# Exhibit 166

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***Empowered Families: Educated, Engaged, Effective!***

SPAN & Family Voices-New Jersey comments to the Department of Health and Human Services on the proposed Protecting Statutory Conscience Rights in Health Care; Delegations of Authority

March 21, 2018

Thank you for the opportunity to comment on the Health and Human Services (HHS) proposed *Protecting Statutory Conscience Rights in Health Care: Delegations of Authority* on behalf of the SPAN Parent Advocacy Network (SPAN.) SPAN houses the NJ State Affiliate for Family Voices, a national network that works to "*keep families at the center of children's healthcare*." SPAN is also NJ's federally designated Parent Training and Information Center, Family-to-Family Health Information Center, Parent to Parent USA affiliate, and chapter of the Federation of Families for Children's Mental Health.

While SPAN provides information, training, technical assistance, parent to parent support, advocacy, and leadership development for all NJ families of children ages birth to 26, our priority is on children at greatest risk due to disability, special health care or emotional needs, poverty, discrimination based on race, culture, language, immigrant status, or economic status, or involvement in the child welfare or juvenile justice systems. Thus, we are particularly concerned with ensuring that the needs of children with special healthcare needs and their families are adequately addressed in federal, state and local policies and practices.

**SUMMARY:**

We understand that this proposed rule is to "ensure that persons or entities are not subjected to certain practices or policies that violate conscience, coerce, or discriminate, in violation of such Federal laws" but we are concerned that the potential consequences can result in discrimination for consumers.

**SUPPLEMENTARY INFORMATION:**
**I. Introduction**

We understand that these "laws ensure, for example, that Americans are not compelled to speak, to salute the flag, to join a national church, or to vote for a particular candidate." We are concerned about conscience protections against abortion, especially in the case of rape, incest, or concern for the mother's life. We are concerned about conscience protections regarding advance directives, particularly if the consumer is incapacitated or unable to self-advocate. We are concerned about conscience protections for vaccination as this will increase the unvaccinated and in turn increase vaccine preventable disease. We are deeply concerned about conscience objections to mental health treatment which is already difficult to obtain and inappropriately stigmatized and some religions such as Scientology disagree with mental health treatment. We

will discuss these concerns in more detail below under the appropriate sections. We understand that the Office of Civil Rights (OCR) has "the authority to initiate compliance reviews, conduct investigations, supervise and coordinate compliance", and would suggest that OCR conduct an analysis for patterns of discrimination against consumers.

**II. America's Tradition of Conscience Protection, Religious Freedom, and the Right to be Free from Unlawful Discrimination**

We do note in this section that there are exemptions for abortion in cases of rape, incest, or when the life of the woman is endangered.

**III. The Federal Health Care Conscience and Associated Anti-Discrimination Laws Applicable to Government, Providers, Patients, Insurers, and Other Entities That Benefit From or Administer Federally Funded Health Care Programs or Activities**

A. The Church Amendments

We note that this section applies to objection to abortion or sterilization on the part of providers, yet sterilization is inappropriately suggested for some people with disabilities and there should be corresponding consumer rights against sterilization as well. We understand that this section also consists of job protections, including training. We further understand that this section applies to biomedical or behavioral research, yet there is the misperception about stem cell research which could cure many diseases.

B. The Coats-Snowe Amendment (Section 245 of the Public Health Service Act) Enacted

This section also applies to training and education of providers, particularly as it relates to abortion.

C. The Weldon Amendment

This section gives consideration of objections to abortion to health care entities.

D. Conditions on Federally Appropriated Funds Requiring Compliance with Federal Health Care Conscience and Associated Anti-Discrimination Laws

This section has additional protections for health care entities regarding abortion.

E. The Patient Protection and Affordable Care Act's Conscience and Associated Anti-Discrimination Protections

The ACA (Affordable Care Act) had protections against funding assisted suicide and abortion. There are also religious protections against the individual mandate.

F. Other Protections Related to the Performance of Advance Directives or Assisted Suicide

SPAN neither supports nor opposes assisted suicide. We support, however, the right of people to have advance directives which should be followed by their healthcare providers. We also note that insurers should cover the medications needed to treat underlying illnesses to minimize the potential for assisted suicide. Medicaid and Medicare should require providers who accept Medicaid and Medicare to provide all legal services.

G. Protections Related to Counseling and Referrals Under Medicare Advantage Plans, Medicaid Plans, and Managed Care Organizations

We are concerned that Medicaid/Medicare are not "compelled to provide, reimburse for, or cover any counseling or referral service in plans over an objection on moral or religious grounds", as counseling could be in any area of healthcare. Medicaid and Medicare should require providers who accept Medicaid and Medicare to provide all legal services.

H. Conscience and Associated Anti-Discrimination Protections Applying to Global Health Programs

We are deeply concerned that "recipients of foreign assistance funds for HIV/AIDS directives if the provider cannot do so 'as a matter of conscience'… (1) to "endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS, or (2) to endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection." Although it is unfair to discriminate against males with HIV/AIDS however contracted, it must be noted that AIDS also affects women and children. US Global Health Programs should cover/pay for and require recipients of funding to provide evidence-based effective treatment and if their religious beliefs interfere with that, they should not receive the funding.

I. Exemptions from Compulsory Medical Screening, Examination, Diagnosis, or Treatment

We note that this includes "medical examination, immunization, or treatment for those who object thereto on religious grounds, except where such is necessary for the protection of the health or safety of others." This is a contradictory statement as vaccination efficacy requires herd immunity. We have concerns with the provisions for parents for immunization based on this. We are particularly concerned about objections to suicide assessment for children "if their parents or legal guardians have religious or moral objections to such services." There may be stigma, denial, or cultural differences in approaches to mental health, which should be considered but not at the risk of the child's life. We are also concerned about lack of mental health treatment in cases of abuse/neglect.

J. Conscience Clauses Related to Religious Nonmedical Health Care

We acknowledge that this could include "nonmedical items and services such as room and board, unmedicated wound dressings, and walkers, and they provide care exclusively through nonmedical nursing personnel assisting with nutrition, comfort, support, moving, positioning, ambulation, and other activities of daily living." However, we are deeply concerned with protections regarding "a person's "right to practice his or her religion through reliance on prayer

alone for healing," particularly when children are involved and have no choice to access health care. Healthcare service providers should have to provide the services needed for their patients.

**IV. The Original Version and Current Version of the Rule**
A. 2008 Federal Health Care Conscience Rule

We understand that the 6 sections included: 88.1 pertained to Church, Coats-Snowe, and Weldon amendments; 88.2 contained definitions of terms; 88.3 was related to scope of applicability; 88.4 was regarding substantive requirements; 88.5 explained written confirmation of compliance; and 88.6 designated OCR to receive complaints.

B. Proposed Changes in 2009 Resulting in New Final Rule in 2011

The final rule concerned mostly conscience protections for providers against abortion.

**V. History of OCR Enforcement of Federal Health Care Conscience Laws**

Although we understand the protections for providers, including training, and insurance companies regarding abortion, we remain concerned with protections for consumers. For example, a health care worker could object to the flu vaccination and put patients at risk.

**VI. Reasons for the Proposed Rule**

Although it is noted that since "November 2016, there has been a significant increase in complaints filed with OCR alleging violations" according to Kaiser News "By way of explanation, officials cite 36 complaints OCR received from, or on behalf of, those working in the health care system from President Donald Trump's election through early January of alleged affronts to religious beliefs and moral convictions — up from 10 such complaints it had fielded since 2008. What officials did not mention is that those 36 complaints pale against the more than 30,000 total complaints that OCR received during 2017, according to the agency's latest budget request; most involved alleged breaches of privacy or discrimination against patients.[i]"

A. Allegations and Evidence of Discrimination and Coercion Have Existed Since the 2008 Rule and Increased Over Time

We understand that there was concern that rescinding the rule would "contribute to these problems by inappropriately politicizing, and interfering in, the practice of medicine and individual providers' judgment." We share that concern with this current rule. We are concerned that this rule does not support separation of church and state.

B. Recently Enacted State and Local Government Health Care Laws and Policies Have Resulted in Numerous Lawsuits by Conscientious Objectors

We recognize there has been an increase in lawsuits and concerns regarding abortion and assisted suicide. We are concerned with stipulations that providers take "all reasonable steps to transfer

the patient to another health care provider, hospital, or health care facility even when there is an objection based on 'religious beliefs, or moral convictions');" as time delays could cause injury or even death. "First, do no harm."

C. Confusion Exists About Conscience Laws' Scope and Applicability

We understand that there was some concern regarding state/federal law and religious entities against abortion.

D. Courts have Found No Alternative Private Right of Action to Remedy Violations
Although individual rights were recognized there was no "remedy to bring suit against a private entity in Federal court."

E. Addressing Confusion Caused by OCR Sub-Regulatory Guidance

We understand the clarification regarding insurers and providers against abortion.

F. Additional Federal Health Care Conscience and Associated Anti-Discrimination Laws

We acknowledge that there are additional laws cited with protections for providers.

**VII. Summary of the Proposed Rule**

We think that reinstating "the structure of the 2008 rule" is regression. It is noted that this will be implemented in the same manner in which OCR prohibits discrimination on race, color, or national origin. However, in protecting providers under religious or moral beliefs, this cannot be reconciled with the rights of consumers. For example if a provider's religious or moral beliefs are against a certain race, color, or nation, and they refuse to treat a patient, whose rights prevail? This is turning the objective of OCR on its head and will have the opposite effect for consumers rather than protection of rights. This is similar to business refusal to serve certain individuals under the guise of religious/moral rights yet here the stakes are higher and people's lives could be at stake. If a health provider doesn't wish to provide all health care for all individuals, they shouldn't be a health provider.

**VIII. Section-by-Section Descriptions of the Proposed Rule**
**Proposed Section 88.1 Purpose.**

We understand that this section will "provide for the implementation and enforcement of Federal health care conscience and associated anti-discrimination laws."

**Proposed Section 88.2 Definitions.**

We acknowledge that the definition of discrimination includes prohibitions on: denying "any grant, contract, subcontract, cooperative agreement, loan, license, certification, accreditation, employment, title… (2) to withhold, reduce, exclude, terminate, restrict,
or otherwise make unavailable or deny any benefit or privilege; (3)… subject individuals or

entities protected under this part to any adverse effect described in this definition...
(4) including intimidating or retaliatory action." Yet we have seen funding cut for family planning clinics which do well care including cancer screening. Discrimination will also occur based on sexual orientation.

We are concerned regarding the statement that "The intersection of religion and health care may also create the more unusual and insidious circumstance" as there must be separation of church and state. Although we agree that "The Supreme Court has made clear that governmental burdens on speech targeting particular viewpoints are presumptively unconstitutional" this is being misused by businesses to not provide services to particular consumers which legitimizes discrimination under the guise of religion.

We understand that "The Department's proposed definition is an illustrative, not exhaustive, list…Thus, the Department's proposed inclusion of the terms ''health care professional'' … is intended…to cover pharmacists, nurses, occupational therapists, public-health workers, and technicians, as well as psychiatrists, psychologists, counselors, and other mental health providers…" We are deeply concerned with the inappropriate use of "conversion therapy" which was proven ineffective and traumatic. We are also concerned that any type of provider may refuse care to consumers as an exercise of their religious beliefs. Would this allow a Christian cardiologist to refuse to treat a Jewish or Muslim consumer in the E.R. with a heart attack because of his religious beliefs? The answer must be "no."

**Proposed Section 88.3 Applicable Requirements and Prohibitions.**

We understand that "The proposed 'Applicability' section outlines the specific requirements." We further understand that "The 'Requirements and Prohibitions' section explains the obligations that the Federal health care conscience and associated anti-discrimination statutes." We seek clarification on the details of applicability and prohibitions. For example, could a healthcare provider whose religion believes that substance abuse or mental health issues are failure of character rather than biologically based illness refuse to treat a consumer with alcohol poisoning or suicidal ideology? The answer must be "no."

**Proposed Section 88.4 Assurance and Certification of Compliance Requirements.**

Although there are written assurances of compliance and consistency "with the requirements of other civil rights laws" we are concerned that this proposal will allow further consumer discrimination. We further understand that there are exemptions for:
(1) physicians, physician offices, and other health care practitioners participating in Part B of the Medicare program; (2) recipients of Federal financial assistance or other Federal funds from the Department awarded under certain grant programs currently administered by the Administration for Children and Families…(3) recipients of Federal financial assistance or other Federal funds from the Department awarded under certain grant programs currently administered by the Administration on Community Living…(4) Indian Tribes and Tribal Organizations when contracting with the Indian Health Service…" This will adversely affect some dual eligibles, children with mental illness or developmental disabilities under ACF, individuals with disabilities in which the ACL helps maximize independent living, and tribes.

**Proposed Section 88.5 Notice Requirement.**

We acknowledge the public posting in physical locations and websites but are concerned that such notices will be inappropriately utilized and increase discrimination.

**Proposed Section 88.6 Compliance Requirements.**

We understand that there must be documentation of compliance but question how a provider can prove religion weighed in their decision not to treat a patient. Further, if a provider's religion interferes with their ability to provide all lawful treatments to a patient in their area of practice, then they should consider another profession.

**Proposed Section 88.7 Enforcement Authority.**

We understand "Many State laws provide additional conscience protections for providers who have objections to abortion, fertility treatments, sterilization, capital punishment, assisted suicide, and euthanasia." However, we are particularly concerned with discrimination in these areas. For example, once Oregon passed the assisted suicide law, insurance companies would cover the "death cocktail" but not the medications to treat the disease. We have no position for or against assisted suicide, but strongly believe that lack of access to medications to help with the underlying disease or condition that may lead a patient to consider assisted suicide must be addressed. We hear that people with disabilities are not considered for transplants as they are seen as unworthy and "less than." Doctors still suggest that young women with disabilities should be sterilized. This was recommended for the daughter of the Family Voices Coordinator regardless of the protective effects of estrogen against heart and bone disease, and despite the fact that the teen had cardiomyopathy (biventricular hypertrophy) and renal osteodystrophy, both of which would have worsened due to estrogen depletion. In addition, some children with disabilities are subjected to "growth attenuation" to keep their physical size small in order to be easier to care for, yet are not given the opportunity to become an adult or independent.

**Proposed Section 88.8 Relationship to Other Laws.**

We appreciate the clarification on how this relates to other laws pertaining to abortion, sterilization, and assisted suicide.

**Proposed Section 88.9 Rule of Construction.**

We are deeply concerned that this rule "shall be construed broadly and to the maximum extent" as there should be some parameters for denying something as important as health care.

**IX. Request for Comment**

We understand that this proposal requests comments on all issues; information, including any facts, surveys, audits, or reports, about the occurrence or nature of coercion, discriminatory conduct; general knowledge about protections; federal funding and abortions; information, including any facts, surveys, audits, or reports, about whether parents or legal guardians are

discriminated against based on objections to testing or treatment of their minor children; objections to counseling; whether health care insurers, health plan sponsors, and health plan participants have religious or moral objections to certain health insurance coverage; applicants…have been discriminated against; individuals did not enter a health care field; students…vulnerable to discrimination; implementation of advance directives; coercion against religious non-medical institutions; expansion of rights…will worsen patient outcomes; undetected unlawful discrimination; state laws; circumscribes the scope of protection; requirements regarding notice; referrals…encompassed in the scope; assistance in performance; written certifications of compliance; appropriateness of exceptions; method of educating recipients; provide notice; conflicting laws; policies in conflict; obligations of recipients; Administration for Children and Families; elimination of ACA penalty; alternate remedies; limitation on access; enforcement tools; trial implications/urban Indian organizations/apply to Tribes; affirming rights; burden requirement; and cost estimates. In addition to our comments above, we would like to also address some of these issues in detail.

We are concerned with the statement as to *whether health care insurers, health plan sponsors…have religious or moral objections* as this allows the carrier which has a vested interest in denying care to now do so on "moral" grounds. Regarding if this *will worsen patient outcomes,* we agree that lack of care will cause higher morbidity and mortality. We are also concerned that this proposal includes *referrals…encompassed in the scope* and question how treatments such as RU86 in cases of rape or even to treat painful endometriosis will be handled. Regarding the requirement to *provide notice,* clarification is needed as to at what point does the provider say they won't treat the patient e.g. up front vs. deep into a treatment plan. With regard to *policies in conflict,* we see this as a conflict between overly protecting religious beliefs of providers vs. patient rights. Concerning the *Administration for Children and Families,* we can see potential conflicts with minor rights to mental health treatment vs. provider objections. As to the *elimination of the ACA penalty*, this point has nothing to do with religious rights of providers and is moot as the individual mandate has been eliminated, an action with which we strongly disagree and which will result in adverse selection. Finally, *limitation on access* due to provider beliefs will worsen outcomes for consumers. The NJ Hospital Association annual conference on the uninsured showed that lack of health care access results in diagnosing 2-4 years later when diseases are less treatable and sometimes fatal.

**X. Public Participation**

We acknowledge that "Because of the large number of public comments we normally receive on *Federal Register* documents, we are not able to acknowledge or respond to them individually."

**XI. Delegations of Authority**

It is ironic that authority is "delegated to the Director of the Office for Civil Rights (OCR)" as this entity is used by consumers with discrimination claims. It remains to be seen how OCR will enforce implementation of this rule if both a provider on "religious" grounds and a consumer suffering from discrimination file a claim.

**XII. Regulatory Impact Analysis**
A. Introduction and Summary
We understand but disagree with the statement that "The Department estimates that the benefits of this rule, although not quantifiable or monetized, justify the burdens of the regulatory action."

Analysis of Economic Impacts: Executive Orders 12866 and 13563

We acknowledge that "HHS has examined the economic implications of this proposed rule" but it does not account for the human cost of the consequences.

C. Executive Order 12866

We understand that under "Section 6(3) (C) of Executive Order 12866 requires agencies to prepare a regulatory impact analysis (RIA) for major rules that are significant…The Department has determined that this rule will have an annual effect on the economy of $100 million or more in one year and, thus, is economically significant." We don't think this cost is justifiable.

D. Executive Order 13563

While we understand that "Executive Order 13563 encourages agencies to promote innovation; avoid creating redundant, inconsistent, or overlapping requirements applicable to already highly-regulated industries and sectors; and consider approaches that maintain flexibility and freedom of choice for the public" we do not think that this maintains flexibility and freedom of choice for the public and will result in discriminatory practices.

*1. Need for the Proposed Rule*
*(i) Problems that the Proposed Rule Seeks to Address*

We understand that that in developing regulatory actions, "[e]ach agency shall identify the problem that it intends to address (including . . . the failures of private markets or public institutions . . .) as well as assess the significance of the problem." As stated above, small increase from 10-36 complaints from providers pales in comparison to the 30,000 consumer complaints of discrimination.

*(ii) How the Proposed Rule Seeks to Address those Problems*

We strongly disagree that "This proposed regulatory action corrects those problems" as there are far more instances of consumer discrimination.

*2. Affected Persons and Entities*

While we understand that "The proposed rule affects: (1) persons and entities obligated to comply with 45 CFR part 88 because they are subject to the Weldon Amendment, Coats-Snowe Amendment, or Church Amendments…" this will also have adverse impacts on consumers.

*(i) Scope of Persons and Entities that 45 CFR Part 88 Covers*
Although we acknowledge that "This proposed rule affects persons and entities obligated to comply with the Weldon, Church, and Coats-Snowe Amendments" again there is no mention of negative impacts due to increased discrimination for consumers.

*(A) The Department*

We acknowledge the examples given as pertaining to HRSA Health Resource and Service Administration), CMS (Centers for Medicare/Medicaid), NIH (National Institutes of Health), and Indian Health Service but disagree with the intent.

*(B) State and Local Governments*

We acknowledge the reference to funding streams including Medicaid/CHIP (Children's Health Insurance Program), HIV/AIDS, research, elderly/APS (adult protective services), and refugees. Here again we are concerned with provider "moral" objections to treating refugees due to anti-immigrant sentiments or those with AIDS due to disagreement with sexual orientation.

*(ii) Persons and Entities Obligated to Comply With Additional Federal Laws that this NPRM Proposes to Enforce*

We are concerned that this includes behavioral health, medical care of unaccompanied minors, and university centers as well as councils on developmental disabilities and protection and advocacy centers. Here again, we are concerned if a provider disagrees with minor consent for treatment, unaccompanied minors here through no fault of their own, and question how university centers, councils, and P&As will be able to appropriately serve and advocate for people with disabilities if they are allowed to discriminate against them.

