not live with disabilities, they often do not receive the reproductive health care they need for multiple reasons, including lack of accessible provider offices and misconceptions about their reproductive health needs.[103] Biased counseling can

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[99] See e.g., *Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government's interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that "the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family"); *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

[100] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, slip op. at 46 (2014).

[101] 83 Fed. Reg. 3892.

[102] *Id.*

[103] RM Haynes et al., *Contraceptive Use at Last Intercourse Among Reproductive-Aged Women with Disabilities: An Analysis of Population-Based Data from Seven States*, CONTRACEPTION (2017), https://www.ncbi.nlm.nih.gov/pubmed/29253580; *See generally* Alex Zielinski, *Why Reproductive Health Can Be A Special Struggle for Women with Disabilities*, THINKPROGRESS, Oct. 1, 2015, https://thinkprogress.org/why-reproductive-health-can-be-a-special-struggle-for-women-with-disabilities-73ececea23c4/.

contribute to unwanted health outcomes and exacerbate health disparities.[104] The proposed rule is especially alarming as it does not articulate a definition of moral beliefs. The prejudices of a health care professional could easily inform their beliefs and consequently, serve as the basis of denying care to an individual based on characteristics alone. The proposed rule will foster discriminatory health care settings and interactions between patients and providers that are informed by bias instead of medically accurate, evidence-based, patient-centered care.

Moreover, in the preamble, the proposed rule states that the exemptions that Weldon provides is not limited to refusals of abortion care on the basis of religious or moral beliefs.[105] Due to this, health care professionals may think they can deny abortion care and other health services just because they do not want to provide the service. The preamble uses language such as "those who choose not to provide" or "Would rather not" as justification for a refusal. This is more concerning because the proposed rule contains no mechanism to ensure that patients receive the care they need if their provider refuses to furnish a service. The onus will be on the patient to question whether her hospital, medical doctor, or health care professional has religious, moral, or other beliefs that would lead them to deny services or if services were denied, the basis for refusal. This is likely to occur as the proposed rule does not have any provisions that stipulate that patients must be given notice that they may be refused certain health care services on the basis of religious or moral beliefs.

c. Referral

The definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information based on which an individual could get the care they need. Any information distributed by any method, including online or print, regarding any service, procedure, or activity could be refused by an entity if the information given would lead to a service, activity, or procedure that the entity or health care entity objects. Under this definition, could a medical doctor refuse to provide a website describing the medical conditions which contraception treats? Or could an entity refuse to provide a list of LGBTQ-friendly providers? In addition, the Department states that the underlying statutes of the proposed rule permits entities to deny help to anyone who is likely to make a referral for an abortion or for other services.[106] The breadth and vagueness of this definition will possibly lead providers to refrain from providing information vital to patients out of anxiety and confusion of what the proposed rule permits them to do.

d. Health Care Entity

The proposed rule's definition of "health care entity" conflicts with Federal religious refusal laws such as the Coats and Weldon Amendments, thus fostering confusion regarding which entities are required to comply with the proposed rule and existing Federal religious refusals. Specifically, under the Coats and Weldon Amendments a "health care entity" is defined to

[104] In one study in Massachusetts, women living with intellectual and developmental disabilities, including those who were Black and Latina, faced increased risks of preterm delivery and very low and low birth weight babies. M. Mitra et al., *Pregnancy Outcomes Among Women with Intellectual and Developmental Disabilities*, AM. J. PREV. MED. (2015), https://www.ncbi.nlm.nih.gov/pubmed/25547927.
[105] 83 Fed. Reg. 3890-91.
[106] *Id.* at 3895.

encompass a limited and specific range of individuals and entities involved in health care delivery. Under the proposed rule, a plan sponsor "not primarily engaged in the business of health care" would be deemed a "health care entity."[107] This definition would mean that an employer acting as a third party administrator or sponsor could count as a "health care entity" and deny coverage. In 2016, OCR found that religiously affiliated employers were not health care entities under the Weldon amendment.[108]