*(ii) Persons and Entities Obligated to Comply With Additional Federal Laws that this NPRM Proposes to Enforce*

We agree that 'there is substantial overlap" and that this rule is duplicative and unnecessary.

*(iii) Methodology*

Although we acknowledge that US. Census Bureau information was utilized regarding businesses, grantees etc. we are deeply concerned that none of this data included impact on consumers.

*(iv) Quantitative Estimate of Persons and Entities Covered by NPRM*

Although Table 1 illustrates the covered entities, there is no quantitative estimate on how many consumers will be affected.

*(A) Estimated Persons and Entities Required to Sign an Assurance and Certification of Compliance*

We acknowledge that a smaller subset of the entities cited in Table 1 would be subject to certification of compliance.

*(B) Estimated Number of Recipients Required to Provide Notice (§ 88.5)*

We acknowledge that "the Department proposes to require all recipients and the Department to comply with the notice requirement."

*Public Comment Requested on Scope of Entities*

Although Table 4 summarizes affected entities, there is no quantification of impact on consumers.

*Estimated Burdens*

*Familiarization Costs*

*Assurance and Certification (Proposed § 88.4)*

*Notice Requirement (Proposed § 88.5)*

*Compliance Procedures (§ 88.6(d))*

*Voluntary Remedial Efforts*

For all of the estimated burdens above on familiarization, assurance/certification, notice, compliance, and remedial efforts which we note are voluntary, we disagree with the estimated costs as this rule is duplicative and unneeded.

*OCR Enforcement*

We agree that there will be increased costs and are concerned these will be doubled when both a provider and consumer file a claim on the same issue.

Request for Comment on Burden Analysis

We strongly disagree with the implementation costs as these are already covered under Church, Coates-Snow, and Weldon.

*Estimated Benefits*

We understand that "This proposed rule is expected to remove barriers to the entry of certain health professionals…Second, in supporting a more diverse medical field...Third, the Department expects that the proposed rule would generate benefits by securing a public good—a society free from discrimination…" First, we think if providers believe only some patients deserve care, that they shouldn't be in a helping profession. Second, this will create a less

diverse health care workforce. Third, this proposal will have the opposite effect by denying certain consumers access to care which is not in the interest of the public good and will increase discrimination in society.

*Historical Support for Conscience Protections*

It is noted that historical support would "protect the Persons and Consciences of men from oppression." Yet this proposal would increase oppression of some consumers. We fail to see how a provider could in good "conscience" deny health care to anyone in need.

*Recruitment and Maintenance of Health Care Professionals*

While this may increase recruitment of health care providers, it may not be the most desirable ones or the most professional ones.

*Patient Benefits from Conscience Protections*

There is nothing here on patient harms from conscience protections. We disagree that this proposal will result in "Facilitating open communication between providers and their patients." Rather, patients will be more hesitant to discuss health with providers due to concern that they may have differing belief systems.

*Societal Benefits from Conscience Protections*

We strongly disagree that this proposal "will also yield lasting societal benefits." We think this will increase intolerance in society. We agree that "It is difficult to monetize the respect for conscience to the individual and society as a whole" but remain concerned that the conscience of the consumer will be subsumed by the wishes of the provider. This proposal contradicts itself with the statement that "the state should not violate the conscience of the individual."

*Analysis of Regulatory Alternatives*

Although it states that the Department considered the status quo and alternatives, there were no alternatives presented and again this proposal is duplicative.

Executive Order 13771

We note that "Executive Order 13771 (January 30, 2017) requires that the costs associated with significant new regulations to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations" yet no other regulations are being eliminated, only duplicated.

Regulatory Flexibility Act

We acknowledge that "Based on its examination, the Department has preliminarily concluded that this proposed rule does not have a significant economic impact on a substantial number of small entities."

Unfunded Mandates Reform Act

We also acknowledge that "HHS similarly concludes that the requirements of the Unfunded Mandates Reform Act of 1995 are not triggered by the proposed rule."

Executive Order 13132—Federalism

We further acknowledge that "The Secretary has also preliminarily determined that this proposed rule does not implicate the requirements of Executive Order 13132."

Congressional Review Act

We understand that "the Department deems that this proposed rule is a major rule for purposes of the Congressional Review Act."

Assessment of Federal Regulation and Policies on Families

We disagree that "It is unlikely that this proposed rule will negatively impact the stability of the family or impact parental authority. " This is particularly true in the cases of minor consent for reproductive, substance abuse, or mental health treatment.

Paperwork Reduction Act

We acknowledge that "This notice of proposed rulemaking would call for new collections of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520)."

*Information Collection for Proposed § 88.4 (Assurance and Certification)*
*Summary of the Collection of Information*:

We understand that there is a requirement for certification on compliance.

*Need for Information*:

We acknowledge that "recipients would be apprised of their obligations under the applicable Federal health care conscience and associated anti-discrimination laws. Second, a recipient's or applicant's awareness of its obligation would increase the likelihood that it would comply with such laws."

*Proposed Use of Information*:

We understand that this requires documentation of familiarity and compliance.

*Description of the Respondents*:

We acknowledge that this applies to those receiving federal financial assistance.

*Number of Respondents*:

We also acknowledge and agree with the estimate of respondents.

*Burden of Response*:

We agree with the estimated amount but think it is an unnecessary expense.

*Information Collection for Proposed § 88.5 (Notice)*
*Summary of the Collection of Information*:

We understand that this involves posting a notice.

*Need for Information*:

We understand that this will provide notice, including the complaints process, and remind providers of their rights but we think there are also patient rights.

*Proposed Use of Information*:

We acknowledge the listing of respondents as recipients.

*Description of the Respondents*:

We are concerned with the addition of home health agencies and educational institutions as these didn't appear originally. Home health agencies allow individuals to remain in their communities rather than institutional care. Also, college students may have "college only" health plans while in school so this could mean some students would have no coverage (e.g. LBGT).

*Number of Respondents*:

We agree with the estimate of respondents per year.

*Burden of Response*:

We acknowledge the estimate but see it as an unnecessary expense.

*Compliance Procedures (§ 88.6(d))*
*Summary of the Collection of Information*:

We acknowledge the reporting requirements.

*Need for Information:*

We also acknowledge that "The information promptly informs applicable Departmental components of OCR's pending investigation and historical complaints."

*Proposed Use of Information:*

We further acknowledge that the Department "may also use the information to monitor the status of the investigation and history of complaints."

*Description of the Respondents:*

Per our comments above, we are concerned about the inclusion of home health care and educational institutions.

*Number of Respondents:*

We acknowledge the number of respondents affected.

*Burden of Response:*

Here again we disagree with the estimate as an unnecessary expense.

Thank you again for the opportunity to provide input on the proposed Protecting Statutory Conscience Rights in Health Care.

Sincerely,

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**To empower families and inform and involve professionals and other individuals interested in the healthy development and education of children, to enable all children to become fully participating and contributing members of our communities and society.**

[1] *https://khn.org/news/at-new-health-office-civil-rights-means-doctors-right-to-say-no-to-patients/*

# Exhibit 167

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March 26, 2018

**PUBLIC COMMENT LETTER**

**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
*Submitted Electronically: www.regulations.gov*

Re: Proposed Rules – Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.

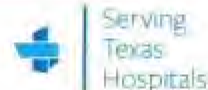
Dear Sir or Madam:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association ("THA"), appreciates the opportunity to provide comments on the above-referenced proposed rules, published January 26, 2018. THA and its members are committed to providing and increasing access to appropriate health care for all. We appreciate your time and work in developing these rules.

THA believes every individual's religious, moral, ethical, or other objection should be respected. This extends to both the providers and recipients of health care. No individual should face discrimination or retaliation for conscientiously objecting to the provision of care. However, THA is concerned the proposed rules are overbroad and could lead to an inability to provide or receive care when necessary, and unintentionally reduce the availability of services to certain populations.

For example, the proposed rule broadly defines the terms "referral" and "refer for." As set forth in the proposed rule's discussion, these definitions would include activities such as: providing, to a patient, the contact information of a physician or facility that may provide an abortion, informing a patient that funding may be available and otherwise providing a referral to abortion services or funding. To continue this example, in some cases an abortion may be necessary to protect the life or health of a mother, and limiting the availability of services could lead to a negative outcome. The health and wellbeing of a patient should take precedent and, in such circumstances, there must be an option for that patient to receive the care they require.

THA is also concerned these definitions are overbroad to the extent that a provider might decline to refer a patient to another provider for unrelated care. For example, could a provider decline to refer to a specialist who provides other services the referring provider objects to, even if the referral does not contemplate the patient seeking such services? If so, this reduction in the availability of services would be unnecessary, unrelated to a provider's objections, and needlessly detrimental to



the patient – especially if the referral is necessary for the patient to receive a proper course of treatment.

Moreover, requiring hospitals to provide assurances and certifications regarding compliance, as well as conspicuous notices to employees and the public, regarding the proposed rules and their applicability would create unnecessary burdens and costs. Health care entities already comply with a myriad of state and federally-mandated notice requirements; creating additional, unnecessary notification burdens in a time of decreased funding and ever-expanding regulatory requirements would be onerous. The notice requirement is also overly broad in that it would require a multi-site organization to post notice at every site where workforce notices are customarily posted, even if a particular site has no connection to the funding or activity giving rise to the obligations and protections set forth in the notice. The proposed rule contains broad enforcement provisions, which should serve to ensure compliance without additional assurances or provision of notice.

Further, the record-keeping requirement found in section 88.6(b) is unnecessary and burdensome, and is problematic in that it is vague and ambiguous and in some instances impossible to comply with. Subsection (b) requires each recipient to "maintain complete and accurate records evidencing compliance with … conscience and anti-discrimination laws…." How could a recipient "maintain complete and accurate records" that it had not discriminated against an individual in violation of an anti-discrimination law? In other words, if an individual refused to perform an action based on conscience and a covered recipient did not discriminate against that individual as a result, what would the recipient do to maintain a complete and accurate record that it complied with the anti-discrimination law in that instance? What would be the "complete and accurate record" of complying with a notice requirement (if that requirement remains a part of the final rule)? More generally, the record-keeping requirement is an additional burden and an additional obligation that is unnecessary and gives rise to an additional regulatory violation that has no statutory basis.

Finally, THA requests additional clarity in the proposed rule's enforcement provisions, as there is concern that the current broad and unclear provisions could lead to inconsistent enforcement and penalties. Since possible penalties include the reduction, termination, and return of funding, as well as any other remedial action deemed appropriate, THA believes enforcement should be uniform with clear potential penalties, to minimize disparate results among providers and facilities.

THA supports the promotion of individual rights and conscientious objections based on religious, moral, ethical, or other grounds. However, providing appropriate care to patients is the hospital's paramount concern – especially when such care is necessary to preserve life. THA does not support or promote discrimination or retaliation against an individual for their conscientious objections, but believes that alternative methods of providing necessary care should be explored. Individuals and organizations of all religious beliefs and moral convictions should be welcomed in the health care industry, and play an integral role in the provision of appropriate care to all. THA respectfully asks that all possible effects of the proposed rules be thoroughly analyzed, with a focus on concerns stated herein, to ensure that providers, facilities, and patients have access to the full spectrum of care and that no individual is denied care essential to their health, safety, and wellbeing.

Your attention to this is very much appreciated. We again thank you for the opportunity to participate in the rulemaking process, for your time and attention to this matter, and look forward

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to working with you. Please feel free to contact me with any questions, comments, or if there is anything else THA can assist with.

Very Truly Yours,

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# Exhibit 168

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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 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 or Docket HHS-OCR-2018-0002**

Dear Secretary Azar:

Thank you for the opportunity to comment on the Department of Health and Human Services' ("HHS") proposed rule, "Protecting Statutory Conscience Rights in Health Care" ("Proposed Rule"), published on January 26, 2018.[1] As a coalition dedicated to advancing women's and LGBTQ rights, The Alliance: State Advocates for Women's Rights & Gender Equality ("The Alliance") is committed to supporting all families and ensuring meaningful access to health care, especially as it relates to sexual and reproductive health and family planning.

The Proposed Rule 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 Rule purports to provide clarity and guidance in implementing existing federal religious exemptions, it instead creates ambiguity and confusion, as well as the potential for patient exposure to medical care that fails to comply with established medical practice guidelines, negating long-standing principles of informed consent, and undermining the ability of health facilities to provide care in an orderly and efficient manner. Importantly, the Proposed Rule fails to account for the significant burden that will be imposed on patients—a burden that is disproportionately experienced by women, people of color, immigrants, people living with disabilities, and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals. These communities already experience severe health disparities and discrimination which the Proposed Rule will exacerbate, leading to poorer health outcomes. By issuing the Proposed Rule along with the newly created "Conscience and Religious Freedom Division," HHS seeks to use the Office for Civil Rights' ("OCR") 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.

We urge HHS to withdraw the Proposed Rule in its entirety. What follows are specific and general comments, organized by theme and accompanied by our rationale.

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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].

### ***I. The Proposed Rule seeks to deny medically necessary care.***

The Proposed Rule, while cloaked in the language of non-discrimination, is designed to deny care and exclude disadvantaged and vulnerable patient populations. The adverse consequences of health care refusals and other forms of discrimination are well documented. As HHS stated in its proposed rulemaking for § 1557,

> "[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."[2]

HHS and OCR have an important role to play in ensuring equal health opportunity and ending discriminatory practices that contribute to health disparities, but 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.[3] As an outcome of this Proposed 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.[4] The Proposed Rule will not achieve these outcomes. Instead, it 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.

### ***II. Expanding religious refusals exacerbates the barriers to care that vulnerable communities already face.***

Women, immigrants, individuals living with disabilities, LGBTQ individuals, 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.[5] 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

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[2] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,194 (Sept. 8, 2015) (codified at 45 C.F.R. pt. 2).

[3] 83 Fed. Reg. 3917.

[4] *Id.*

[5] *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.

[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.

health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.[7] 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-Latinx counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs). 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.[8] These disparities exist across the board; Black women, for example, are three to four times more likely than white women to die during or after childbirth.[9] Moreover, the disparity in maternal mortality is growing rather than decreasing,[10] which in part may be due to the reality that women have long been subject to discrimination in health care settings. Women's pain is routinely undertreated and often dismissed[11] and due to gender biases and gaps in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[12] LGBTQ individuals also encounter high rates of discrimination in health care.[13] 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.[14]

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

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[7] In 2014, Latinx women 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* 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.

[9] *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.

[10] *See id.*

[11] *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).

[12] *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).

[13] *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.

[14] *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.

***a. The Proposed Rule harms 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,[15] 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.[16] Notably, immigrant, Latinx women have far higher rates of uninsurance than Latinx women born in the United States (48 percent versus 21 percent, respectively).[17] 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.[18] 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.[19]

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.[20] In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[21] 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.[22] 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.[23] The Proposed Rule gives health care providers, such as Catholic hospitals, a license to opt

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[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. KAISER FAMILY FOUND., *Women's Health Insurance Coverage* 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 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf.

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

[18] 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.

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

[20] 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.

[21] *Id* at 12.

[22] *Id* at 9.

[23] 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/.

out of evidence-based care that the medical community endorses. This would place more women, particularly women of color, 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 harms LGBTQ communities.***

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. HHS' Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[24] LGBTQ people 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.[25] 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.[26] 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.[27]

Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[28] Numerous federal courts

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[24] *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).

[25] 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.

[26] 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.

[27] *Id.*

[28] *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) (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*

have found that federal sex discrimination statutes reach these forms of gender-based discrimination.[29] In Minnesota, Gender Justice brought one of the first cases to extend this to discrimination in health care under Section 1557.[30] 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."[31]

Yet, such discrimination in health care is rampant. Twenty-nine percent of transgender individuals were refused services 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.[32] 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.[33]

The federal government's role in ending such discrimination cannot be understated. Data obtained by Center for American Progress (CAP) under a FOIA request indicates HHS' 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 HHS under Section 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."
- "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."[34]

The Proposed Rule would undermine the gains of Section 1557, and 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

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*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).

[29] *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).

[30] *Rumble v. Fairview Health Serv.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015).

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

[32] 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.

[33] 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*].

[34] 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/.

the hospital. Transition-related care is not only medically necessary, but for many transgender people it is lifesaving.

Religiously affiliated health care providers are also employers subject to Title VII. In Minnesota, Gender Justice obtained an EEOC determination that a health care provider with a health insurance plan that excluded transition-related care violated Title VII. Gender Justice has brought a lawsuit against this provider under Section 1557.[35] The Proposed Rule could create legal conflicts for health care providers that must continue to follow Title VII and Section 1557.

Lesbian, gay, and bisexual people also continue to face discrimination in health care. 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.[36] Almost 10 percent of LGB respondents reported that they had been denied necessary health care expressly because of their sexual orientation.[37] 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 their heterosexual peers to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities.[38]
- Lesbian and bisexual women report poorer overall physical health than heterosexual women.[39]
- 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.[40]
- 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.[41]
- Bisexual people face significant health disparities, including increased risk of mental health issues and some types of cancer.[42]

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

[35] *See Hearing in Case to End Discrimination in Trans Health Coverage*, Gender Justice (March 23, 2018), http://www.genderjustice.us/news/2018/3/23/tovarhearing.
[36] 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.
[37] *Id.*
[38] 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/.
[39] *Id.*
[40] *Id.*
[41] 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.
[42] 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.

family or them [identifying as LGBTQ]".[43] 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.[44]

#### c. *The Proposed Rule harms 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.[45] 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.[46] Given these and other experiences, the Proposed Rule's extremely broad proposed language 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 the Proposed Rule, 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 denial based on someone's personal moral objection will impact every facet of life for a person living with disabilities, including visitation rights, autonomy, and access to the community. 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.[47] Finding providers competent to treat people with certain disabilities can increase the challenge. Add in the

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[43] HUMAN RIGHTS WATCH, *supra* note 28.

[44] Mirza, *supra* note 34.

[45] 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).

[46] 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.

[47] 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.

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 accessing accommodations.

***d. The Proposed Rule harms people suffering from substance use disorders (SUD).***

Rather than promoting the evidence-based standard of care, the Proposed Rule would 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.

According to the Centers for Disease Control and Prevention (CDC), over 63,000 people in the U.S. died from drug overdose in 2016.[48] 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.[49] The clear, evidence-based treatment standard for opioid use disorder (OUD) is medication-assisted treatment (MAT).[50] 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."[51] 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.[52] 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.[53] 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.

The stigma associated with drug use hinders access to lifesaving care.[54] 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

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[48] Holly Hedegaard M.D., et al. *Drug Overdose Deaths in the United States, 1999-2016*, NAT'L CTR. FOR HEALTH STATISTICS 1-8 (2017).

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

[50] 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.

[51] World Health Organization, 19th WHO Model List of Essential Medicines (April 2015), http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf

[52] 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].

[53] *See* James M. Chamberlain & Bruce L. Klein, *A Comprehensive Review of Naloxone for the Emergency Physician*, 12 AM. J. EMERGENCY MED. 650 (1994).

[54] 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.

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.[55] 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.[56]

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."[57] This belief is so common that even the former Secretary of HHS 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."[58] 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.[59] 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."[60]

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.[61] 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.[62] 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.[63] The current Secretary of HHS 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

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[55] 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.

[56] 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.

[57] Lopez, *supra* note 75.

[58] 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.

[59] 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.

[60] 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

[61] 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

[62] 42 C.F.R. §8.610.

[63] 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.

standard of care.[64] The Proposed Rule instead allows misinformation and personal beliefs to further obstruct access to lifesaving treatment.

### *III. The ability to refuse care to patients leaves many individuals with no health care options.*

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[65] 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.[66] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[67] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[68] In Washington State, Legal Voice took on a case where a religiously affiliated hospital denied a transgender patient gender affirming surgery. 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.[69] 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.[70]

Patients living in less densely populated, rural 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.[71] 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

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[64] Azar, *supra* note 84.
[65] *See, e.g.*, *supra* note 3.
[66] *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.
[67] *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.
[68] *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.
[69] *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.
[70] *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.
[71] 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.

transgender adults nationwide found that respondents needed to travel much farther to seek care for gender dysphoria as for other kinds of care.[72] This means if these patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In a recent study, nearly one in five LGBTQ people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBTQ communities living in rural areas, with 41% reporting it would be very difficult or impossible to find an alternative provider.[73] For these patients, being turned away by a medical provider is not just an inconvenience—it means being denied care entirely with nowhere else to go.

Medically underserved areas already exist in every state,[74] with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[75] 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.[76] 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.[77] 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.[78] 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.[79] 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.[80] 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.[81] Individuals with Hepatitis C infection find few providers in rural areas with the specialized knowledge to manage the emerging treatment options,

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

[73] 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.

[74] 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).

[75] 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/.

[76] 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.

[77] 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/.

[78] 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/.

[79] *Id.*

[80] 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.

[81] 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/.

drug toxicities and side effects.[82] All of these barriers will worsen if providers are allowed to refuse care to particular patients.

Meanwhile, immigrant, Latinx women and their families often face cultural and linguistic barriers to care, especially in rural areas.[83] These women often lack access to transportation and may have to travel great distances to get the care they need.[84] 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.

## IV. *The Proposed Rule's inappropriate expansion of religious exemptions may lead to dangerous denials of medically necessary treatments.*

The Proposed Rule claims to clarify current "religious refusal clauses" related to abortion and sterilization in three federal statutes, each of which refers to specific, limited circumstances in which health care providers or health care entities may not be required to participate in abortion and sterilization procedures. The Proposed Rule, however, creates ambiguity about these limited circumstances, promoting an overly broad misinterpretation that extends beyond what the statutes permit. For example, section (d) of the Church Amendments refers to circumstances when a person may refuse to participate in any part of a health service program or research activity that "would be contrary to his religious beliefs or moral convictions." While longstanding legal interpretation singularly applies this section to participation in abortion and sterilization procedures, the Proposed Rule does not make this limitation clear. This ambiguity encourages an overly broad interpretation of the statute that empowers providers to refuse to provide *any* health care service or information for a religious or moral reason. This potentially includes not just sterilization and abortion procedures, but also Pre-Exposure Prophylaxis (PrEP), infertility care, treatments related to gender dysphoria, and HIV treatment, among other lifesaving services. This puts the health of the patient, and potentially that of others, at risk. Some providers may try to claim even broader refusal abilities, as a recent analysis of complaints to HHS showed that transgender patients are most often discriminated against simply for being who they are rather than for the medical care they are seeking.[85]

Furthermore, by unlawfully redefining the statutory term "assisting in the performance" of a procedure, the Proposed Rule encourages health care workers to obstruct access to a health care service even when they have only a tangential connection to delivering that service, such as scheduling a procedure or running lab tests to monitor side-effects of a medication. The extension and broadening of this clause will impair patients' access to care services if interpreted to permit providers to choose patients based upon sexual orientation, gender identity, or family structure.

The Proposed Rule undermines both open communication between providers and patients and informed consent which is necessary to patient-centered decision-making. We are particularly

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[82] 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.

[83] 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.

[84] 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.

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

concerned that the Proposed Rule will be used to refuse medically necessary care to transgender patients. The Proposed Rule's extensive terms promotes the mistaken belief that treatments that have an incidental impact on fertility, such as some procedures used to treat gender dysphoria, are sterilization procedures. Treatments for serious medical conditions may have the incidental effect of causing or contributing to infertility; for example, a hysterectomy to treat gender dysphoria, chemotherapy to treat cancer, and a wide range of medications can have the incidental effect of temporarily or permanently causing infertility. The primary purpose of such procedures, however, is not to sterilize, but to treat an unrelated medical condition. If religious or moral exemptions related to sterilization are misinterpreted to include treatments that have an incidental effect on fertility, refusals will unlawfully include a dangerously broad range of medically needed treatments. Individuals seeking any kind of health care should be treated with dignity and respect, regardless of their reasons for needing these services. 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.

### *V. The Proposed Rule lacks safeguards to protect patients from harmful refusals of care.*

The Proposed Rule does not limit exemptions in order to protect patients' rights under the law and ensure that they receive medically warranted treatment. Extensive religious accommodations need to be accompanied by equally extensive patient protections to safeguard medical needs and guarantee accurate information and quality health services. Under Executive Order 12866, when engaging in rulemaking, "each agency shall assess both the costs and the benefits of the intended regulation and, recognizing that some costs and benefits are difficult to quantify, propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify the costs."[86] 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."[87] The Proposed Rule fails on all counts; although the Proposed Rule attempts to quantify the costs of compliance, it 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.[88] Moreover, the Establishment Clause of the First Amendment requires the government to adequately account for these types of consequences when considering whether to grant religious exemptions and bars granting an exemption when it would detrimentally affect any third party.[89] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[90]

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[86] Executive Order 12866 on Regulatory Planning and Review (September 30, 1993).

[87] 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.

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

[89] 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).

[90] 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 Proposed Rule also conflicts with many federal patient protections, profoundly undermining the federal government's ability to properly enforce federal laws. While patient protections are subject to religious exemptions provided under federal statute, they are not subject to exemptions that extend beyond federal law, including many of the exemptions expanded in the Proposed Rule. The Proposed Rule's lack of patient safeguards conflicts with the well-established standard under Title VII of the Civil Rights Act which ensures that employers can consider the effect that providing a religious accommodation would have on coworkers, customers, and patients, as well as factors including public safety and public health.[91] The Proposed Rule allows for none of these considerations, instead requiring automatic exemptions. 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.[92] Under EMTALA, all hospitals are required to comply, regardless of religious affiliation.[93] 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 also undermines Title X as it allows health care entities to receive grants and contracts while refusing to provide key services required by those programs.[94] Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[95] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[96] Under the Proposed Rule, HHS allows entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties these funds are generally conditioned upon.[97] Every year millions of low-income, under-insured, and uninsured individuals rely on Title X clinics to access services they otherwise might not be able to afford.[98] At best, the Proposed Rule creates confusion and at worst, it promotes dangerous discrimination.

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

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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.

[91] *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.

[92] 42 U.S.C. § 1295dd(a)-(c) (2003).

[93] 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).

[94] *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.

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

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

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

[98] *See id.*

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.[99] The expansion of these refusals as outlined in the Proposed Rule puts women, particularly women of color, who experience these medical conditions at greater risk for harm.

***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.[100] 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 they are ready to become pregnant.[101]

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.[102] 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.[103] The Institute of Medicine has documented negative health effects of unwanted pregnancy for mothers and children. Unwanted

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[99] For example, Black women are three times more likely to be diagnosed with lupus than white women. Latinx 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 Latinx 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.

[100] 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

[101] *Id.* at S114.

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

[103] 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).

pregnancy is associated with maternal morbidity and risky health behaviors as well as low-birth weight babies and insufficient prenatal care.[104]

***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 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.[105] 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.[106]

***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.[107] For example, the rate of preeclampsia is 61% higher for Black women than for white women, and 50% higher than women overall.[108] 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.[109] ACOG and American Heart Association recommend

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[104] 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).
[105] *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.
[106] 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.
[107] 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.
[108] 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.
[109] AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).

that a pregnancy be avoided or ended for certain conditions such as severe pulmonary hypertension.[110] 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.[111] In addition, some medical guidelines counsel patients to end a pregnancy if they are taking certain medications for thyroid disease.[112]

***d. Emergency contraception***

The Proposed Rule will magnify the harm in circumstances where women are already denied the standard of care. A 2005 study of Catholic hospital emergency rooms by Ibis Reproductive Health for Catholics for Choice found 55 percent would not dispense emergency contraception under any circumstances.[113] 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.[114] At the bare minimum, survivors should be given comprehensive information regarding emergency contraception.[115]

***e. 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

[110] 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.

[111] 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).

[112] For example, the American College of Obstetricians and Gynecologists specifically recommends that if a woman taking Iodine 131 becomes pregnant, ther physician should caution them 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).

[113] 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

[114] *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.

[115] *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.

Nursing Society.[116] 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.

#### *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. The American College of Obstetricians and Gynecologists recommends that PrEP be considered for individuals at high risk of contracting HIV.[117] 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.

### *VI. The Proposed Rule hinders state efforts to protect patients' health and safety.*

HHS claims that its new interpretations of federal law supersede laws passed by state and local governments to ensure patients' access to health care. The preamble of the Proposed Rule discusses state laws that HHS 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.[118] The Proposed Rule also 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.[119] By allowing providers to broadly refuse care to patients based on their religious or moral beliefs, the Proposed Rule creates

[116] 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).

[117] 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.

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

[119] *See id.*

conflicts with hundreds of state and local nondiscrimination laws around the country that apply to health care. It further hinders the enforcement of and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. This directly contradicts HHS' claim that the Proposed Rule "does not impose substantial direct effects on States," "does not alter or have any substantial direct effects on the relationship between the Federal government and the States," and "does not implicate" federalism concerns under Executive Order 13132.

### *VII. HHS' rulemaking process failed to follow required procedures.*

Although agencies have general authority to engage in rulemaking, that authority is not without limits. Under the Administrative Procedure Act, "agency action, findings, and conclusions found to be... arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," "contrary to a constitutional right," or "in excess of statutory jurisdiction, authority, or limitations" shall be held unlawful and set aside.[120] 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."[121] Additionally, an agency can only change an existing policy if it provides a "reasoned explanation" for disregarding or overriding the basis for the prior policy.[122] HHS failed to provide "adequate reasons" or a "satisfactory explanation" for this rulemaking based on the underlying facts and data; between 2008 and November 2016, the Office of Civil Rights ("OCR") received 10 complaints alleging violations of federal religious refusal laws; an additional 34 similar complaints were received between November 2016 and January 2018. By comparison, 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 Proposed Rule is arbitrary and capricious and should be completely withdrawn.

### *VIII. Conclusion*

The Proposed Rule is a radical departure from HHS' mission to combat discrimination, protect patient access to care, and eliminate health disparities. We urge HHS to withdraw the Proposed Rule which poses tangible harm to millions of people who need meaningful access to health care.

Sincerely,
The Alliance: State Advocates for Women's Rights & Gender Equality

Betsy Butler
Executive Director
California Women's Law Center*

Pamelya Herndon
Executive Director
Southwest Women's Law Center*

Megan Peterson
Executive Director
Gender Justice*

Lisa M. Stone
Executive Director
Legal Voice*

Carol Tracy
Executive Director
Women's Law Project*

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[120] 5 U.S.C. § 706(2)(A), (B), (C).
[121] *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)).
[122] *Id.* at 2125-26.

* **The California Women's Law Center** ("CWLC") is a statewide, nonprofit law and policy center advocating for justice for women and girls through impact litigation, policy advocacy and education. CWLC's priorities include reproductive justice, gender discrimination, violence against women, and women's health. Since its inception in 1989, CWLC has fought for unburdened and equal access to reproductive health choices for all women.

***The Southwest Women's Law Center** is a non-profit policy and advocacy Law Center founded in 2005 to advance opportunities for women and girls in the State of New Mexico. We work to ensure that women have equal access to quality, affordable healthcare, including reproductive services and information. Our work strongly supports protections for individuals without regard to sexual orientation as we advocate to eliminate stereotypes and biases that women and LGTB individuals often face.

*Based in Minnesota, **Gender Justice** serves the upper Midwest through strategic and impact litigation, policy advocacy, and public education to address the causes and consequences of gender inequality. Gender Justice expands the rights and access to justice for women, LGBTQ people, and all people who experience barriers based on gender bias and stereotypes

* **Legal Voice** is a non-profit public interest organization that works in the Pacific Northwest to advance the legal rights of women and LGBTQ people through public impact litigation, legislation, and legal rights education. Since its founding in 1978 as the Northwest Women's Law Center, Legal Voice has sought to ensure that women and LGBTQ people's rights to self-determination, access to health care, and freedom from both discrimination and violence are a reality.

* **The Women's Law Project** (WLP) is a Pennsylvania-based nonprofit women's legal advocacy organization providing legal representation, policy advocacy, and public education on a wide range of legal issues related to women's health, well-being, and equality. Grounded in the perspective that equality for women and girls cannot be achieved without reproductive freedom, which includes equal access to the full range of reproductive healthcare, WLP has been working to protect and advance reproductive rights in Pennsylvania since it opened in 1974.

# Exhibit 169

# THE DISABILITY COALITION

*A Coalition of Persons with Disabilities, Family Members, and Advocates*

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March 27, 2018

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

Re: Department of Health and Human Services, Office for Civil Rights RIN 0945–ZA03, Proposed Regulation on "Protecting Statutory Conscience Rights in Health Care", Docket No. HHS-OCR-2018-0002

The Disability Coalition of New Mexico is a broad coalition of persons with disabilities, family members and advocates for the rights of people with disabilities of all kinds, including physical, mental, developmental, intellectual, and sensory. We submit these comments in opposition to the proposed rule on "Protecting Statutory Conscience Rights in Health Care" ("the Proposed Rule") published in the Federal Register by the Department of Health and Human Services (DHHS) on January 26, 2018. 83 Fed.Reg. 3880.

Our central concern is that the Proposed Rule will allow or even promote discrimination specifically on the basis of disability. However, we note that persons with disabilities would also be subject to increased discrimination on non-disability-specific bases that they share with other individuals, such as discrimination related to reproductive health services or end-of-life care, or that based on sexual orientation or gender identity.

People with disabilities already face significant barriers to obtaining the health care they need, in the form of such obstacles as inaccessible medical offices and equipment, providers who do not understand or address the needs of persons living with disabilities, or those who do not value the lives of individuals with disabilities to the same degree as those of the "able-bodied". The Proposed Rule would compound those problems by giving license to an extremely broad range of people involved – however tangentially – in the provision of health care services to impose

their individual beliefs on patients, to the extent of entirely depriving them of access to necessary services.

Refusals to provide care are often based on subjective beliefs about the quality of life that a person with a disability experiences – or will experience if allowed to live. For example, life-saving care may be denied to a newborn because treating providers believe that the child's quality of life as an individual with a disability is not worth saving. Or care may be withheld from someone who has been severely injured in an automobile accident based on the belief that his quality of life going forward does not merit providing life-saving services. Or a person with an intellectual disability may be denied services based on a belief that the person does not deserve the same access to services that a person with "normal" functional capacity would receive. The Proposed Rule would give free rein to providers to impose these beliefs on their patients, exacerbating the already difficult situation that people with disabilities face in obtaining health care services.

Health care providers already enjoy ample protection from being forced to participate in services that violate their religious beliefs. The Proposed Rule would constitute an enormous broadening of those protections, to the detriment of patients in need of care.

1. The Proposed Rule would allow any person's individual belief to be the basis of an exemption from providing needed care to a patient, regardless of whether the belief is based on religious precepts.
2. The exemption would extend well beyond clinicians directly involved in the provision of health care services, and allow anyone with any "articulable connection" to service provision to refuse participation. 83 Fed.Reg. at 3892 (preamble) and 3923 (proposed 45 CFR §88.2). For example, a hospital administrator could refuse to process paperwork to admit a patient for a procedure disfavored by that employee, a cafeteria worker could refuse to bring a meal to a patient receiving services the worker does not agree with, or a technician could refuse to prepare equipment to be used in a procedure.
3. The "health care entities" protected under the Proposed Rule would include an extremely broad range of organizations beyond those directly engaged in the provision of health care services. The proposed definition expressly includes, for example, research organizations, insurance plans, and "plan sponsor[s]" such as employers, and goes on to state that the proposed list is intended to be merely illustrative and is not exhaustive. 83 Fed.Reg. at p. 3893 (preamble) and 3924 (proposed 45 CFR §88.2). The extent to which entities or individuals with only the most tangential tie to the care would be permitted to block provision of that care is breath-taking.
4. A provider refusing to participate would be under no obligation to give the patient information on or referral to alternate sources of care that would enable the individual to obtain needed services, or to facilitate the patient's transfer to such a provider. Withholding such information from a patient is a gross violation of the trust relationship that should exist between provider and patient and could lead to serious harm to a patient who is thereby prevented from accessing needed care from an alternative source after a "conscience-based" refusal.

In addition to its extremely broad scope, we have many other concerns about the Proposed Rule, including the following:

1. The Proposed Rule would improperly give the religious, moral or ethical beliefs of health care providers (or other individuals distantly associated with the provision of care) primacy over those of the patient. The Proposed Rule goes well beyond protecting the religious and moral beliefs of health care providers and allows those providers (and others with even a tenuous connection to provision of services) to impose their beliefs on their patients and other third parties.

2. The Proposed Rule would improperly give the religious, moral or ethical beliefs of providers primacy over medical standards of care. All patients have the right to expect that they will be treated in accordance with such generally accepted standards and should not be deprived of that appropriate treatment based on individual provider beliefs.

3. The Proposed Rule would protect the rights of providers to refuse to provide care, but does nothing to protect providers whose consciences call on them to provide services. For example, a physician would have the right to refuse to provide abortion services, but another physician whose moral convictions called for her to provide an abortion as a necessary service for a patient would not have the same protection for her beliefs and could be subjected to retaliation, disciplinary action or outright denial of her right to act on her beliefs by providing appropriate medical care. In so doing, the Proposed Rule appears to privilege some moral convictions as worthy of protection over others that are deemed to be unworthy of such safeguards.

4. The disclosure requirements in the Proposed Rule are inadequate. While it would require health care entities to notify patients of the provider's right to refuse services, it requires no notification of the types of care or services that will be denied. This could lead to a patient unknowingly finding herself in a position where she will be denied services, to her detriment. For example, a patient may mistakenly believe that a full-service hospital offers sterilization services, only to find out that she cannot obtain a tubal ligation at the time she delivers her baby but must instead undergo a second surgical procedure at a separate facility at another time.

5. The Proposed Rule goes beyond protecting the religious and moral beliefs of providers and would constitute government authorization for discrimination.

6. The Proposed Rule would conflict with existing law and does not clarify how its provisions would interact with those other provisions.

a) The Proposed Rule would create a conflict with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1295dd. That statute requires that a hospital must screen patients to determine the existence of an emergency condition and must provide necessary services to stabilize the individual's condition or, in appropriate cases, transfer the patient to another provider for care. The Proposed Rule appears to encourage providers to flout EMTALA by denying care, disregarding the requirements to screen and stabilize, and refusing to arrange for transfer to an appropriate provider. The Proposed Rule (including the preamble) published in the Federal Register makes neither any mention of EMTALA or any attempt to clarify the intended interaction of the Proposed Rule's provisions with statutory obligations under EMTALA.

b) Title VII of the 1964 Civil Rights Act requires reasonable accommodations for the religious beliefs or practices of employees, including those of health care entities, unless the accommodation imposes a undue burden on the entity's operations. The Proposed Rule would go well beyond such accommodations and thereby put employers in the position of operating within two different and inconsistent sets of rules. As with EMTALA, the Proposed Rule published in the Federal Register neither mentions nor addresses Title VII.

Finally, the Proposed Rule appears to authorize an unconstitutional establishment of religion. Freedom of religion, as enshrined in the U.S. Constitution, is the right to free exercise of one's own religion and is not a license to impose one's religious beliefs on others or to engage in discrimination against others based on one's own beliefs. The U.S. Supreme Court has warned that accommodation of religious beliefs may, if taken too far, become an "unlawful fostering of religion", *Corp. of Presiding Bishop v. Amos*, 483 U.S. 327, 334-35 (1987), and that religious accommodations that unduly burden others are not protected by the Constitution's Establishment Clause. See *Sherbert v. Verner*, 374 U.S. 398 (1963); see also *Burwell v. Hobby Lobby*, 573 U.S. ___,134 S. Ct. 2751 (2014). The Proposed Rule would authorize individuals and institutions involved in the provision of health care to impose their private beliefs on others who do not share those beliefs and thus unduly burden those other persons, and is therefore unconstitutional.

We strongly urge the Department to withdraw the Proposed Rule. Thank you for your consideration of these comments.

Sincerely,

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# Exhibit 170

March 27, 2018

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

In health care, the health and well-being of patients must always come first. The new proposed rule issued by the Department of Health and Human Services Office of Civil Rights (HHS OCR), titled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," could allow health care providers to refuse to serve patients on the basis of moral and religious beliefs. This could place vulnerable and marginalized populations, such as lesbian, gay, bisexual, and transgender (LGBT) individuals and people living with HIV, at risk for being denied necessary and life-saving medical care. This proposed rule is contrary to the ethical standards that all health care providers are charged to uphold.