Moreover, the Department states that their definition of "health care entity" is "not an exhaustive list" for concern that the Department would "inadvertently omit[ting] certain types of health care professionals or health care personnel."[109] Additionally, the proposed rule incorporates entities as defined in 1 USC 1 which includes corporations, firms, societies, etc.[110] States and public agencies and institutions are also deemed to be entities.[111] The Department's inclusion of entities who are primarily not engaged in the health care delivery system highlights the true purpose of the proposed rule, to permit a greater number of entities to interfere in the provider-patient relationship and deter a patient from making the best decision based on their circumstances, preferences, and beliefs.

Conclusion

NMAC opposes the proposed rule as it expands religious refusals to the detriment of patients' health and well-being. Than you for your attention to these comments. If you have any questions or require any further information, please contact Matthew Rose, Policy and Advocacy Manager, at 202.834.1472 or mrose@nmac.org.

Sincerely,

Paul Kawata
Executive Director

[107] *Id.* at 3893.
[108] Office for Civil Rights, Decision Re: OCR Transaction Numbers: 14-193604, 15-193782 & 15-195665, 4 (Jun. 21, 2016).
[109] 83 Fed. Reg. 3893.
[110] *Id.*
[111] *Id.*

Exhibit 143

March 27, 2018

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

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

To Whom It May Concern:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

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

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

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

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

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

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

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

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

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

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

[13] 42 U.S.C. § 2000e-2 (1964).

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

[15] *See id.*

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

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

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

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

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

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

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

[17] Uttley, L, et all, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.
[18] *See, e.g.*, *supra* note 2.
[19] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[20] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[21] *See* Kira Shepherd, et al., *supra* note 19, at 29.
[22] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.
[23] *See* Kira Shepherd, et al., *supra* note 19, at 27.
[24] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. *Women's Health Insurance* Coverage, KAISER FAMILY FOUND. 1, 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.
[25] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health &

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

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

7. The Department is abdicating its responsibility to patients

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

North Carolina Justice Center

Exhibit 144

March 27, 2018

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

Submitted electronically

Re: Public comment in response to Proposed New 45 CFR Part 88 Regarding Refusals of Medical Care, Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03,

Northwest Health Law Advocates (NoHLA) submits these comments on the proposed rule published at 83 FR 3880 (January 26, 2018), RIN 0945-ZA03, with the title "Ensuring that the Department of Health and Human Services [the "Department"] Does Not Fund or Administer Programs or Activities that Violate Conscience and Associated Anti-Discrimination Laws" (the "Proposed Rule" or "Rule").

NoHLA's mission is to advocate for improved access to health care, particularly for low-income and vulnerable Washington State residents. NoHLA is working to achieve a health care system in which all Washingtonians receive quality, affordable health care.

Without any regulatory authority, the Department has proposed a rule that vastly expands narrow statutory sections in ways Congress never intended, in a manner unsupportable by the terms of the statutes, and in a way that upsets the careful balance struck by other federal laws, all in an effort to grant health care providers unprecedented license to refuse to provide care and information to patients. In so doing, the Proposed Rule does not mention, nor grapple with, the consequences of refusals to provide full information and necessary health care to patients. The denials that the Rule proposes to protect will have significant consequences for individuals' health and well-being, in addition to financial repercussions. the regulations fail to account for the significant burden that will be imposed on patients, a burden that will fall disproportionately and most harshly on women, people of color, people living with disabilities, poor and low-income people, and Lesbian, Gay, Bisexual, and Transgender (LGBT) individuals. These communities already experience severe health disparities and discrimination, conditions that will be exacerbated by the Proposed Rule, possibly ending in poorer health outcomes.