LGBT people already face widespread discrimination in health care, such as being verbally or physically harassed or being denied treatment altogether. This discrimination acts as a barrier to seeking necessary routine and emergency care. For example, a 2009 Lambda Legal survey of 4,916 LGBT people across the U.S. found that 56% of lesbian, gay and bisexual people, and 70% of transgender people, reported experiencing discrimination in health care. [1] The 2015 U.S. Transgender Survey of nearly 28,000 transgender people found that in the last year, 33% of respondents had experienced anti-transgender discrimination in health care, and 23% of respondents chose to forego necessary health care due to fear of discrimination.[2] A 2017 survey of a nationally representative probability sample of 489 LGBT adults found that roughly 1 in 6 (18%) reported avoiding medical care, even when necessary, because of concerns that they would be discriminated against.[3]

Rules and regulations that allow health care providers to discriminate based on religious beliefs will only exacerbate anti-LGBT discrimination in health care. Religion has already been invoked to deny LGBT people access to health care. For example, LGBT individuals have been denied appropriate mental health services and counseling;[4] a newborn was denied care because her parents were lesbians;[5] transgender patients have been denied transition-related medical care;[6] and an individual was denied his HIV medication,[7] all because of someone else's religious beliefs. All of this contributes to the health disparities that disproportionately burden LGBT people. A health care provider's religious beliefs should never determine the care a patient receives. In order to make meaningful progress in reducing these health disparities to "enhance and protect

the health and well-being of all Americans," as is the mission of HHS, it is essential that any rule meant to protect freedom of religion explicitly prohibits discrimination on the basis of sexual orientation and gender identity.

While this proposed rule does not specifically mention LGBT people, sexual orientation, or gender identity, it could easily be interpreted as codifying anti-LGBT discrimination in health care. The proposed rule states that "freedom from discrimination on the basis of religious belief or moral conviction…does not just mean the right not to be treated differently or adversely; it also means being free not to act contrary to one's beliefs." This language is exceptionally broad, and could be interpreted to allow providers to deny general health care services to LGBT people, as well as specific services such as STI screening to a gay man, fertility treatment to a lesbian couple, or gender affirmation treatment to a transgender individual.

OCR's proposed definition of discrimination is exceptionally broad.[8] This section is of particular concern:

> OCR will regard as presumptively discriminatory any law, regulation, policy, or other such exercise of authority that has as its purpose, or explicit or otherwise clear application, the targeting of religious or conscience-motivated conduct. In determining the purpose or justification of such an exercise of authority, OCR will consider all relevant factors and proposes to include in that analysis, when supported by the applicable statute, whether or not the exercise of authority has a disparate impact on religious believers or those who share a particular religious belief or conviction.[9]

We are concerned that this language could authorize OCR to challenge federal regulations protective of LGBT people, and state and municipal sexual orientation and gender identity nondiscrimination laws. These laws are needed because LGBT people experience widespread social discrimination in employment, housing and public accommodations, including health care.[10] As U.S. Supreme Court Justice Kennedy stated for the majority in *Romer v. Evans* (94-1039), 517 U.S. 620 (1996), "Enumeration is the essential device used to make the duty not to discriminate concrete and to provide guidance to those who must comply." Sexual orientation and gender identity nondiscrimination regulations and laws are essential to ensure access of LGBT people to health care. This is something that OCR should be defending, not undermining.

The proposed rule is especially concerning given existing state and federal legislation that would allow anti-LGBT discrimination under the guise of religious liberty. Altogether, 10 states have some form of religious refusal legislation that could authorize discrimination against LGBT people–such as refusing to allow LGBT people to adopt children, refusing to marry same-sex couples, and refusing to provide medical services to LGBT people–based on religious beliefs.[11] For example, Mississippi law HB 1523 allows discrimination based on the religious belief or moral conviction that "marriage is or should be recognized as the union of one man and one woman; sexual relations are properly reserved to such a marriage; and male (man) or female (woman) refer

to an individual's immutable biological sex as objectively determined by anatomy and genetics at time of birth."[12] This law allows businesses, individuals, and even government employees to refuse to serve LGBT people.[13] In terms of federal legislation, the First Amendment Defense Act (FADA), which prohibits the government from intervening against a person who "speaks, or acts, in accordance with a sincerely held religious belief or moral conviction that marriage is or should be recognized as a union of one man and one woman," was reintroduced in the Senate in March 2018. FADA has the support of President Trump, Vice President Pence, Attorney General Sessions, and the Republican Party.

We are also concerned that the proposed rule[14] expands the definition of several terms in ways that could make it harder for LGBT people to access health care. It greatly expands the definition of "health care program or activity," and expands the definition of "entity" to "include any State, political subdivision of any State, instrumentality of any State or political subdivision thereof, and any public agency, public institution, public organization, or other public entity in any State or political subdivision of any State." The proposed rule extends the entities covered far beyond the scope of traditional health care providers.

We are also concerned that the definition of "assist in the performance" is defined to include "participat[ing] in any program or activity with an *articulable* connection to a procedure, health service, health program, or research activity..." Previously this term was defined to include "participat[ing] in any program or activity with a *reasonable* connection to a procedure, health service, health program, or research activity..." We are concerned that this will allow for a much broader spread of religious refusals to participate in care, thus limiting access to needed health care for patients. We strongly urge OCR to narrow these proposed definitions, and to revert back to previous definitions of "health care program or activity," "entity," and "assist in the performance."

The proposed rule from HHS is also concerning given a number of recent federal policies and actions regarding religious liberty. In September 2017, HHS released its Draft Strategic Plan FY 2018-2022,[15] which stated that HHS will "vigorously enforce" and "affirmatively accommodate" religious beliefs, language which closely mirrors that of state religious refusal legislation being used to discriminate against LGBT people. The Draft Strategic Plan FY 2018-2022 also made no mention of LGBT health at all, while the Draft Strategic Plan FY 2014-2018 had several references to improving LGBT health. On October 6, 2017, Attorney General Sessions issued a memorandum[16] to all federal agencies which authorizes and encourages anti-LGBT discrimination in health care and other services. In the memo, Sessions cited the 2014 U.S. Supreme Court ruling in *Burwell v. Hobby Lobby Stores* in stating that private businesses can deny contraception coverage to employees based on religious beliefs. By this logic, a company could also refuse to provide sexual health care to LGBT people. The Trump Administration has also submitted an *amicus curiae* brief[17] to the U.S. Supreme Court in support of a baker who refused to make a wedding cake for a gay couple based on religious beliefs. In the brief, the Department of Justice argues that there is no compelling federal government interest in preventing anti-gay discrimination. Roger Severino, who President Trump appointed as

head of HHS OCR, has a long history of anti-LGBT activism. Severino has argued that sexual orientation and gender identity can be changed and should not be included in nondiscrimination legislation.[18,19] Given this federal context, this newest proposed rule from HHS appears to be the latest in a string of recent actions which encourage and allow anti-LGBT discrimination under the guise of religious liberty.

Freedom of religion is an important American value, which is why it is already protected by the First Amendment of the Constitution. But as we have learned time and time again in our nation's history, we need both freedom *of* religion (free exercise) and freedom *from* religion (freedom from state-sponsored discrimination in the name of some religious beliefs and practices that are privileged over others—the Establishment Clause).

Unlike other free exercise laws—such as the Religious Freedom Restoration Act of 1993, which protected American Indians' right to ritually use peyote—these recent religious refusal laws and executive branch actions cause real harm to third parties. As Douglas NeJaime and Reva Siegel point out in *The Yale Law Review*, these laws inflict both material harm and dignitary harm—harms that exacerbate stigma and reduce social status—on other citizens.[20]
The U.S. Constitution bars HHS from crafting "affirmative" accommodations within its programs if the accommodations would harm program beneficiaries. The Constitution dictates that "an accommodation must be measured so that it does not override other significant interests,"[21] "impose unjustified burdens on other[s],"[22] or have a "detrimental effect on any third party."[23]

In addition to causing third party harm, the recent wave of anti-LGBT religious refusal legislation also violates the Establishment Clause of the First Amendment. Our nation's courts have ruled that, under this clause, the government is prohibited from passing laws that favor one religion over another, or laws that favor religion over non-religion.[24] In the *Estate of Thornton v. Caldor* ruling, the U.S. Supreme Court struck down a Connecticut statute which gave workers the absolute right to refuse to work on the Sabbath. The U.S. Supreme Court ruled that this law violated the Establishment Clause because it impermissibly advanced religion by requiring employers to conform business practices without exception to accommodate a particular religious belief that was not even practiced by all employees.[25]

The recent wave of anti-LGBT religious refusal legislation also violates the Establishment Clause by impermissibly advancing religion, and burdening LGBT people by forcing them to accommodate certain religious beliefs or practices to their personal detriment. A group of legal scholars from several Mississippi law schools and from Columbia University School of Law wrote, regarding Mississippi's HB 1523, that "HB 1523 violates the Establishment Clause by impermissibly accommodating religion in a way that harms third parties…the law strips Mississippians of applicable antidiscrimination protections in order to accommodate the preferences of religious individuals and institutions."[26] The legal scholars go on to say that the law grants "public and private actors broad immunities that allow them to discriminate against

Mississippians based on a specific set of religious beliefs…although [the beliefs] are far from universal, even among religious individuals or denominations."[27] In addition to violating the Establishment Clause of the First Amendment to the U.S. Constitution, government-sanctioned and -funded discrimination against LGBT people, same-sex couples, and potentially others, such as unmarried single mothers, violates the due process provisions of the Fifth and Fourteenth Amendments, and violates the equal protection provision of the Fourteenth amendment. The Fifth Amendment states, "No person shall be…deprived of life, liberty, or property, without due process of law..."[28] The Fourteenth Amendment states:

> …No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.[29]

Several important U.S. Supreme Court cases have found discriminatory laws to violate the equal protection and due process rights of gay, lesbian, and bisexual people. In *Romer v. Evans* (1996) the Court ruled against a Colorado state constitutional amendment that prevented the state from passing legislation or adopting policies that prohibited discrimination based on sexual orientation, and overturned existing municipal nondiscrimination statutes.[30] Writing for the majority, Justice Anthony Kennedy ruled that Colorado's Amendment 2, passed by a majority of voters in a 1992 ballot campaign, violated the equal protection clause of U.S. Constitution. The Court ruled that Amendment 2 was not motivated by a rational state interest, but rather by "animus" toward gay men, lesbians, and bisexual people. The Court ruled that Amendment 2 singled out homosexual and bisexual persons, imposing harm by denying them the right to seek and receive specific legal protection from discrimination. The Court stated, "If the constitutional conception of 'equal protection of the laws' means anything, it must at the very least mean that a bare desire to harm a politically unpopular group cannot constitute a legitimate governmental interest."[31]

The two landmark marriage equality decisions, *United States v. Windsor* (2013) *and Obergefell v. Hodges* (2015), both appealed to the due process and equal protection clauses in striking down federal non-recognition of same-sex marriages, and state non-recognition, respectively. In *Windsor*, Justice Kennedy, writing for the majority, found that the federal non-recognition provision of the 1996 Defense of Marriage Act violated the equal liberty of persons protected by the Fifth Amendment's due process and equal protection principles.[32] In *Obergefell*, Justice Kennedy, writing for the majority, ruled that the right of same-sex couples to marry is guaranteed by the equal protection and due process clauses of the Fourteenth Amendment.[33]

Faith-based organizations can play an important role in health care. For example, Black churches have played a major role in promoting HIV screening and raising awareness of HIV. However, the proposed rule goes too far in authorizing discriminatory action under the guise of free exercise of religion. The focus of HHS should be to assist individuals in need of critical services and support by increasing access to health care, supporting individual decision

making and informed consent, and prohibiting discrimination in the provision of human services. We respectfully urge HHS to rethink this proposed rule and any other attempts to allow health care providers to be able to use religion to engage in taxpayer-funded discrimination. Instead, we recommend that HHS instead focus on addressing health disparities and ensuring equal access to services regardless of race, color, national origin, religion, sex, gender identity, sexual orientation, age, or disability. Religious freedom does not include the freedom to discriminate and cause harm to others by denying basic services we all need to live—including health care.

Thank you for the opportunity to provide comment. Should you have any questions or require further information, please contact Sean Cahill at scahill@fenwayhealth.org or 617-927-6016.

Sincerely,

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# Exhibit 171

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March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: RIN 945-ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

*By electronic submission*

**RE: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, Proposed Rule (RIN 0945-ZA03 and Docket No. HHS-OCR-2018-0002)**

Dear Director Severino:

The Leadership Conference on Civil and Human Rights and its Health Care Task Force appreciate this opportunity to provide comments in response to the Department of Health and Human Services' (HHS) Notice of Proposed Rulemaking (NPRM), which would create protections for health care workers who refuse to administer services that violate their religious or moral beliefs. The Leadership Conference on Civil and Human Rights is a coalition charged by its diverse membership of more than 200 national organizations to promote and protect the civil and human rights of all persons in the United States. The Leadership Conference's Health Care Task Force is committed to eliminating health disparities and ensuring that all people in the United States can access quality, affordable health care, without discrimination. The Department's proposed rule would greatly expand current "conscience" protections and religious refusals, allowing employees in health care settings to discriminate against patients and deny care.

As discussed in more detail below:

- The proposed rule is contrary not only to HHS' mandate, but also to the Office for Civil Rights (OCR) mandate to protect against discrimination.
- The proposed rule is arbitrary and capricious, not otherwise in accordance with law, and in excess of the statutory authority of the laws that it seeks to enforce.
- HHS and OCR should be putting their resources to protecting patients from discrimination, not attempting to make it easier for providers to discriminate.

## I. The proposed rule is contrary not only to HHS' mandate, but also to the Office for Civil Rights (OCR) mandate to protect against discrimination.

OCR has a long and storied record of combating discrimination, protecting patient access to care, and eliminating health disparities. 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[i] prohibition against discrimination on the basis of race, color, or national origin. The change not only in hospital polices but in actual practice, as verified by an army of volunteer inspectors, was dramatic. In less than four months, private hospitals went from being among the most segregated institutions in the United States to being among the most integrated.

Integration had a profound effect on patient care. Black patients were no longer relegated to basement wards or separate "charity" hospitals. And for the first time, those who needed the most medical care received the most medical care.[ii] One study estimated that between 1965 and 1975, integration of hospitals saved the lives of over 5,000 Black infants in the rural South and 25,000 through 2002.[iii]

After this auspicious start, the Office of Equal Health Opportunity, which would eventually become OCR, would go on to ensure that the health programs and activities it regulated complied with key anti-discrimination laws including:

- Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin by recipients of federal funds;[iv]
- Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex in education programs;[v]
- Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability by recipients of federal funds;[vi]
- The Age Discrimination Act of 1976, which prohibits discrimination on the basis of age;[vii]
- Title VI and XVI of the Public Health Service Act, which requires health facilities that receive certain federal funds to provide certain services to members of its designated community;[viii] and
- Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, age, and disability and marks the first time sex discrimination was broadly prohibited in health care.[ix]

Through robust enforcement of these 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 services, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[x] OCR has also sought to ensure compliance with civil rights statutes by requiring hospitals and covered entities to provide auxiliary aids and services to ensure effective communication for individuals with disabilities and taking steps to ensure that individuals with limited English proficiency have meaningful access to health facilities, such as providing interpreters free of charge.[xi] These actions have gone a long way towards combating discrimination and disparities in health care.

Nevertheless, further work needs to address discrimination and disparities in health care. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. For example, 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.[xii] Bias also contributes to providers treating patients differently because of their race or gender.[xiii]

In addition to racial disparities, women have long been the subject of discrimination in health care and the resulting health disparities.[xiv] Black women, for example, are three to four times more likely than White women to die during or after childbirth.[xv] Further, the disparity in maternal mortality is growing rather than decreasing.[xvi] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[xvii] 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 in the year before the survey.[xviii]

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 of ending discrimination that harms patients and contributes to health inequality. 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 not only does not make sense but is affirmatively harmful.

The regulations for the civil rights statutes such as Title VI and Section 1557, for example, were written to improve access to health care, consistent with the purpose of both the statutes. By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the Department seeks to use OCR's limited resources to prioritize allowing institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people needed health care.

Rather than protecting access to health care, however, the proposed rule will limit access not only to health care but even to information about basic health care services. That OCR is prioritizing allowing health care providers and institutions to deny health care services to patients is particularly problematic, given that informed consent law protections were put in place to address the longstanding practices in which researchers experimented on people of color without their consent. In the "US Public Health Study of Syphilis at Tuskegee," 399 men who tested positive for syphilis were not told of their diagnosis nor were they provided treatment so that researchers could study the effects of syphilis.[xix] OCR has a responsibility to ensure that such denials never happen again. Yet, the proposed rule has the potential to expand upon not just denials of care but also information about that care, including a patient's diagnosis.

Discrimination in health care against women, transgender persons, and people of color has been exacerbated by providers invoking religious 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 medical care for transgender patients, and end of life care.[xx] The reach of religious refusals to provide care was growing with the proliferation of both the types of entities using religious beliefs to discriminate[xxi] and the number of religiously affiliated entities that provide health care and related services.[xxii] The harms of these refusals do not fall equally on all. One recent study, for

example, found that women of color are more likely than White women to give birth at Catholic or Catholic-affiliated hospitals that impose religious restrictions on the health care that can be provided.[xxiii]

OCR's work should 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 what should be OCR's mission – eliminating discriminatory practices that contribute to persistent health inequality.

## II. The proposed rule is arbitrary and capricious, not otherwise in accordance with law, and in excess of the statutory authority of the laws that it seeks to enforce.

Although agencies have broad authority to engage in rulemaking, that authority is not without limits. Under the Administrative Procedure Act, "agency action, findings, and conclusions found to be… arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," "contrary to a constitutional right," or "in excess of statutory jurisdiction, authority, or limitations" shall be held unlawful and set aside.[xxiv] 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."[xxv] Further, an agency can only change an existing policy if it provides a "reasoned explanation" for disregarding or overriding the basis for the prior policy.[xxvi]

In promulgating this NPRM, HHS has plainly failed to meet the basic requirement of providing a satisfactory explanation for its action. As stated in the NPRM itself, between 2008 and November 2016, the Office for Civil Rights received 10 complaints alleging violations of federal religious refusal laws; OCR received an additional 34 similar complaints between November 2016 and January 2018. By comparison, during a similar time period from fall 2016 to fall 2017, OCR received *more than 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. HHS also relies in part on comments submitted during the 2011 rulemaking process objecting to full rescission of the prior 2008 rule as grounds for the NPRM. However, those comments are inapposite and reliance on them misplaced, given that the 2011 Rule ultimately only partially rescinded the 2008 Rule and retained enforcement authority for Coats-Snowe, Weldon and Church Amendments with OCR (which it still has to date). Further, the NPRM far exceeds the parameters of the 2008 Rule and no rationale has been given for this new or enhanced regulatory language.

Finally, HHS asserts that because some courts have held, in the context of the Church Amendments and the Coats-Snowe Amendment, that there is no private right of action, the role of the agency in providing "adequate governmental enforcement mechanisms" is somehow more critical with regards to all of the statutes over which it now claims enforcement authority. Not only is this assertion baseless, but HHS uses these justifications to expand enforcement authority far beyond what would be "adequate," removing basic – and constitutionally-mandated – due process requirements for those against whom a complaint has been filed. No rational connection exists between these facts and ad hoc justifications and HHS' decision

to regulate to expand the scope of its enforcement of religious refusal laws. Therefore, HHS is acting in an arbitrary and capricious manner, and this NPRM should be rescinded.

Further, the proposed rule is not in accordance with law, in that much of its language exceeds the plain parameters and intent of the underlying statutes it purports to enforce. For example, the Church Amendments prohibit federal funding recipients from discriminating against those who refuse to perform, or "assist in the performance" of, sterilizations or abortions on the basis of religious or moral objections, as well as those who choose to provide abortion or sterilization.[xxvii] The statute does not contain a definition for the phrase "assist in the performance." Instead the NPRM creates a definition, but one that is not in accordance with the Church Amendments themselves. As Senator Church stated from the floor of the Senate during debate on the Church Amendments:

> "The amendment is meant to give protection **to the physicians, to the nurses, to the hospitals themselves**, if they are religious affiliated institutions. There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal to perform what would otherwise be a legal operation."[xxviii]

Instead, the NPRM proposes to define "assist in the performance" as meaning "to participate in any activity with an articulable connection to a procedure, health service or health service program, or research activity." This overly broad definition opens the door for religious and moral refusals from precisely the type of individuals that the amendment's sponsor himself sought to exclude. This arbitrary and capricious broadening of the amendment's scope goes far beyond what was envisioned when the Church Amendment was enacted.

This is just one example of a trend throughout the NPRM, where HHS repeatedly includes text that is not in accordance with, and exceeds the statutory authority of, the underlying statutes. On these grounds, the NPRM constitutes arbitrary and capricious agency action and should be rescinded.

## III. HHS and OCR should be putting their resources to protecting patients from discrimination, not attempting to make it easier for providers to discriminate.

OCR should devote its resources to protecting patients' ability to access health care and providers' ability to provide that health care. This includes full and robust enforcement of Section 1557, the anti-discrimination provision of the Affordable Care Act (ACA). Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities that receive federal financial assistance or are administered by an executive agency or any entity established under Title I of the ACA. Section 1557 protects individuals from discrimination "on the ground[s] prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973."[xxix]

The work of OCR is essential to ensuring that all people can lead healthy lives free of discriminatory barriers. OCR's efforts are important because discrimination in health care prevents many individuals

from getting the care they need to stay healthy and directly contributes to health care disparities in the communities we represent.

Sex discrimination takes many forms and occurs at every step in the health care system—from obtaining insurance coverage to receiving proper diagnosis and treatment. This discrimination seriously harms women, transgender patients, and other patients who face sex-based discrimination and threatens their health, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments.

Some examples of discrimination against women in health programs and activities and their impacts include:

- Studies have found that women receive inadequate care when gender bias inappropriately influences medical decision-making. Although physical differences may account for some differences in treatment received by men and women, non-biological or non-clinical factors — including overt or unconscious gender bias — also affect clinical decision-making.[xxx] For example, although women disproportionately experience chronic pain[xxxi] and certain chronic pain conditions occur primarily in women,[xxxii] women experience disparities in pain care that result from gender bias, "neglect, dismissal and discrimination from the health care system."[xxxiii]

- Some health plans continue to exclude maternity coverage from the benefits provided to certain female plan participants. Treating pregnancy differently, such as by excluding pregnancy care from an otherwise comprehensive insurance plan, is sex discrimination under civil rights laws such as Title IX and Title VII, and also sex discrimination under Section 1557.[xxxiv]

- Providers, hospitals, or clinics that refuse to provide reproductive health services to a woman who is not married or because she does not conform to sex stereotypes force women to seek care elsewhere or forgo it completely.[xxxv]

- Female health care providers experience discrimination in employment. New research shows a gap in earnings between male and female physicians has persisted over the last 20 years.[xxxvi] In 1987-1990, male physicians earned $33,840 (20 percent) more in annual salary than their female counterparts. By 2006-2010, the gender gap was $56,019 (25.3 percent).

- While progress has been made, past and current exclusion of women in medical research continues to negatively affect advances in women's health.[xxxvii]

Some examples of discrimination against LGBT individuals in health programs and activities and their impacts include:

- Studies have found that transgender people are frequently turned away by providers who refuse to treat them because of personal disapproval of who they are and deny them medical care — both

care related and unrelated to gender dysphoria — or who subject them to abusive or degrading treatment.[xxxviii]

- Despite the medical consensus that treatment for gender dysphoria is medically necessary, many religiously affiliated hospitals have not only refused to provide treatment related to gender dysphoria, but have also prevented physicians who otherwise have admitting privileges to treat transgender people in the hospital.

- Many health plans refuse to cover treatments related to gender dysphoria, and many have even refused to cover treatments unrelated to gender dysphoria simply because a beneficiary is transgender.

- The regulation could also lead a physician to refuse to provide fertility treatments to same-sex couples, single women, or interfaith couples.

The burdens of costly health care fall disproportionately on communities of color. These communities are more likely to experience higher rates of unemployment, to have jobs that do not have health insurance, and have lower incomes that put higher insurance premiums out of their financial reach. Additionally, these communities are less likely to receive preventative care. Some examples of discrimination against people of color include:

- Racial and ethnic minorities are much more likely to be uninsured than Whites. Even after enactment of the ACA, they constitute about one-third of the U.S. population, but make up more than half of the over 27 million people who are uninsured. Twelve percent of African Americans and 17 percent of Hispanics were uninsured in 2016, compared to 8 percent of non-Hispanic Whites.[xxxix]

- The uninsured have higher rates of illness and suffer the effects of lost educational, employment, and other social and civic opportunities. Better health status in childhood is associated with higher incomes, higher wealth, more weeks worked, and a higher growth rate in income.[xl] Conversely, being uninsured correlates with poor education outcomes, such as failing to graduate from high school or to enroll in college. The uninsured often amass significant debt as a result of unforeseen medical expenses, leading to a downward, destabilizing financial spiral, including poor credit, bankruptcy, lost wages, lower annual earnings, and unemployment. These associated effects of being uninsured are more likely to affect racial minorities.

- African Americans have poorer quality of care than Whites for about 50 percent of quality measures.[xli] A significant proportion of Hispanics (24 percent) and African Americans (21 percent) often did not see a doctor or delayed routine and preventive care for reasons other than cost (28 percent and 27 percent respectively).[xlii] In addition, Hispanics, Blacks, and American Indians and Alaska Natives are more likely than Whites to rely on a clinic or other provider rather than a doctor's office as their source of care.[xliii]

- Even after enactment of the ACA, Hispanics and Blacks are less likely to have utilized health or dental care in the past year compared to Whites. In addition, the percent of Asians reporting a health care visit and the percent of American Indians and Alaska Natives reporting a dental visit are lower than Whites. And Black children are less likely than White children to be immunized.[xliv]

Discrimination on the basis of national origin, which encompasses discrimination on the basis of limited English proficiency (LEP),[xlv] creates unequal access to health. LEP is often compounded with the "cumulative effects of race and ethnicity, citizenship status, low education, and poverty," resulting in more barriers to access.[xlvi] In the United States today, there are about 25 million individuals with LEP.[xlvii] About 9 million LEP adults are uninsured.[xlviii] The affirmative obligation to provide language assistance services under Section 1557 is as important now as it was decades ago when Title VI was passed, as increased complexity in medical information and program bureaucracy have made navigating systems for limited English proficient individuals more difficult.[xlix]

- Language assistance services are especially critical for individuals with LEP who are unfamiliar with our complex healthcare system. Visiting health care facilities and agencies that administer health programs and activities are often uncomfortable for individuals with LEP who are "unfamiliar with [the system's] cultural norms, vocabulary, and procedures."[l] Unfamiliarity with the health care system often results in inaction that could compromise a basic standard of living for individuals and families. Furthermore, the lack of language assistance services negatively impacts communities at large, not just LEP individuals. When interpreter services are inadequate, children often serve as language brokers for their parents.[li]

- Older adults who did not grow up in the United States are particularly susceptible to discrimination based on national origin because they may be more likely than younger individuals to have limited English proficiency, different mannerisms, or dress. Furthermore, older adults may be less likely or able to advocate for themselves because of language barriers and the complexity of the health care system. If an individual cannot communicate with a provider who is unwilling to get an interpreter or is refused care because of her perceived national origin, the consequences could be harmful, even deadly. About 5 million of America's older adults are limited English proficient,[lii] including over 4 million Medicare beneficiaries.[liii]

- Older adults who are LEP already face difficulties finding providers, especially for in-home supports and services, who speak their preferred language and often are forced to rely on family members to interpret for them.[liv] These issues can result in delayed care in any context, but can be especially problematic in long-term care where older adults and persons with disabilities make important decisions about their own care are therefore more reliant on the relationship and effective communication with their providers.

People with disabilities experience significant health disparities and barriers to health care, as compared with people who do not have disabilities.[lv] In fact, people with disabilities are 2.5 times more likely to have unmet health care needs than non-disabled peers. Individuals with all types of disabilities report

discriminatory physical, programmatic, and attitudinal barriers to accessing health care in hospitals, clinics, diagnostic facilities, and practitioners' offices of all sizes throughout the country.[lvi]

- Some of the barriers to comprehensive, quality health care present in the physical environment include cramped waiting and exam rooms, inaccessible bathrooms, and inaccessible equipment (such as exam tables, weight scales, and imaging and other diagnostic equipment).[lvii] A California study reported, for example, that among more than 2,300 primary care practices, only 3.6 percent had accessible weight scales.[lviii] Related research reveals that wheelchair users report almost never being weighed even though weight measurement is a crucial metric for many types of health care including determining anesthesia and prescription dosages, and ongoing health and fitness monitoring. The Americans with Disabilities Act requires full and equal access to healthcare services and facilities for people with disabilities, yet patients with mobility impairments are frequently denied services, receive less preventive care and fewer examinations, and report longer waits to see subspecialists despite this mandate.[lix]

- People with disabilities often rely on Medicaid-funded Home and Community-Based Services (HCBS) for supports with daily living, including assistance with dressing, grooming, bathing, transportation to social and health-related appointments, and participating in recreational activities. These services are intensely intimate and implicate a person's right to pursue and maintain romantic relationships, build a family, and make basic decisions about one's life. Moreover, in many areas people with disabilities may have access to only one provider who is capable of meeting their needs. Allowing such providers to discriminate, or to refuse to provide certain services, would result in dramatic limitations in people's ability to exercise their right to basic self-determination.

- Failure to provide needed policy modifications and reasonable accommodations as required by current disability rights laws affects healthcare treatment decisions and outcomes. For example, lack of effective communication when Sign Language interpreters are not provided for Deaf patients or print materials are not available in alternative, accessible formats for people with visual impairments, can lead to ineffective communication about medical problems and treatment. Accommodations such as alternative formats are not offered or available even when their necessity is clinically obvious and predictable. For example, there is a high correlation between diabetes and vision loss, but printed self-care and treatment instructions in alternative formats such as Braille, large font type, CD, or audio recording, and accessible glucometers, are rarely available although the Americans with Disabilities Act of 1990 and Section 504 of the 1973 Rehabilitation Act requires the provision of auxiliary aids and services when required for effective medication.

Finally, we want to emphasize the importance of intersectionality to implementation and enforcement of civil rights laws. When The Leadership Conference worked with members of Congress to craft Section 1557, for example, we sought to create uniformity in the enforcement of antidiscrimination protections. By bringing all forms of discrimination under one civil rights provision, we sought to ensure that individuals would not face different legal results merely because of differences in the relevant underlying

civil rights law. This also recognizes that many individuals may face discrimination due to multiple factors.

For example, discrimination against an African-American woman could be discrimination on the basis of both race and sex.[lx] Similarly, individuals with disabilities may face discrimination based on their disability as well as concurrent or additional discrimination based on other factors such as race/ethnicity or sexual orientation/gender identity. Therefore, in your implementation and enforcement activities, OCR must examine all aspects of a complainant to understand the full scope of discrimination; that discrimination may not be one-dimensional but could be cumulative based on a number of interrelated factors.

For all the reasons stated above, as well as the additional issues intersectionality raise, we urge you not to finalize the proposed rule and instead to focus OCR's attention on enforcing Section 1557 and the other civil rights statutes within its purview.

## IV. Conclusion

Thank you for your attention to our comments. If you have any questions or need any further information, please contact Corrine Yu, Managing Policy Director, The Leadership Conference on Civil and Human Rights, at yu@civilrights.org.

Sincerely,

The Leadership Conference on Civil and Human Rights
American Civil Liberties Union
American Federation of State, County and Municipal Employees (AFSCME)
Asian & Pacific Islander American Health Forum
Autistic Self Advocacy Network
Center for Reproductive Rights
Families USA
Human Rights Campaign
Justice in Aging
NAACP
National Center for Lesbian Rights
National Center for Transgender Equality
National Health Law Program
National Latina Institute for Reproductive Health
National Partnership for Women & Families
National Women's Law Center

[i] 42 USC § 2000d

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[ii] David Barton Smith, The "Golden Rules" for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act (2015)
[iii] Almond, Chay, & Greenston (2006) at 2
[iv] 42 U.S.C. § 2000d et. seq.
[v] 20 U.S.C. § 1681 et. seq.
[vi] 29 U.S.C. § 794.
[vii] 42 U.S.C. § 6101 et. seq.
[viii] 42 U.S.C. § 291-300.
[ix] 42 U.S.C. § 18116.
[x] https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html.
[xi] https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/agreements/compliance-review-initiative-report-bulletin/index.html.
[xii] Skinner et al, After Acute Myocardial Infarction in Hospitals that Disproportionately Treat Black Patients (2005).
[xiii] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=383803.
[xiv] Women have been charged more for health care on the basis of sex and have continually been denied health insurance coverage for services that only women 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. Women's pain is routinely undertreated and often dismissed. *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). Due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease. *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).
[xv] https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.
[xvi] *Id.*
[xvii] *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. *Id.* at 5-6. Twenty-eight percent of transgender and gender non-conforming individuals already report facing harassment in medical settings, and 19 percent report being refused medical care altogether due to their transgender status. Lesbian, gay, and bisexual people also report facing continued discrimination in health care and health insurance coverage. *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 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.
[xviii] https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.
[xix] https://www.history.com/news/the-infamous-40-year-tuskegee-study.
[xx] 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.
[xxi] Entities ranging from religiously-affiliated school districts and Universities, large department stores, small businesses such as bridal salons, photo studios, and even land owners have attempted to evade important anti-

discrimination laws through the assertion of religious beliefs. *See The Hobby Lobby "Minefield": The Harm, Misuse, and Expansion of the Supreme Court Decision*, NAT'L WOMEN'S L. CTR. (2015), https://nwlc.org/wp-content/uploads/2015/08/nwlchobbylobbyreport2015.pdf; *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.

[xxii] The government explicitly acknowledges the growth of religiously-affiliated health care entities in the RFI stating, "one in six hospital patients were cared for in Catholic hospitals in 2015." *See* Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding, 82 Fed. Reg. 49,300, 49,301 (Oct. 25, 2017). These hospitals have some affiliation with the Catholic religion and elect to follow Catholic health care teachings, which impose restrictions on the type of care that can be offered. *See* 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. When religious and secular hospitals merge, the religious restrictions often apply to both the religiously-affiliated and secular hospitals. *See About Hospital Mergers*, MERGER WATCH (2017), http://www.mergerwatch.org/about-hospital-mergers/.

[xxiii] Kira Shepherd, et. al, Bearing the Faith, The Limits of Catholic Health Care for Women of Color (2018).

[xxiv] 5 U.S.C. § 706(2)(A), (B), (C).

[xxv] *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)).

[xxvi] *Id.* at 2125-26.

[xxvii] 42 U.S.C. § 300a-7.

[xxviii] S9597, https://www.gpo.gov/fdsys/pkg/GPO-CRECB-1973-pt8/pdf/GPO-CRECB-1973-pt8.pdf (emphasis added). Senator Church went on to reiterate that "[t]his amendment makes it clear that Congress does not intend to compel the courts to construe the law as coercing r**eligious affiliated hospitals, doctors, or nurses to perform surgical procedures** against which they may have religious or moral objection." S9601 (emphasis added).

[xxix] 42 U.S.C. § 18116.

[xxx] Council on Ethical and Judicial Affairs of the American Medical Association, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559 (1991).

[xxxi] Dept. of Health & Human Servs., Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Statistics, *Health United States*, 13, 69 (2006) (with special feature on pain), *available at* http://www.cdc.gov/nchs/data/hus/hus06.pdf.

[xxxii] Instit. of Med., *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, 75 (2011), *available at* http://www.nap.edu/download.php?record_id=13172.

[xxxiii] *Id.* at 77 (quoting (Campaign to End Chronic Pain in Women, *Chronic Pain in Women: Neglect, Dismissal, and Discrimination*, 4 (May 2010), *available at* http://www.endwomenspain.org/resources).

[xxxiv] *See, e.g.*, Nat'l Women's Law Ctr., *NWLC Section 1557 Complaint: Sex Discrimination Complaints Against Five Institutions*, http://www.nwlc.org/resource/nwlc-section-1557-complaint-sex-discrimination-complaints-against-five-institutions (Section 1557 complaints filed against five institutions that exclude pregnancy coverage for plan beneficiaries who are dependent children of employees at institutions).

[xxxv] *See* Nat'l Women's Law Ctr., *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care* (Jan. 2013), *available at* http://www.nwlc.org/resource/health-care-refusals-harm-patients-threat-reproductive-health-care.

[xxxvi] Seth A. Seabury, et al., *Trends in the Earnings of Male and Female Health Care Professionals in the United States, 1987 to 2010* JAMA Intern Med. (Online First) (Sept. 2013).

[xxxvii] *See, e.g.*, K. Coleman-Phox, et al., *Recruitment and Retention of Pregnant Women for a Behavioral Intervention: Lessons from the Maternal Adiposity, Metabolism, and Stress (MAMAS) Study*, 10 Prev. Chronic Dis. (Mar. 2013), http://www.cdc.gov/pcd/issues/2013/12_0096.htm; Mary A. Foulkes, et. al., *Clinical Research Enrolling Pregnant Women: A Workshop Summary*, 20(10) J. Women's Health 1429 (2011).

[xxxviii] *See, e.g.*, Sandy E. James, *The Report of the U.S. Transgender Survey* (2015), www.ustranssurvey.org/reports.

[xxxix] Kaiser Family Foundation, *Uninsured Rates for the Nonelderly by Race/Ethnicity (2016)*, https://www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

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[xl] James A. Baker III Institute for Public Policy of Rice University. *The Economic Impact Of Uninsured Children On America* June 2009. http://www.bakerinstitute.org/publications/HPF-pub-HoShortUninsuredChildren-060309.pdf.
[xli] Agency for Healthcare Research and Quality, *2016 National Healthcare Quality and Disparities Report*, https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr16/final2016qdr-cx.pdf.
[xlii] Kaiser Family Foundation, *Key Facts on Health and Health Care by Race and Ethnicity*, 2016, https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-2-health-access-and-utilization/.
[xliii] *Id.*
[xliv] *Id.*
[xlv] *Lau v. Nichols*, 414 U.S. 563 (1974).
[xlvi] Kaiser Family Foundation, Overview of Health Coverage for Individuals with Limited English Proficiency, at 3.
[xlvii] U.S. Census Bureau, *American Community Survey, Selected Social Characteristics in the United States: 2011 American Community Survey 1-Year Estimates* (25,303,308 speak English less than "very well"). http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_DP02&prodType=table.
[xlviii] Kaiser Family Foundation, *Overview of Health Coverage for Individuals with Limited English Proficiency*, at 2 (Figure 5) (2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8343.pdf.
[xlix] Katz, *Children as Brokers of their Immigrant Families' Healthcare Connections* , at 37.
[l] Vikki Katz, *Children as Brokers of their Immigrant Families' Healthcare Connections*, at 24 (2013) (under review).
[li] Katz, *Children as Brokers of their Immigrant Families' Healthcare Connections* , at 31.
[lii] Camille Ryan, U.S. Census Bureau, Language Use in the United States: 2011, *available at* www.census.gov/content/dam/Census/library/publications/2013/acs/acs-22.pdf.
[liii] CMS Office of Minority Health, Understanding Communications and Language Needs of Medicare Beneficiaries, at 8 (April 2017), *available at* www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf.
[liv] *See, e.g.*, National Senior Citizens Law Center, Improving Language Access to Keep California's Older Adults at Home (Feb. 2011), *available at* www.justiceinaging.org/wp-content/uploads/2015/08/Improving-Language-Access-in-IHSS.pdf.
[lv] See, e.g.: The National Council on Disability, (2009). *The Current State of Health Care for People with Disabilities*. Retrieved from website: http://www.ncd.gov/publications/2009/Sept302009;
Reis, J. P., Breslin, M. L., Iezzoni, L. I., & Kirschner, K. L. (2004). *It Takes More Than Ramps to Solve the Crisis of Healthcare for People with Disabilities.* Informally published manuscript, Rehabilitation Institute of Chicago, Chicago, IL, Retrieved from www.tvworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf.
[lvi] Disabilities are diverse. As the Surgeon General said in his 2005 Call to Action to Improve the Health and Wellness of Persons with Disabilities stated: "Some disabilities are visible; others are not. Some are physical, some visual or auditory, some developmental or cognitive, and some mental or behavioral. Some persons are born with one or more disabilities; others acquire a disability during the course of a lifetime . . . . No single disabling condition necessarily affects one person in exactly the same way as it does another."
[lvii] Mudrick, N.R.; Breslin, M.L.; Liang, M.; and Yee, S. (2012) "Physical Accessibility in Primary Health Care Settings: Results from California On-site Reviews," *Disability and Health Journal*, October, Vol. 3, Issue 4, Pages 253-261.
[lviii] Mudrick, Breslin, Liang, 2012.
[lix] Tara Lagu et al., *Access to Subspecialty Care for Patients With Mobility Impairment*, Annals of Internal Medicine, 2013; 158:441–446.
[lx] Section 1557 Final Rule, 81 Fed. Reg. at 31405.