The Proposed Rule and its impact on patients' access to care is particularly concerning in Washington state where, due to refusals of care, transgender individuals have been denied access to medically necessary treatments, terminally ill patients have faced often insurmountable barriers in accessing death with dignity services (Chapter 70.245 RCW), and women suffering miscarriages have experienced delays and denials of care - placing their health and lives at risk. While Washington state has strong state laws to protect patient access to care, the Proposed Rule attempts to increase rather than decrease the number of patients denied needed medical care and information. Further, a 2016 report found that Catholic hospital beds made up over 40% of the hospital beds in Washington state, making it the state with the third highest number of Catholic beds nationally. *See* Health Care Denied, 26 (May 2016), *available at* https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied. In Washington state and especially in rural areas of the state, religious health care entities are often the only providers available to patients. The Proposed Rule, by giving providers an unfettered right

to deny care, will have a detrimental impact on Washington state patients, especially for those with limited health care options.

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

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

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

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

But the Department does not possess *any* legislative rulemaking powers under those Amendments and wholly lacks the authority to promulgate the Proposed Rule as it applies to them. The Amendments do not include or reference, any explicit delegation of regulatory authority. *Compare, e.g.,* 42 U.S.C. § 2000d-1 (expressly directing all relevant federal agencies to issue "rules, regulations, or orders of general applicability" to achieve the objectives of Title VI). Nor does any implicit delegation of legislative rulemaking authority exist for these provisions. For this reason alone, the Department cannot properly proceed to adopt the Proposed Rule or any similar variation of it.

2. The Proposed Rule Impermissibly Expands the Narrow Intent of the Referenced Statutes and Does So in Ways That Ignore the Statutes' Limited Terms and Purposes

Even if the Department had the necessary rulemaking authority (which it does not), the Proposed Rule dangerously expand the application of the underlying statutes by offering an extremely broad definition who can refuse and what they can refuse to do. Under the Proposed Rule, any one engaged in the health care system could refuse to provide services or care. The result is confusion, conflict with existing federal law, and denial of appropriate care to patients. Some examples of the impermissible expansion of the Refusal Statutes follow.

A. Assist in the Performance

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

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

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

B. Referral or Refer for

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

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

("referral" is "the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment").

C. Discriminate or Discrimination

The Proposed Rule's definition of "discrimination" purports to provide unlimited immunity for institutions that receive some federal funds to deny abortion care, to block coverage for such care, or to stop patients' access to information, no matter what the patients' circumstances or the mandates of state or federal law. Likewise, the definition appears aimed at providing immunity for employees who refuse to perform central parts of their job, regardless of the impact on the ability of a health care entity to provide appropriate care to its patients. This expansion of "discrimination" treats virtually any adverse action – including government enforcement of a patient non-discrimination or access-to-care law – against a health care facility or individual as *per se* discrimination. The Proposed Rule abandons the nuanced and balanced approach required by Title VII, the leading federal law barring employment discrimination, and also ignores other federal and state laws, and providers' ethical obligations to their patients. This broad definition of discrimination is nonsensical, vague and inappropriate as it provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

D. Other Expansions of the Scope of the Refusal Statutes

The Proposed Rule not only distorts the definitions of words in the statutes, but also alters the statutes' substantive provisions in other ways to attempt to expand the ability of individuals and entities to deny care in contravention of legal and ethical requirements and to the severe detriment of patients. Some illustrative examples follow.

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

The Rule similarly attempts to expand the Coats Amendment beyond its limited application to certain "governmental activities regarding training and licensing of physicians," 42 U.S.C. § 238n (quoting title), to apply *regardless* of context. Thus, rather than being confined to residency training programs as Congress intended, the Proposed Rule gives all manner of health care entities, including insurance

companies and hospitals, a broad right to refuse to provide abortion and abortion-related care. In addition, the Rule's expansion of the terms "referral" and "make arrangements for" extends the Coats Amendment to shield any conduct that would provide "any information ... by any method ... that could provide *any assistance* in a person obtaining, assisting, ... financing, or performing" an abortion or that "render[s] aid to anyone else reasonably likely" to make an abortion referral. 83 FR 3894-95 (emphasis added), 3924. This interpretation not only goes far beyond congressional intent and the terms of the statute, it may result in negative patient health outcomes. For example, it would apparently shield, against any state or federal government penalties, a women's health center that required any obstetrician-gynecologist practicing there who diagnosed a pregnant patient as having a serious uterine health condition to refuse to provide them with even the name of an appropriate specialist, because that specialist "is reasonably likely" to provide the patient with information about abortion.