# Exhibit 172

March 25, 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:

The Movement Advancement Project (MAP) is writing in response to the request for public comment regarding the proposed rule entitled "Protecting Statutory Conscience Rights in Health Care," published January 26.

MAP is an independent think tank that provides rigorous research, insight, and analysis to help speed equality for LGBT people. MAP's policy research informs the public and policymakers about the legal and policy needs of LGBT people and their families.

MAP strongly believes that the proposed regulation will cause significant harm to millions of Americans – including women, people in rural areas, and LGBT people – by creating and exacerbating existing obstacles to accessing quality health care. The proposed regulation does not put patients' needs first, but rather allows for increased discrimination and denials of care to some of the most vulnerable Americans. It does so in the following ways.

- **Religious refusals exacerbate the barriers to care that vulnerable groups already face.** LGBT people, women, and other vulnerable groups around the country already face enormous barriers to getting the care they need.[1] Accessing quality, culturally competent care and overcoming outright discrimination is even a greater challenge for those living in areas with already limited access to health providers. Religious exemptions, as well as the newly proposed regulation, threaten to make access even harder and for some people nearly impossible.

  Patients living in rural or less densely populated areas already face many barriers to care including less access to health insurance coverage, lower incomes, and lower rates of paid sick leave. This is in

[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.

addition to the universal costs of transportation, taking time from work, and other incidentals that go along with obtaining care in the first place. More than half of rural women, for example, live more than 30 minutes away from a hospital that provides basic obstetric care.[2] Patients seeking more specialized care like that required for fertility treatments, endocrinology, or HIV treatment or prevention are often hours away from the closest facility offering these services. For example, a 2015 survey of nearly 28,000 transgender adults nationwide found that respondents needed to travel much further to seek care for gender dysphoria compared to other kinds of care.[3]

This means if these patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. 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.

- **The regulation's efforts to broaden religious exemptions can lead to dangerous denials of medically necessary, sometimes life-saving treatments.** The regulation attempts to clarify current "religious refusal clauses" related to abortion and sterilization in three federal statutes. These statutes refer to specific, limited circumstances in which health care providers may not be required to participate in abortion and sterilization procedures. This newly proposed regulation, however, creates sufficient ambiguity as to allow these narrow circumstances to be applied to a wide range of health care procedures and patient needs.

  For example, existing laws allow exemptions related to "sterilization," but this proposed regulation could allow providers to refuse care for a wide range of procedures and treatments that have merely incidental, if any, impact on fertility and which are primarily performed to treat an unrelated medical condition, such as chemotherapy for cancer. Some providers may try to claim even broader refusal abilities, as a recent analysis of complaints to HHS showed that transgender patients are most often discriminated against simply for being who they are rather than for the medical care they are seeking.[4]

  In fact, medical staff may interpret the regulation to indicate that they can not only refuse, but decline to tell the patient where he would be able to obtain these lifesaving services or even inform patients of their treatment options. This puts the health of the patient, and potentially that of others, at risk. In addition, by unlawfully redefining the statutory term "assisting in the performance" of a procedure, the rule could encourage health care workers to obstruct or delay access to a health care service even when they have only a tangential connection to delivering that service, such as providing food to a patient, scheduling a procedure, or running lab. The extension and broadening of this clause will impair vulnerable patients' access to important and, in some cases, medically necessary health care services.

  We are particularly concerned that the proposed rule will be used to refuse medically necessary care to women and LGBT people. We are concerned that the rule's sweeping terms will encourage

[2] American College of Obstetrics and Gynecologists, *Health Disparities in Rural Women* (2014), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women#17.
[3] Sandy E. James et al., *The Report of the U.S. Transgender Survey* 99 (2016), www.ustranssurvey.org/report
[4] https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/

the mistaken belief that medically necessary treatments can be refused or medical best practices can be ignored if they go against a provider's personal beliefs. If religious or moral exemptions related to sterilization are misinterpreted to include treatments that have simply an incidental effect on fertility (such as chemotherapy for cancer) —as the vague and sweeping language of this rule encourages—it can lead to refusals that go even further beyond what federal law allows and unlawfully encourages individuals and institutions to refuse a dangerously broad range of medically needed treatments.

- **The proposed rule disregards the rights of state and local governments and their efforts to protect patients' health and safety, including their nondiscrimination laws.** Increasingly, state and local governments around the country are passing inclusive nondiscrimination laws that forbid discrimination against women, LGBT people, and other vulnerable populations in the context of health care and other public accommodations. HHS claims that its newly proposed regulation and re-interpretation of federal law supersede these state and local laws designed to ensure patients' access to health care. However, HHS' proposed rule instead creates conflicts with hundreds of state and local nondiscrimination laws around the country that apply to health care. It therefore is disingenuous for the Department to claim that the proposed rule "does not impose substantial direct effects on States," "does not alter or have any substantial direct effects on the relationship between the Federal government and the States," and "does not implicate" federalism concerns under Executive Order 13132.

The proposed rule will allow healthcare providers to ignore standard medical best practices and instead put their personal beliefs before patient health. This has the potential to gravely harm millions of people and their families' health. We urge you to withdraw the proposed rule, and instead put patients' health and wellbeing first.

Sincerely,

Naomi Goldberg, MPP
Research and Policy Director
The Movement Advancement Project

Logan S. Casey, Ph.D.
Policy Researcher
The Movement Advancement Project

# Exhibit 173

March 27, 2018

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

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

Dear Secretary Alex Azar,

The New York State Lesbian, Gay, Bisexual, and Transgender (LGBT) Health & Human Services Network (The Network), a coalition of 72 LGBT-serving organizations across New York State, strongly opposes the proposed rule titled, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," as published by the Office for Civil Rights in the January 26, 2018 Federal Register.

The Network's mission is to address and eliminate LGBT-related health disparities and empower LGBT communities to access affordable and culturally informed health services, resulting in a stronger and safer healthcare environment for all LGBT people. This regulation would permit and promote discrimination by healthcare providers, under the guise of moral or religious protections. In particular, we are concerned that this regulation would formally and explicitly allow health care providers to deny healthcare services to LGBT people who already face health disparities due to discrimination and bias in healthcare.

**The Network strongly urges against the proposed Protecting Statutory Conscience Rights in Health Care rule for three (3) main reasons: 1) religious liberty cannot override patient autonomy or anti-discrimination principles; 2) this regulation would contribute to increased levels of discrimination for already medically vulnerable communities, particularly LGBT communities; and 3) this regulation does not reflect the viewpoint of the majority of voters.**

**Religious liberty cannot override patient autonomy or anti-discrimination principles.** Religious exemption policies like this one would allow health care workers to prioritize their

own religious beliefs above patient care. These regulations allow providers to base the course of a patient's medical treatment on their own personal beliefs, not on what is best for the patient's health and circumstances. The proposed rule "ensure[s] that persons or entities are not subjected to certain practices or policies that violate conscience, coerce, or discriminate," however, medical providers are already protected and supported through their code of ethics and law. The United State Equal Employment Opportunity Commission (EEOC) protects medical providers in the workplace; they can already refuse to provide treatment that violates their religious, moral, or ethical values under religious discrimination & reasonable accommodation, as long as this does not place undue hardship on the employer.[1]

Additionally, the American Medical Association (AMA) Principles of Medical Ethics states that, "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care." Medical providers already can choose not to provide care based on moral, religious, or other objections. However, formalizing this code of ethics into law would legally permit discrimination and prevent patients who have experienced refusal of care from pursuing legal action. It is the government's duty to ensure that all people have access to healthcare services, free from discrimination. While this regulation claims to protect religious freedom, it is actually a thinly veiled attempt to devalue women and LGBTQ people.

**This regulation would contribute to increased levels of discrimination for already medically vulnerable communities, particularly LGBT communities.** LGBT people often experience difficulty finding affirming and competent care. In the 2015 United States Trans Survey, 33% of transgender and gender non-conforming people reported having at least one negative experience related to being transgender, such as verbal harassment, refusal of treatment, or having to teach the health care provider about transgender people to receive appropriate care, with increased rates for people of color.[2] Medical negligence and mistreatment led to the death of Robert Eads, a transgender man with ovarian cancer whom over 20 different doctors refused to treat; one provider claimed the diagnosis should make Robert Eads "deal with the fact that he is not a real man."[3]

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[1] United States. Equal Employment Opportunity Commission. (1992). *EEOC compliance manual*. Washington, DC: U.S. Equal Employment Opportunity Commission.
[2] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.
[3] Lambda Legal. (2013). *Transgender Rights Toolkit: Overcoming Health Care Discrimination*. New York: Lambda Legal

Furthermore, 50% of LGB people and 90% of transgender people believe there are not enough medical personnel who are properly trained to care for them. Over 50% of LGB and 85% of transgender people indicated that overall community fear or dislike of people like them is a barrier to care.[4] This proposed rule would likely exacerbate the fear, mistreatment, harassment, and barriers to care for this already vulnerable population.

**This regulation does not reflect the viewpoint of the majority of voters.** In a March 2017 nationally representative survey done on behalf of the National Women's Law Center, 61% of voters showed opposition to religious exemption laws. In particular, voters express strong concerns that religious exemption laws do not allow patients to access to optimal medical care, information, and referrals without interference. The majority of constituents (60%) also emphasize that hospitals, medical providers, or public health programs that receive public funding should not be allowed to deny medical care based on religious beliefs. [5] Given that religious exemption policies are not supported by the majority of voters, they should not be implemented.

In closing, The Network strongly opposes the proposed regulation, Protecting Statutory Conscience Rights in Health Care. The Office for Civil Rights has a duty to ensure that LGBTQ individuals are not targeted with this discriminatory regulation.

We appreciate the opportunity to provide these comments. Please contact Corey Westover, the Director of The Network, at cwestover@gaycenter.org or 646.358.1733 with any questions or concerns.

Sincerely,
The New York State LGBT Health & Human Services Network

[4] Lambda Legal. (2010). *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV*. New York: Lambda Legal.
[5] Greenberg Quinlan Rosner Research. (2017). *Voters Oppose Religious Exemption Laws: Findings from a National Survey of Voters*. Washington, DC: Greenberg Quinlan Rosner Research.

**Members of The Network who oppose the proposed ruling,
"Protecting Statutory Conscience Rights in Health Care; Delegations of Authority"**

ACR Health - Q Center
Albany Damien Center
Ali Forney Center
Alliance for Positive Health
Apicha Community Health Center
Audre Lorde Project
Bassett Healthcare Network - The Gender Wellness Center
Binghamton University - Lesbian and Gay Family Building Project/Pride and Joy Families
Callen-Lorde Community Health Center
Community Awareness Network for a Drug-Free Life and Environment (CANDLE)
Chinese American Planning Council - Project Reach
Community Health Action of Staten Island
Cortland LGBT Resource Center
CRUX Climbing
DBGM, Inc.
Destination Tomorrow
Empire Justice Center - LGBT Rights Project
Gay & Lesbian Youth Services of Western New York
GMHC
Grand Street Settlement
GRIOT Circle, Inc.
Harm Reduction Coalition
Hetrick-Martin Institute
Hispanic AIDS Forum - Latino Pride Center
Hudson Valley LGBTQ Community Center
In Our Own Voices
Institute for Human Identity (IHI)
Latino Commission on AIDS
Long Island Crisis Center - Pride for Youth
Long Island Gay and Lesbian Youth (LIGALY)
Long Island LGBT Center
Make the Road New York - LGBTQ Program
Metropolitan Community Church of New York
Montefiore Medical Center- Adolescent AIDS Program
Mount Sinai - Institute for Advanced Medicine
New York City Anti-Violence Project

New York Legal Assistance Group (NYLAG) - LGBT Law Project
New York Transgender Advocacy Group (NYTAG)
Northwell Health - Center for Transgender Care
Out Alliance
Planned Parenthood Mohawk Hudson
Planned Parenthood of the North Country New York - LGBTQ Services, Education, & Outreach
Planned Parenthood of the Southern Finger Lakes - Out For Health
Pride Center of Staten Island
Pride Center of the Capital Region
Pride Center of Western New York
Princess Janae Place, Inc.
Queens Community House- Queens Center for Gay Seniors/Generation Q
Queens LGBT Community Center (Q-Center)
Rainbow Access Initiative
Rainbow Heights Club
Rockland County Pride Center
Safe Horizon - Streetwork Project
SAGE
SAGE Long Island
SAGE Upstate
Southern Tier AIDS Program - Identity Youth
St. Lawrence University - SAFE Project
State University of New York (SUNY) - The HEAT Program
Sylvia Rivera Law Project
The Legal Aid Society - LGBT Law and Policy Initiative
The Lesbian, Gay, Bisexual, Transgender Community Center
The LOFT: LGBT Community Services Center
Translatina Network
The National LGBT Cancer Network
The Trevor Project
Transgender Legal Defense and Education Fund (TLDEF)
Trillium Health
Unity Fellowship Breaking Ground
Urban Justice Center - Peter Cicchino Youth Project

# Exhibit 174

PO Box 4994, New York, NY 10185
609.759.0322

March 27, 2018
New York, NY

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

To Whom It May Concern:

The Patients' Rights Action Fund (PRAF) is a national, secular, non-partisan leader defending the rights of patients, people with disabilities, our elders, and the disadvantaged from the threat of legalized assisted suicide. We do this by building, sourcing, and helping state-level coalitions of local organizations; through our educational programs; and by working to promote measures that protect patients' civil rights, to weaken the breadth and effectiveness of pro-assisted suicide laws and rulings, to work toward repeal of the same, and to oppose efforts to make suicide a legal medical treatment option.

We applaud OCR's enforcement of current law – most notably to our mission, the ACA, expressly protecting the conscience rights of healthcare professionals who choose not to participate in assisted suicide – through its proposed regulation, which stands to protect the Constitutionally guaranteed civil rights of all people in America. From our experience in working together in very broad-based coalitions, it is clear that there are physicians from every worldview who oppose the legalization of assisted suicide and will not participate if legalized in their state of license. These range from secular atheists and humanists through to ardent believers of every stripe, and from Left to Right, politically. This protection would not only be for those of a religious persuasion, but for all physicians who see the practice of assisted suicide as fundamentally incompatible with their role as healer[1] and who see the practice putting a great many of their patients at risk of deadly harm through mistakes, coercion, and abuse.

To subtly or explicitly infringe on these doctors' right to their own conscience in this regard is unacceptable. Not only is this an erosion of their rights enshrined in both the constitution and laws like the ACA, but also of the breadth of options for the thousands of patients who would prefer to be treated by physicians and in facilities that do not participate in assisted suicide. Already in Canada[2] and, now in legislation here in the United States[3][4], physicians are being forced to participate. We have been advised by

[1] https://www.ama-assn.org/delivering-care/physician-assisted-suicide
[2] https://www.mercatornet.com/careful/view/canadian-court-tells-doctors-they-must-refer-for-euthanasia/20975
[3] http://www.vaeh.org/vermont-allow-us-to-respect-our-consciences-and-oaths/
[4] See Sec. 15: https://malegislature.gov/Bills/190/H1194

PO Box 4994, New York, NY 10185
609.759.0322

doctors that employers are making participation a requirement of employment in advertisements for open positions, and in one case, the physician changing employment and moving out of state due to the pressures she was under to participate. The proponents of assisted suicide are working to set the stage to deprive physicians of their rights through amicus briefs[5] and attacking institutions in the media for exercising their right to opt out[6] and for following policies[7] in line with federal law that prohibits the use of federal funds for assisted suicide. Allowing proponents their right to free speech in the media must come part and parcel with medical professionals' and institutions' right to their own consciences.

Thank you for enforcing the law through proactive regulation.

Very Best Regards
Matt Vallière

Executive Director
Patients' Rights Action Fund

[5] https://www.supremecourt.gov/DocketPDF/16/16-1140/36461/20180223163632153_NIFLA%20v%20Becerra%20Brief%20of%20Amicus%20Curiae.pdf
[6] http://www.latimes.com/business/lazarus/la-fi-lazarus-assisted-suicide-20160607-snap-story.html
[7] http://time.com/5189523/veterans-assisted-suicide-state-home-laws/

# Exhibit 175

Founders
Peggy Rajski
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Amit Paley
CEO & Executive Director

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

March 27, 2018

**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 Trevor Project in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. The Trevor Project is the leading and only accredited national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) young people under the age of 25. The Trevor Project offers a suite of crisis intervention and suicide prevention programs, including TrevorLifeline, TrevorText, and TrevorChat as well as a peer-to-peer social network support for LGBTQ young people under the age of 25, TrevorSpace. Trevor also offers an education program with resources for youth-serving adults and organizations, a legislative advocacy department fighting for pro-LGBTQ legislation and against anti-LGBTQ rhetoric/policy positions, and conducts research to discover the most effective means to help young LGBTQ people in crisis and end suicide.

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

The Trevor Project
Los Angeles - 8704 Santa Monica Blvd. Suite 200 West Hollywood, CA 90069
New York - 575 8th Ave #501 New York, NY 10012
DC - 1200 New Hampshire Ave. NW Suite 300 Washington, DC 20036
p 310.271.8845 | f 310.271.8846 www.thetrevorproject.org

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

LGBTQ people, women, and other vulnerable groups around the country already face enormous barriers to getting the care they need.[1] Accessing quality, culturally competent care and overcoming outright discrimination is even a greater challenge for those living in areas with already limited access to health providers. The proposed regulation threatens to make access even harder and for some people nearly impossible.

Patients living in less densely populated areas already face a myriad of barriers to care including less access to health insurance coverage, lower incomes, and lower rates of paid sick leave. This is in addition to the universal costs of transportation, taking time from work, and other incidentals that go along with obtaining care in the first place. For many, the sheer distance to a healthcare facility can be a significant barrier to getting care. For example, more than half of rural women live more than 30 minutes away from a hospital that provides basic obstetric care.[2] Patients seeking more specialized care like that required for fertility treatments, endocrinology, or HIV treatment or prevention are often hours away from the closest facility offering these services. For example, a 2015 survey of nearly 28,000 transgender adults nationwide found that respondents needed to travel much further to seek care for gender dysphoria as for other kinds of care.[3]

This means if these patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In a recent study, nearly one in five LGBTQ people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were

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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

turned away. That rate was substantially higher for LGBTQ people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.[4] For these patients, being turned away by a medical provider is not just an inconvenience: it often means being denied care entirely with nowhere else to go.

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

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

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

Doctors may be misled into believing they may refuse on religious grounds to administer an HIV test or prescribe PrEP to a gay or bisexual man, or refuse screening for a urinary tract

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

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

We are particularly concerned that the proposed rule will be used to refuse medically necessary care to transgender patients. We are concerned that the rule's sweeping terms and HHS's troubling discussions of a case involving a transgender patient will encourage the mistaken belief that treatments that have an incidental impact on fertility, such as some procedures used to treat gender dysphoria, are sterilization procedures. Treatments for serious medical conditions may have the incidental effect of causing or contributing to infertility: for example, a hysterectomy to treat gender dysphoria, chemotherapy to treat cancer, and a wide range of medications can have the incidental effect of temporarily or permanently causing infertility. The primary purpose of such procedures, however, is not to sterilize, but to treat an unrelated medical condition. If religious or moral exemptions related to sterilization are misinterpreted to include treatments that have simply an incidental effect on fertility—as the vague and sweeping language of this rule encourages—it can lead to refusals that go even further beyond what federal law allows and unlawfully encourages individuals and institutions to refuse a dangerously broad range of medically needed treatments.

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

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

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

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

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

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

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

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

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

The Department rushed to publish this rule without first publishing any notice regarding in its Unified Regulatory Agenda, as is normally required. The failure to follow proper procedure reflects an inadequate consideration of the rule's impact on patients' health. The timing of the proposed rule also illustrates a lack of sufficient consideration. The proposed rule was published just two months after the close of a public comment period for a Request for Information closely related to this rule. The 12,000-plus public comments were not all posted until mid-December, a month before this proposed rule was released. Nearly all of the comments submitted at that time related to the subjects covered by the proposed rule—namely, the refusal of care by federally funded health care institutions or their employees on the basis of personal beliefs. This short period of time calls into question the comprehensiveness of the review of the Request for Information and whether the proposed rule was developed in an arbitrary and capricious manner.

**Conclusion**

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

Sincerely,

Sam Brinton
Head of Advocacy and Government Affairs / The Trevor Project
202.768.4413 / Sam.Brinton@thetrevorproject.org

# Exhibit 176

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 Transgender Law Center in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. Transgender Law Center is the largest trans-led organization advocating self-determination for all people. While this proposed rule poses a broad risk to all LGBTQ people, transgender people face intense discrimination and myriad barriers to accessing lifesaving care. The proposed regulation ignores the prevalence of discrimination and the damage it causes and will undoubtedly lead to increased discrimination and flat-out denials of care for some of the most vulnerable members of our community. We all deeply value freedom of religion, but sweeping exemptions that obstruct access to care are a fundamental distortion of that principle. Transgender people deserve better.

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

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

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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.

already limited access to health providers. The proposed regulation threatens to make access even harder and for some people nearly impossible.

Patients living in less densely populated areas already face a myriad of barriers to care including less access to health insurance coverage, lower incomes, and lower rates of paid sick leave. This is in addition to the universal costs of transportation, taking time from work, and other incidentals that go along with obtaining care in the first place. For many, the sheer distance to a healthcare facility can be a significant barrier to getting care. For example, more than half of rural women live more than 30 minutes away from a hospital that provides basic obstetric care.[2] Patients seeking more specialized care like that required for fertility treatments, endocrinology, or HIV treatment or prevention are often hours away from the closest facility offering these services. For example, a 2015 survey of nearly 28,000 transgender adults nationwide found that respondents needed to travel much further to seek care for gender dysphoria as for other kinds of care.[3]

This means if these patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In a recent study, nearly one in five LGBTQ people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBTQ people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.[4] For these patients, being turned away by a medical provider is not just an inconvenience: it often means being denied care entirely with nowhere else to go.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Conclusion**

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

Sincerely,

Corinne Green
Policy Coordinator
Transgender Law Center

# Exhibit 177

March 27, 2018

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

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

To Whom it May Concern:

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

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

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

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

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

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

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

Women, individuals living with disabilities, LGBTQ persons, people living in rural communities, young people, and people of color face severe health and health care disparities, and these disparities are compounded for individuals who hold these multiple identities. For example, among adult women, 15.2% of those who identified as lesbian or gay reported being unable to obtain medical care in the last year due to cost, as compared to 9.6% of straight individuals.[2] Women of color experience health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.[3] Meanwhile, people of color in rural America are more likely to live in an area with a shortage of health professionals, with 83% of majority-Black counties and 81% of majority-Latino/a counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

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

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

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

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

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

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

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

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

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

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

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

[8] Id.

[9] Ctr. for Reprod. Rights, Nat'l Latina Inst. for Reprod. Health & SisterSong Women of Color Reprod. Justice Collective, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter *Reproductive Injustice*]; In Our Own Voice: Nat'l Black Women's Reprod. Justice Agenda, *The State of Black Women & Reproductive Justice* 32-33 (2017), *available at* http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

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

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

The Proposed Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion and transition-related care. This is especially concerning for states that already severely restrict access to abortion care, including all of the states in which URGE has membership chapters.[11] The proposed regulation will create yet another barrier to health care for these young people. Specifically, the Department and OCR are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[12] Read in conjunction with the rest of the Proposed Rule, it is clear this is intended to allow any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care.

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

Already existing refusal of care laws are used across the country to deny patients the care they need.[13] The Proposed Rule attempts to expand these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions specifically related to the service or research activity to which they object.[14] But the Proposed Rule attempts to broaden this provision to allow individuals to refuse to perform aspects of their jobs based on a mere reference to a religious or moral belief regardless of whether it relates to the specific biomedical or behavioral service or research activity they

[11] These states are as follows: Alabama, Georgia, Kansas, Ohio, and Texas.
[12] *See id.* at 12.
[13] *See, e.g., Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, Nat'l Women's L. Ctr. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Catherine Weiss, et al., *Religious Refusals and Reproductive* Rights, Am. Civil Liberties Union (2002), https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report; Julia Kaye, et al., *Health Care Denied*, Am. Civil Liberties Union 1 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, Pub. Rights Private Conscience Project 1 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[14] The Church Amendments, 42 U.S.C. § 300a-7 (2018).

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

Similarly, the Proposed Rule defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. For example, the definition of "assist in the performance" greatly expands the types of services that can be refused to include merely "making arrangements for the procedure" no matter how tangential.[16] This means individuals not "assisting in the performance" of a procedure within the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, can now assert a new right to refuse. The Proposed Rule's definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information, including location or funding, that could help an individual to get the care they need.[17]

Furthermore, the Proposed Rule's new and unwarranted expanded definitions often exceed, or are not in accordance with, existing definitions contained within the statutes the Proposed Rule seeks to enforce. Specifically, under the Coats and Weldon Amendments "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.[18] The Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term.[19] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but goes directly against congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert.[20]

When these impermissibly broad definitions are combined with the expansive interpretations of the underlying statutes, they work together to further expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, one way the Weldon Amendment is expanded under the Proposed Rule is through the definition of "discrimination."[21] In particular, the Proposed Rule defines "discrimination" against a health care entity broadly to include a number of activities,

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[15] *See* Rule *supra* note 1, at 185.
[16] *Id.* at 180.
[17] *Id.* at 183.
[18] The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018).
[19] *See* Rule *supra* note 1, at 182.
[20] The doctrine of expressio unius est exclusio alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[21] *See* Rule *supra* note 1, at 180.

including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[22] In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is nonsensical and inappropriate. Further, such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

## II. The Proposed Rule Will Undermine Critical Federal Health Programs, including Title X

The Proposed Rule would seemingly allow health care entities to receive grants and contracts under HHS-funded programs or other federal health programs, such as Title X, the only domestic family planning program, while refusing to provide key services required by those programs.[23] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[24] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[25] Title X is a crucial service for young women, as it is one of the only providers in the United States where they can receive confidential health care.[26] The proposed regulation is exceptionally detrimental to low-income women and women of color, who make up the majority of patients who use Title X funded clinics.[27] Under the Proposed Rule, the Department would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such funds are generally conditioned.[28] The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[29] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including underinsured, and

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[22] *Id.*
[23] *See* Rule *supra* note 1, at 180-181, 183. *See also Title X Family Planning*, U.S. Dep't of Health & Human Servs. (2018), https://www.hhs.gov/opa/title-x-family-planning/index.html; *Title X an Introduction to the Nation's Family Planning Program*, Nat'l Family Planning & Reproductive Health Assoc. (2017) (*hereinafter* NFPRHA), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf.
[24] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[25] *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).
[26] Kiersten Gillette-Pierce & Jamila Taylor, *The Threat to Title X Family Planning*, Center for American Progress (Feb. 9, 2017), *available at* https://www.americanprogress.org/issues/women/reports/2017/02/09/414773/the-threat-to-title-x-family-planning/.
[27] Planned Parenthood Federation of America, *Title X: America's Family Planning Program*, *available at* https://www.plannedparenthoodaction.org/issues/health-care-equity/title-x.
[28] *See, e.g.*, Rule *supra* note 1, at 180-185.
[29] *See* NFPRHA *supra* note 34.

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

## III. Conclusion

The proposed rule goes far beyond established law, appears to have been developed in a rushed and arbitrary manner, and most importantly will put the health and potentially even the lives of patients at risk. Young people deserve health care no matter who they are or where they live. We urge you to withdraw the proposed rule.

[30] *See id.*

# Exhibit 178

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

March 26, 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, D.C. 20201

The Washington State Department of Health (DOH) appreciates the opportunity to comment on the proposed rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," printed in the Federal Register on January 26, 2018 (83 FR 3880). We are specifically responding to the request for feedback on the rule's potential to improve or worsen health outcomes.

The proposed rule significantly broadens the criteria by which people or entities can claim conscience objections to deny patients care, the types of entities that must accommodate their employees' or volunteers' objections, and the types of activities to which an entity can object. This threatens to directly reduce access to essential health care services, especially for vulnerable populations—including those living in rural areas—and thereby worsen health outcomes. In addition, the proposed rule conflicts with program requirements in existing successful HHS programs (e.g., immunizations and family planning) that have been shown to improve outcomes. This change will jeopardize the integrity of and funding for these programs. This would further reduce access to care and lead to poorer health outcomes and wider inequities.

**The proposed rule does not appropriately balance the conscience rights of providers with health outcomes of their patients or the public health system's role to ensure access to health care services for *all* people.**

**For these reasons, we recommend HHS withdraw the proposed rule.**

If not withdrawn, we strongly urge HHS to revise the language to:

- Allow entities, including states, health systems, clinics, providers, and insurers, to consider significant public health concerns, such as patient access to care, when managing conscience objections.
- Remove requirements for accommodations when they directly conflict with the statutory requirements of HHS programs as determined by the U.S. Congress.

The rule proposes definitions that broaden the type of entity who can claim a conscience objection and the types of activities for which a moral or religious objection could be made, including referrals. The proposed definitions for "assist in the performance," "health care entity,"

and "referral/refer for," taken in conjunction with one another, significantly broaden the number of entities or persons who have a basis to file a complaint and will lead to significant unintended consequences.

First, the broadening of these definitions will make it difficult for some organizations to manage conscience objections without harming their business operations. Small clinics cannot afford multiple schedulers, billers, or assistants who may raise moral or religious objections, which previously were accommodated only for healthcare providers.

It is also our expectation these expanded definitions would create substantial gaps in access to preventive services and limit referrals to services that are provided elsewhere. These gaps could be especially harmful for vulnerable populations such as women and families with low incomes; people who are lesbian, gay, bisexual, or transgender (LGBT); people of color; and people living in rural or otherwise underserved areas. While 20 percent of the population lives in rural areas, less than 10 percent of physicians practice in rural areas. As a result, many individuals across the U.S. already have limited options to receive medical care, including preventive services such as family planning or vaccinations. If the only provider in an area does not administer vaccines because it is against his or her personal religious beliefs, for example, entire communities could be left vulnerable to devastating infectious diseases. Similarly, all women in a given community could find themselves without access to contraception or other reproductive health care if the only provider in the area asserts moral or religious objections.

Finally, the broadening of these definitions may create confusion or be interpreted in a way that facilitates discrimination against women, low-income individuals, LGBT people, or people of color, under the guise of a conscience objection. These groups already face barriers to care and experience health inequities. The proposed rule could further decrease their access to necessary health care and worsen health outcomes and disparities. This clearly runs counter to the mission of HHS "to enhance and protect the health and well-being of all Americans," and it neglects the responsibility of our public health system to ensure access to quality health services.

**The proposed rule conflicts with existing requirements in HHS programs.**

Definitions in the proposed rule allow for refusals that conflict with the requirements of some existing HHS programs. These programs have a documented history of providing quality preventive health care services, improving health outcomes, and saving costs. This proposed rule will jeopardize the integrity and continued success of these programs, funding for them, and the delivery of the quality services they provide.

- The Vaccines for Children program requires participating healthcare providers to offer all routinely recommended vaccines to eligible at-risk children (42 USC 1396s(c)(2)(B)(i)). Under this proposed rule change, a person or entity may object to administering a vaccine. States and health care providers may struggle to comply with federal requirements for at-risk children to access and receive the recommended standard-of-care vaccines, because of an expanded number and basis for conscience objections.

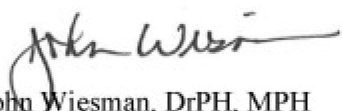
- The Title X family planning projects are designed to "consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children" (42 CFR 59.1). The Title X statute specifically requires that "all pregnancy counseling shall be nondirective" (Public Law 112-74, p. 1066-1067), 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)).

The proposed rule protects individuals and entities who refuse to provide some essential services or provide complete information about all of a woman's pregnancy options. The proposed rule could force the Washington State Department of Health and Title X sub-recipients to choose between violating the Title X requirements or violating the proposed rule.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency department to provide emergency treatment to *anyone* seeking treatment. The proposed rule could potentially conflict with EMTALA statutory requirements. For example, a hospital or provider could decline service to a woman with possible complications following an abortion. These proposed rules could jeopardize patient lives.

Preserving religious freedom in the U.S. is important, and so is our responsibility as government leaders to ensure access to health care services for all people. Existing laws have sought to preserve balance between conscience objections based on sincerely held religious beliefs and moral convictions, and the needs of patients and the public health. It is imperative to the nation's health and well-being that this rule does the same. Unfortunately, the rule as written fails to strike an appropriate balance, clearly placing the health of patients and the public at risk. I urge you to withdraw it.

Sincerely,



John Wiesman, DrPH, MPH
Secretary of Health

# Exhibit 179

**BEFORE THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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

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

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

**Interest of Whitman-Walker Health**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Conclusion**

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

Respectfully Submitted,

Naseema Shafi, JD, Deputy Executive Director
Meghan Davies, MPH, CHES, CPH, Chief of Operations and Program Integration
Sarah Henn, MD, MPH, Senior Director of Health Care Operations and Medical Services
Randy Pumphrey, D.Min., LPC, BCC, Senior Director of Behavioral Health
Daniel Bruner, JD, MPP, Senior Director of Policy
Erin M. Loubier, JD, Senior Director of Health and Legal Integration
Carole Schor, PhD, SPHR, Director of Human Resources

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March 27, 2018

# Exhibit 180

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 SW
Washington, D.C. 20201
*Submitted through the Federal eRulemaking portal*

RE: DEPARTMENT OF HEALTH AND HUMAN SERVICES; Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (83 Fed. Reg. 3800–3931) (**Docket: HHS-OCR-2018-00002**)

To Whom It May Concern:

Thank you for the opportunity to comment on the Notice of Proposed Rulemaking of the Office for Civil Rights ("OCR") of the U.S. Department of Health and Human Services ("HHS"), titled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" ("Proposed Rule"). The undersigned are scholars at the Williams Institute, an academic research center at UCLA School of Law dedicated to conducting rigorous and independent research on sexual orientation and gender identity, including on health disparities and discrimination facing lesbian, gay, bisexual, and transgender (LGBT) people.

The mission of HHS and OCR is to protect and enhance the health and well-being of all Americans and eliminate discrimination in health care and health coverage. Indeed, the civil rights laws that OCR is charged with enforcing – including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act – require that health care entities avoid discriminating based on race, national origin, disability, age, and sex as a condition of their receipt of federal funds.

But that mission is undermined, and those civil rights laws potentially violated, if OCR authorizes refusals of care that go beyond the narrow terms permitted in the provider-conscience statutes. The Proposed Rule risks these consequences in numerous respects, as we explain below with respect to the Church, Coats-Snowe, and Weldon Amendments. We recognize that Congress drafted the provider-conscience laws to protect religious liberty, which is a core principle of our democracy, but drafted these laws narrowly in light of the importance of health care. As a result, any Final Rule and OCR's enforcement of it must strictly comply with the narrow refusals of care that Congress has authorized, and should minimize unauthorized denials of care or other barriers to care any Final Rule encourages.

In addition, because at least some, if not all, anti-LGBT prejudice in society (including discrimination in the provision of health care) is associated with some religious or faith-based beliefs, OCR must consider – including as part of a Regulatory Impact Analysis – how the Proposed Rule and any Final Rule will increase barriers for LGBT and other people to fully access vital programs, services, and activities, and will adversely impact the health and well-being of the LGBT population and other vulnerable populations in the United States.

## I. To Pass Legal Muster, Any Final Rule Must Conform to the Underlying Statutes and be Consistent with the Mission of HHS and the Various Civil Rights Laws that OCR Enforces.

In the Church, Coats-Snowe, and Weldon Amendments, Congress insulated certain medical providers from being required – or being discriminated against for refusing – to perform abortions and certain specific other services that may violate their religious or moral beliefs. Each of these statutes was carefully and narrowly drafted, and each is different; as a result, each must be read separately and applied in careful compliance with Congressional intent. For the purposes of this comment, we accept the provider-conscience laws as written.

For example, the Weldon Amendment prohibits certain federal funding to federal, state, and local agencies and programs that "subject[] any institutional or individual health care entity to discrimination [for refusing to] provide, pay for, provide coverage for, or refer for abortions."[1] The Coats-Snowe Amendment prohibits the federal government, as well as state and local governments receiving federal funding, from discriminating against a "health care entity" that "refuses to undergo training in the performance of induced abortion, to require or provide such training, to perform such abortion, or to provide referrals for such training or such abortions,"[2] and certain other similar activities.[3] Neither the Weldon Amendment nor the Coats-Snowe Amendment mention on its face religious beliefs. However, OCR has determined that Congress intended the Weldon Amendment to apply only to health care entities that have objections to abortion based on religious or moral grounds; this limitation is necessary to comport the statute with clear Congressional intent.[4] Legislative history on the Coats-Snowe Amendment indicates it, too, should have such a limitation.[5]

In addition, the Church Amendments are largely focused on religious or moral objections to abortion and sterilization. The Church Amendments protect individual and entity recipients of "any grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act" from being required by "any court or any public official or other public

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[1] *See, e.g.*, *Consolidated Appropriations Act, 2018*, H.R. 1625, 115th Cong. § 507(d) (2018).

[2] 42 U.S.C. § 238n(a)(1).

[3] *Id.* §§ 238n(a)(2), (a)(3), (b).

[4] *See* U.S. Dep't of Health and Human Services, Opinion Letter from Office of Civil Rights Director re: OCR Transaction Numbers: 14-193604, 15-193782, & 15-195665, at 3-4 (June 21, 2016) (on file with agency); *see also* 83 Fed. Reg. 3886 (citing Letter from OCR Director to Complainants (June 21, 2016)).

[5] *See, e.g.*, 142 Cong. Rec. S2268-2276 (daily ed. Mar. 19, 1996) (statements of Senators Snowe, Coats, Boxer, Kennedy, Feinstein).

authority" to "perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions,"[6] among certain other similar protections related to abortion and sterilization.[7]

Thus, the primary purpose of the provider-conscience laws was to insulate certain providers from certain obligations related to abortion and, in the case of the Church Amendments, sterilization. Only the Church Amendments in any way go further. Subsection (d) of the Church Amendments provides that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."[8] By its terms, this protection applies only to individuals, not entities such as hospitals. And unlike the Weldon and Coats-Snowe Amendments, only the Church Amendments explicitly allow providers to deny medical care based on "moral convictions."[9]

The limitations in the language and application of the statutes reflect Congress's intent to carefully circumscribe the occasions on which providers are authorized to refuse medical care. This is because it is clear that denials of care, even when based on religious or moral beliefs, impose harms on patients, undermine the mission of HHS to protect the health and well-being of all Americans, and can violate the terms of fundamental civil rights protection. Any Final Rule must strictly conform to these statutes and must make clear the limited circumstances in which each statute applies.

Any Final Rule must also make clear that the Weldon, Coats-Snowe, and Church Amendments are not absolute and are to be applied consistent with the obligations placed on health care entities by other laws. For example, nothing in the provider-conscience laws exempts hospitals from the requirement to comply with the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires all Medicaid- and Medicare-funded hospitals with an emergency department to screen, stabilize, and at times transfer patients with emergency medical concerns.[10] Not only does EMTALA not contain an exemption for religious or moral beliefs,[11]

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[6] 42 U.S.C. § 300a-7(b)(1).

[7] *Id.* § 300a-7(b)(2)-(c)

[8] *Id.* § 300a-7(d).

[9] *Id.* § 300a-7.

[10] 42 U.S.C. § 1395dd.