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

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

3. The Proposed Rule Ignores Its Impact on Patient Health and Invites Harms That Will Disproportionately Fall on Women and Marginalized Populations

The Proposed Rule seeks to immunize refusals of health care but fails to consider the harmful impact it would have on patient health. 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." 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. For example, the Proposed Rule:

- Appears to provide immunities for health care institutions that receive federal funding and professionals who work in federally funded programs to refuse to provide complete information to patients about their condition and treatment options;

- Purports to create new "exemptions," so that patients who rely on federally subsidized health care programs, such as Title X, may be unable to obtain services those programs are required by law to provide;
- Causes confusion about whether hospitals can prevent staff from providing emergency care to pregnant patients who are suffering miscarriages or otherwise need emergency abortion care; and
- Invites health care providers to discriminate against individuals based on who they are, for example, by refusing to provide otherwise available services to a patient for the sole reason that the patient is transgender.[1]

These harms would fall most heavily on historically disadvantaged groups and those with limited economic resources. Women, LGBT individuals, people of color, immigrants, young people, the elderly, and members of other groups who continue to struggle for equal rights are those who most often experience refusals of care.

In Washington state we have seen that members of these groups experience disproportionate denials of care. *See e.g. Enstad v. PeaceHealth,* No. 2:17-cv-01496-RSM (W.D. Wash Oct. 5, 2017)(Complaint)(a case currently being litigated in which a transgender individual was denied insurance coverage for medically necessary treatment); *see also* In Their Own Words: Patient Stories, *available at* https://www.aclu-wa.org/pages/their-own-words-patient-stories (last viewed March 20, 2018) (stories of women in Washington state that have experienced refusals in care while miscarrying); *see also* JoNel Aleccia, *Aid-in-Dying Laws Don't Guarantee That Patients Can Choose To Die,* Kaiser Health News (Jan. 26, 2017) *available at* https://khn.org/news/aid-in-dying-laws-dont-guarantee-that-patients-can-choose-to-die/ (discussing a complaint filed by a hospice nurse regarding a terminally ill man who shot himself after he was repeatedly denied information about death with dignity at a Washington state hospice).

Likewise, poor and low-income people will also suffer acutely under the Proposed Rule as they are more likely to rely on health care that is tied to federal funding, and less likely to have other options at their disposal. Because the Proposed Rule will limit access to health care, harm patient outcomes, and undermine the central, public health mission of the Department, the Rule should be withdrawn.

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

The Proposed Rule appears to allow institutional and individual health care providers to manipulate and distort provider-patient communications and deprive patients of critical health care information about their condition and treatment options. While the Proposed Rule's Preamble suggests the Rule will improve physician-patient communication because it will purportedly "assist patients in seeking counselors and other health-care providers who share their deepest held convictions," 83 FR 3916-17, the notion that empowering health care providers to deny care to and withhold information from some patients is somehow necessary to enable other patients to identify like-minded providers strains

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

credulity: Patients are already free to inquire about their providers' views and patients' own expressions of faith and decisions based on that faith must already be honored. *Cf. id.* Allowing *providers* to decide what information to share– or not share—with patients, regardless of the patient's needs or the requirements of informed consent and professional ethics would gravely harm trust and open communication in health care, rather than aiding it.

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

By erroneously expanding the meaning of "assist in the performance of," "refer for" and "make arrangements for," as described above, the Proposed Rule purports to allow health care providers to refuse to provide basic information to patients in ways that were never contemplated by the underlying statutes. Further indication that the Rule is an overreach not contemplated in the underlying statutes is provided in federal regulations. *See e.g.*, 42 CFR 438.10(e)(2)(v)(C) "For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, the State *must* provide information about where and how to obtain the service" (emphasis added). As described above, the broad definitions included in the Proposed Rule may be used to immunize the denial of basic information about a patient's condition as well as their treatment options.

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

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

A. Title VII

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

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

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

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

B. EMTALA

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

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

It is particularly troubling, therefore, to have the Department use attempts to require hospitals to comply with their obligations under EMTALA in its Preamble as *justification* for expanding the Refusal Statutes. 83 FR 3888-89. The Preamble discusses the case of Tamesha Means who at 18 weeks of pregnancy began to miscarry and sought care, not once but three times, at her local hospital. 83 FR 3888-89. Even though she was bleeding, in severe pain, and had developed a serious infection, the hospital repeatedly sent her away and never told her that her health was at risk and that having an abortion was the safest course for her. *See* Health Care Denied 9-10 (May 2016), *available at* https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied. The ethical imperative is to provide care: "In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections." 83 FR 3888

(quoting American Congress of Obstetricians and Gynecologists ("ACOG") Committee Opinion No. 365) (reaffirmed 2016).

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

C. Section 1557

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

The Refusal Statutes must be read to coexist with the statutory nondiscrimination requirements of the ACA and similar state nondiscrimination laws – such as the Washington law against discrimination, Chapter 49.60 RCW. If a nondiscrimination requirement has any meaning in the health care context, it must mean that a patient cannot be refused care simply because of their race, color, national origin, sex, age, or disability. And as courts have recognized, the prohibition on sex discrimination under the federal civil rights statutes includes a prohibition on discrimination based on gender identity. *See Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1049-50 (7th Cir. 2017) (discrimination against transgender students violates Title IX, which is the basis for the ACA's prohibition on sex discrimination); *see also EEOC v. R.G. & G.R. Funeral Homes, Inc.*, 2018 WL 1177669 at *5-12 (6th Cir. Mar. 7, 2018) (Title VII). Notwithstanding these protections, as well as explicit statutory protections from discrimination based on gender identity and sexual orientation in many states, including in Washington state (*see e.g.*, RCW 49.60.030 and RCW 49.60.040(26)), the Proposed Rule invites providers to discriminate against LGBT patients, particularly transgender people.

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

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

But no clarity, only more questions ensue, because the Proposed Rule does not explain how its requirements interact with state and local law (nor does it provide any statutory authority on which those requirements rest under federal law, as discussed above). The Rule's expansion of definitions, covered entities, and enforcement mechanisms appears to impermissibly invite institutions and individuals to violate state law and attempts to inhibit states from enforcing their own laws that require institutions to provide care, coverage, or information (*see e.g.* RCW 48.43.065). The Proposed Rule also includes a troubling preemption provision, which specifies state and local laws that are "equally or more

protective of religious freedom" should be saved from preemption, 83 FR 3931, and ignores the importance of maintaining the protection of other state laws, such as laws mandating non-discrimination in the provision of health care or requiring that state funding be available for certain procedures.

For example, *Stormans Inc. v. Weisman* upheld Washington state rules that pharmacies had a duty to dispense lawfully prescribed medication in a timely manner while accommodating an individual pharmacist who had a moral or religious objection to dispensing a drug such as emergency contraception (794 F. 3d 1064 (9th Cir, 2015), cert. den. 579 US __(2016)). The Department fails to explain how the Proposed Rule interacts with this case and other similar laws and policies. It is especially concerning to see a lawsuit to enforce Washington state's Reproductive Privacy Act, Chapter 9.02 RCW, a 1991 law enacted by voter initiative that guarantees fundamental rights for Washington state residents, cited as part of the rationale for the Rule. *See* 83 FR 3889; *see also Coffey v. Pub. Hosp. Dist. No 1*, 15-2-00217-4 (Skagit Cnty. Super. Ct. June 20, 2016). The Proposed Rule and its treatment of state and local laws put at risk not only the Reproductive Privacy Act, but also our states' strong anti-discrimination protections including the Washington State Equal Rights Amendment, Wash. Const. Art. XXXI, the Washington Law Against Discrimination, Chapter 49.60 RCW, the Reproductive Parity Act, SSB 6219, 65th Leg. (Wa. 2018) (amending 48.43 RCW), and the Washington Death with Dignity Act, Chapter 70.245 RCW.

The Rule, if not withdrawn in its entirety, must clarify that any preemption of state or local lawsis limited to that which already existed, if any, by virtue of the extremely limited, pre-existing Refusal Statutes.

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

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

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

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

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

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

Conclusion

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

Sincerely,

/s/
Huma Zarif
Staff Attorney
Northwest Health Law Advocates
www.nohla.org

Exhibit 145

Collaborating to
Ensure a Healthy Ohio

March 27, 2018

Submitted via Federal eRulemaking Portal at http://www.regulations.gov

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 SW
Washington, DC 20201

Re: Proposed Rule re: Protecting Statutory Conscience Rights in Health Care
Department of Health and Human Services, Office for Civil Rights, RIN 0945-ZA03
Docket No.: HHS-OCR-2018-0002

Dear Office for Civil Rights, Office of the Secretary, HHS:

On behalf of our 233 member hospitals and 13 health systems, the Ohio Hospital Association (OHA) appreciates the opportunity to provide feedback on the Office of Civil Rights (OCR) proposed rules ensuring the protection of statutory conscience rights in health care. Ohio's hospitals support the need to protect health care workers' deeply held religious beliefs and moral convictions.

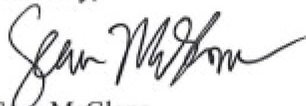
As health care organizations, Ohio hospitals' fundamental goal is to provide safe and effective care to all patients who present for care in the hospital, including those who present in the hospital emergency department. At the same time, conscience protections for health care professionals are long-standing under current law and hospitals have policies in place to accommodate differing religious and moral convictions of their workforce. Though OHA largely supports the goals to be achieved by the proposed rule, we have a concern that strict application or enforcement of the rule as proposed could result in unpredictable and adverse consequences for some patients. For example, the rule could be read to allow a health care professional to refuse to deliver care to a patient even in an emergency situation, based on the health care professional's religious beliefs or moral convictions.

OHA believes the needs of the patient must be met to the greatest extent possible in all cases. Accordingly, OHA believes there is a solution that will both respect and accommodate a caregiver's beliefs and moral convictions while at the same time ensuring patients get the care they need. Specifically, OHA suggests the rule require the caregiver to provide advance written notification of their religious beliefs or moral convictions to their employer prior to any such encounter, so that an accommodation of those beliefs can be made while also allowing for a developed contingency plan to be put in place to ensure patients get the timely and uninterrupted care they need. Such a requirement would also ensure that a patient in need of emergency care is not refused care by a caregiver whose beliefs do not permit them to care for the patient. And the requirement would allow the employer sufficient notice to put a plan in place to ensure the patient receives the necessary care, while accommodating the caregiver's beliefs, and without undue embarrassment for any of the parties.

OHIO HOSPITAL ASSOCIATION • 155 E. Broad St., Suite 301 • Columbus, OH 43215-3640 • t 614.221.7614 • f 614.221.4771 • ohiohospitals.org

OHA appreciates your consideration of its proposed solution, which both respects the beliefs of caregivers and ensures all patients can receive whatever care they need in whatever circumstance they present themselves for care, including in cases of emergency.

Sincerely,



Sean McGlone
Sr. V.P. & General Counsel