[11] *See id.*; *see also* U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid, *Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions*, https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/Downloads/CMS-1063-F.pdf; *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008) ("[I]t is far from clear whether the Weldon Amendment would prohibit California from enforcing its own version of the EMTALA in medical emergencies [which does exempt health care workers with religious objections to abortion from assisting in emergency or spontaneous abortions]."); *see generally In the matter of Baby "K"*, 16 F.3d 590, 598 (4th Cir. 1994) ("Congress rejected a case-by-case approach to determining what emergency medical treatment hospitals and physicians must provide and to whom they must provide it; instead, it required hospitals and physicians to provide stabilizing care to any individual

EMTALA was directed at stopping patient dumping by limiting hospitals' ability to refuse patients.[12]

Any Final Rule must not only conform to the underlying statutes and be construed consistently with other statutory obligations on health care providers, but must also adhere to HHS's mission "to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services."[13] Likewise, one of the primary purposes of the Patient Protection and Affordable Care Act ("ACA") was to expand access to health care and health coverage.[14] And the ACA has, in fact, expanded health insurance coverage in the United States, including among LGBT people.[15] Any Final Rule should be consistent with this purpose of the ACA, as well.

Moreover, in some circumstances, religiously-motivated denials of care risk violating the core civil rights laws that OCR is charged with enforcing. In fact, in support of HHS's mission, OCR was established in response to a need to remove discriminatory barriers to HHS-funded programs.[16] Since its creation, OCR has been instrumental in enhancing access to health care and health coverage by enforcing civil rights laws that bar discrimination on the basis of race, color, national origin, disability, age, or sex in health care activities and programs that HHS conducts or funds.[17] Indeed, OCR's most recent civil rights statute, Section 1557, was passed as part of the ACA because Congress recognized that discriminatory barriers to health care and

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presenting an emergency medical condition."); *Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996) (holding, once stabilizing treatment has been provided for a patient who arrives with an emergency condition, "the patient's care becomes the legal responsibility of the hospital and the treating physicians" and is no longer governed by EMTALA).

[12] *See, e.g.*, G. Smith, II, The Elderly and Patient Dumping, Fla. B.J. 85 (Oct. 1999) ("Before COBRA and EMTALA limited a hospital's right to refuse medical treatment to patients, the common law's no-duty rule was restricted only by four exceptions: 1) once a hospital provides medical care, it must do so nonnegligently; 2) once a person gains "patient" status, the caregiver must aid and protect that patient; 3) where a person relies upon a caregiver's custom of providing emergency care, a duty to provide that care exists; and 4) true "emergency" cases obviate the no-duty rule.").

[13] U.S. Dep't of Health and Human Services, *Introduction: About HHS*, https://www.hhs.gov/about/strategic-plan/introduction/index.html.

[14] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); *see also* U.S. Dep't of Health and Human Services, Office for Civil Rights, *Nondiscrimination in Health Programs and Activities; Final Rule*, 81 Fed. Reg. 31376, 31444 ("One of the central aims of the ACA is to expand access to health care and health coverage for all individuals.").

[15] *See, e.g.*, M. Karpman et al., *QuickTake: Uninsurance Rate Nearly Halved for Lesbian, Gay, and Bisexual Adults since Mid-2013*, Health Reform Monitoring Survey (April 2015), http://hrms.urban.org/quicktakes/Uninsurance-Rate-Nearly-Halved-for-Lesbian-Gay-and-Bisexual-Adults-since-Mid-2013.html; G. Gonzales et al., *The Affordable Care Act and Health Insurance Coverage for Lesbian, Gay, and Bisexual Adults: Analysis of the Behavioral Risk Factor Surveillance System*, LGBT HEALTH 62-67 (2017).

[16] *See, e.g.*, U.S. Commission on Civil Rights, *Funding Federal Civil Rights Enforcement: 2000 and Beyond*, http://www.usccr.gov/pubs/crfund01/ch5.htm.

[17] *See* U.S. Dep't of Health and Human Services, *Office for Civil Rights (OCR)*, https://www.hhs.gov/ocr/index.html; U.S. Office of Health and Human Services, *Summaries of select case activities*, https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/examples/index.html.

coverage remained and wanted to provide additional tools to limit discrimination against vulnerable communities.[18]

Thus, any Final Rule must protect OCR's ability to fully enforce the civil rights laws within its jurisdiction. For example, there is nothing in the provider-conscience laws that we believe would authorize providers to offer abortion services to Caucasian women but deny them to women of color, even were the providers to claim that doing so was consistent with religious belief. The Final Rule cannot impinge on basic civil rights protections.

For all of these reasons, the Final Rule must, at a minimum:

- **Make clear that the authorizations under subsection (d) of the Church Amendments apply only to individuals and not to health care entities**, as required by the plain language of the statute.

- **Make clear that the authorizations under subsections (b) and (c) of the Church Amendments apply only to abortion and sterilization in the limited circumstances provided for in the statute, and that these protections only apply where there are religious or moral objections**, as required by the plain language of the statute.

- **Make clear that the protections of the Coats-Snowe and Weldon Amendments apply only to particular abortion services in the limited circumstances provided for in the statutes,** as required by the plain language of the statutes, **and that these protections only apply where there are religious or moral objections** in order to be consistent with Congressional intent.

- **Identify when "moral" objections, as distinct from religious objections, will permit a provider to deny care, and define the limits of those objections.**

- **Make clear that these provider-conscience laws apply only to specific services and procedures, but nothing in the laws authorizes a denial of care based on the provider's rejection of persons because of their demographic characteristics or identity or status.** For example, any Final Rule should make clear that providers cannot deny cardiac care or setting of a broken leg to an individual based on the provider's disapproval or rejection of that individual's LGBT identity or status, if they provide these services to persons who are not LGBT, whatever the provider's religious or moral views are about that individual's LGBT status.

- **Ensure that definitions do not go beyond the meanings authorized under the relevant statute.** The Proposed Rule appears to broaden the definitions of several keys words in the provider-conscience laws, and any Final Rule should adhere to the narrower definitions found in the statutes.

[18] *See* U.S. Dep't of Health and Human Services, *Section 1557 of the Patient Protection and Affordable Care Act*, https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html.

- **Make clear that nothing in the rule authorizes hospitals or other providers to refuse care when EMTALA or other applicable law or duty of care requires them to provide it.**

- **Make clear that in its enforcement, OCR will balance the harm to patients from denials of medical care with the religious liberty interests of the provider denying the care.** As noted above, provisions of provider-conscience laws are not absolute. Balancing is necessary not only because health care is so critical, but also to avoid constructions of the laws that would violate the Establishment Clause.[19] Balancing would also be consistent with federal laws that weigh statutory religious liberty protections against other state interests.[20] Such balancing should take into account all relevant factors in a particular case, which may include the medical necessity of the service or procedure, the availability of alternative providers within the reasonable distance, and whether delay in care risks significant harm to the patient.

As a result of these points, it is clear that any Final Rule can permissibly have only limited, if any, impact on health care for LGBT individuals. There is nothing in the underlying statutes that would permit, *for example*, a cardiologist to deny cardiac care based on a patient's sexual orientation or gender identity. Similarly, whatever protections may attach to an individual health professional, there is nothing in the underlying statutes that would authorize a hospital or other institution to, *for example*, deny fertility treatment to same-sex couples, HIV treatment or prevention treatment to gay or bisexual men, or hormones for gender transition to a transgender patient.

Failure to clarify these points in any Final Rule risks impermissibly encouraging providers to deny care beyond the limited circumstances authorized by Congress, violating HHS and OCR's mission of enhancing health and well-being, and impermissibly elevating provider-conscience laws above the civil rights laws OCR enforces. Indeed, as currently drafted, the rule may improperly signal to providers that religious beliefs should be prioritized over medical standards or the health and care of patients, and could lead people to avoid seeking care as to which there can be no right to deny service just for fear of being turned away – all of which risk exacerbating barriers to care that vulnerable populations experience, as we discuss below.

[19] U.S. CONST. amend. I; *Cutter v. Wilkinson*. 554 U.S. 709, 714, 720 (2005) ("At some point, accommodation may devolve into an unlawful fostering of religion. . . . [Therefore, courts] must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries." (internal quotation marks and citations omitted)); *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).

[20] *See, e.g.*, *Shelton v. University of Med. and Dentistry of N.J.*, 223 F.3d 220 (3d Cir. 2000) (holding, under Title II of the Civil Rights Act, hospital offered reasonable accommodation to transfer a nurse to a different unit when she refused on religious grounds to treat emergencies that she believed would result in abortions); Religious Freedom Restoration Act, 42 U.S.C. § 2000bb (1993) (establishing the federal government is permitted to substantially burden a person's exercise of religion in furtherance of a compelling government interest that is advanced in the least restrictive manner).

## II. Any Final Rule Must Conform to the Underlying Statutes to Avoid Significant Harm to the Health and Well-Being of Vulnerable Populations; OCR Must Consider the Costs Related to Potential Harm to LGBT and Other Patients of the Proposed Rule, Including as Part of a Regulatory Impact Analysis

Under Executive Orders 12866 and 13563, OCR must conduct a Regulatory Impact Analysis ("RIA") that "analyzes the benefits, costs, and other impacts of" the Proposed Rule and any Final Rule.[21] A RIA is required here because the Proposed Rule and any Final Rule is likely to "impose costs, benefits, or transfers of $100 million or more in any given year"[22] and because the rule is significant for other reasons, as well.[23] As part of its RIA, OCR must consider the costs in terms of harm to patients that denials of health care and other barriers to care the Proposed Rule and any Final Rule are likely to cause.[24] Even if a RIA is not required, OCR should still consider these harms and make every effort to minimize them consistent with HHS's mission and the civil rights laws OCR enforces.

Denials of health care can result in several categories of harm, including:

- to the patient's physical and mental health when necessary medical services to treat particular medical conditions are denied;

- to the patient's health and well-being because refusals of service, independent of the underlying medical condition, result in dignitary harm to the individual; and

- to the community of which the patient is a member and the ability and willingness of others in that community to seek medical care.

Below we discuss these harms with respect to the LGBT population, which has been subject to persistent and pervasive stigma and discrimination and which, as a result, faces numerous health disparities. Because at least some anti-LGBT stigma and discrimination in society stems from or is otherwise related to certain religious or faith-based beliefs – regardless of moral intent – the Proposed Rule risks encouraging or excusing denials of care and other forms of discrimination against LGBT people in the health care context. Any Final Rule that does not strictly comply with the narrow circumstances permitted for denials of care in the underlying provider-conscience laws and does not minimize the potential for unauthorized denials of care risks

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[21] U.S. Dep't of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Guidelines for Regulatory Impact Analysis* 1 (2016), https://aspe.hhs.gov/system/files/pdf/242926/HHS_RIAGuidance.pdf, [hereinafter *HHS Guidelines for Regulatory Impact Analysis*].

[22] Exec. Order No. 12866, §§ 1(a), 3(f)(1); *HHS Guidelines for Regulatory Impact Analysis* at 2-3.

[23] *HHS Guidelines for Regulatory Impact Analysis,*at 3.

[24] Exec. Order No. 12866 § 1(a), 58 Fed. Reg. 51735 (Oct. 4, 1993); Exec. Order No. 13563 §§ 1(b), 1(c), 76 Fed. Reg. 3821 (Jan. 21, 2011) ("In applying these [regulatory impact and review] principles, each agency is directed to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible. Where appropriate and permitted by law, each agency must consider (and discuss qualitatively) values that are difficult or impossible to quantify, *including equity, human dignity, fairness, and distributive impacts*." (emphasis added)).

impermissibly perpetuating these harms in violation of HHS's and OCR's mission, the purpose of the ACA, and laws that prohibit race, sex, and other forms of discrimination in health care.

Despite recent advances in the legal and social acceptance of LGBT people, research finds that LGBT people continue to experience persistent and pervasive discrimination as well as widespread stigma, prejudice, and violence.[25] The existence of this discrimination and stigma in health care, as well as other barriers to care and well-being for LGBT people, is well-documented.[26] According to the Institute of Medicine, "LGBT individuals face discrimination in the health care system that can lead to an outright denial of care or to the delivery of inadequate care. There are many examples of manifestations of enacted stigma against LGBT individuals by health care providers. LGBT individuals have reported experiencing refusal of treatment by health care staff, verbal abuse, and disrespectful behavior, as well as many other forms of failure to provide adequate care."[27]

Denials of, or other forms of discrimination in, health care have repercussions for an LGBT people's dignity, health, and well-being. As is explained in detail in the attached amici brief that scholars, including the undersigned, recently filed with the U.S. Supreme Court in *Masterpiece Cakeshop v. Colorado Human Rights Commission*,[28] refusals of service based on

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[25] *See e.g.,* INSTITUTE OF MEDICINE, THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING, 5, 13 (2011); Ilan H. Meyer, The Elusive Promise of LGBT Equality, 106:8 AM. J. PUB. HEALTH 1356 (2016).

[26] *See, e.g.*, INSTITUTE OF MEDICINE, *supra*, at 212-14 (discussing evidence of stigma, discrimination, and violence against LGBT people because of their sexual orientation or gender identities), Ilan H. Meyer et al., Demographic Characteristics and Health Status of Transgender Adults in Select US Regions: Behavioral Risk Factor Surveillance System, 2014, 107 AM. J. PUB. HEALTH 582 (2017). LGBT people can face discrimination and stigma in a wide variety of settings and from many sources in addition to health care, such as employment, housing, and family life. *See, e.g.*, Jennifer Pizer et al., Evidence of Persistent and Pervasive Workplace Discrimination Against LGBT People: The Need for Federal Legislation Prohibiting Discrimination and Providing Equal Employment Benefits, 45 LOY. L.A. L. REV. 715, 720-42 (2012). In turn, such discrimination can have negative consequences for the health and well-being of LGBT individuals. *See, e.g.*, INSTITUTE OF MEDICINE, *supra*, at 734-42 (discussing research documenting that workplace discrimination negatively affects the income and health of LGBT people). Moreover, contrary to popular stereotypes about the affluence of the LGBT community, research demonstrates the economic diversity of LGBT people, including higher rates of poverty and food insecurity for LGBT people nationally compared to non-LGBT people. *See, e.g.*, M.V. Lee Badgett et al., Williams Institute, *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community* (2013), http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf; Taylor N.T. Brown et al., Williams Institute, *Food Insecurity and SNAP Participation in the LGBT Community* (2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Food-Insecurity-and-SNAP-Participation-in-the-LGBT-Community.pdf; Gary J. Gates & Frank Newport, Gallup, *Special Report: 3.4% of U.S. Adults Identify as LGBT* (2013), http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx; Sandy E. James et al., *The Report of the U.S. Transgender Survey* (2016), www.ustranssurvey.org/report. Given poverty, homelessness, and other evidence of economic and social vulnerability among LGBT people—including in child welfare contexts—it is crucial that HHS ensure not only that health programs and activities but also the various human services it funds and regulates are available to all in a non-discriminatory manner.

[27] INSTITUTE OF MEDICINE, *supra*, at 62.

[28] Amici Brief of Ilan H. Meyer, PhD, and Other Social Scientists and Legal Scholars Who Study the LGB Population in Support of Respondents, *Masterpiece Cakeshop Ltd. v. Colorado Human Rights Commission*, No. 16-111 (filed Oct. 30, 2017), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Williams-Masterpiece-Cakeshop-Amici-Brief.pdf.

sexual orientation or gender identity are "minority stressors" that can profoundly harm the health and well-being of LGBT people who are directly subject to these refusals of service.

When a health care provider denies care or provides lesser care to a LGBT person because of their sexual orientation or gender identity – regardless of the intent behind the discrimination – it is a prejudice event, a type of minority stress, which has both tangible and symbolic impacts on the LGBT patient. If a provider denies care to an individual patient, that denial creates harmful repercussions for the patient: An individual who is denied care must, at a minimum, experience the inconvenience of seeking alternative providers for the service. This can be especially critical for individuals who live in communities where no such alternatives are available or where reaching an alternative care provider can only be done with great cost and effort. Where delay in obtaining care has consequences for physical or mental health, those damaging repercussions are further exacerbated and could, in emergency cases, result in disability or death.

Prejudice events, such as health care denials, also carry a strong symbolic message of disapprobation. This symbolic message makes a prejudice event more damaging to the victim's psychological health than a similar event not motivated by prejudice. Research also indicates that "[f]ear of stigmatization or previous negative experiences with the health care system may lead LGBT individuals to delay seeking care."[29] Such expectations of discrimination generate a state of extra vigilance in LGBT people that is also stressful and could lead to people not finding care when it is needed.

Stress related to being part of a group that is systematically stigmatized and discriminated against, due to religious or cultural belief systems, affects overall health, which HHS has recognized with respect to LGBT people. For example, in stating that the LGBT population requires special public-health attention, HHS explained that "[p]ersonal, family and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals."[30] Indeed, according to HHS, "[s]ocial determinants affecting the health of LGBT individuals largely relate to oppression and discrimination."[31] Similarly, the Centers for Disease Control and Prevention ("CDC") reports that homophobia, stigma, and discrimination can negatively affect the physical and mental health of gay and bisexual men, as well as the quality of the healthcare they receive.[32] HHS's Office of Women's Health has recognized that discrimination and stigma may lead lesbians and bisexual women to have higher rates of depression and anxiety than other women, as well as to be less likely than other women to get routine mammograms and clinical breast exams.[33] The CDC also reports that

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[29] *Id.* (discussing "felt stigma"); *see also id.* at 63-64 (discussing "internalized stigma" and other personal barriers to care).

[30] *Id.*

[31] *Id.*

[32] U.S. Dep't of Health and Human Services, Centers for Disease Control and Prevention, Gay and Bisexual Men's Health, Stigma and Discrimination, http://www.cdc.gov/msmhealth/stigma-and-discrimination.htm.

[33] U.S. Department of Health and Human Services, Office of Women's Health, Lesbian and Bisexual Health, https://www.womenshealth.gov/a-z-topics/lesbian-and-bisexual-health (last visited Nov. 20, 2017) (an archive of this webpage is available at https://web.archive.org/web/20170919061935/https://www.womenshealth.gov/a-z-topics/lesbian-and-bisexual-health).

discrimination and social stigma may help explain the high risk for HIV infection among transgender women,[34] among other health concerns facing transgender people. With respect to LGBT youth, the Institute of Medicine (now called the National Academies of Sciences, Engineering, and Medicine), which operates under a congressional charter and provides independent, objective analysis of scientific research, has observed that "the disparities in both mental and physical health that are seen between LGBT and heterosexual and non-gender-variant youth are influenced largely by their experiences of stigma and discrimination during the development of their sexual orientation and gender identity and throughout the life course."[35]

The disparities between health outcomes for LGBT and non-LGBT people have been well-documented. For example, in Healthy People 2010 and Healthy People 2020, which set health priorities for the country,[36] HHS found that LGBT people face these health disparities:

- LGBT youth are 2 to 3 times more likely to attempt suicide;
- LGBT youth are more likely to be homeless;
- Lesbians are less likely to get preventive services for cancer;
- Gay men are at higher risk of HIV and other STDs, especially among communities of color;
- Lesbians and bisexual females are more likely to be overweight or obese;
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or LGB individuals;
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers;
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.[37]

The discrimination and related health disparities facing the LGBT population stand to worsen if health care providers are authorized to refuse to serve LGBT people. In light of the importance of health care to the public's health, the provider-conscience laws must carefully and narrowly delineate those circumstances where denials of care are authorized, and any Final Rule must adhere to those limitations. Any Final Rule must also make the explicit point that hospitals and other entities are not permitted to turn away a LGBT or any other person because of rejection of the class of people they belong to or appear to belong to. Any Final Rule must make these points clear so as to avoid unauthorized denials and improperly chilling patients in accessing care.

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[34] U.S. Dep't of Health and Human Services, Centers for Disease Control and Prevention, HIV Among Transgender People, http://www.cdc.gov/hiv/group/gender/transgender/index.html.

[35] INSTITUTE OF MEDICINE, THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING 142 (2011), https://www.ncbi.nlm.nih.gov/books/NBK64806/pdf/Bookshelf_NBK64806.pdf.

[36] U.S. Dep't of Health & Human Services, Office of Disease Prevention and Health Promotion, Healthy People, Lesbian, Gay, Bisexual, and Transgender Health, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25.

[37] *Id.*

## III. OCR Must Continue To Devote Sufficient Resources To Its HIPAA and Civil Rights Functions.

We are concerned that any Final Rule – along with OCR's concomitant decision to create a separate Conscience and Religious Freedom Division – will result in the allocation of an enhanced portion of OCR's resources to defending refusals of medical care. That reallocation of resources will come at the expense of OCR's other critical enforcement responsibilities and will undermine the protections of both fundamental civil rights laws and the Health Insurance Portability and Accountability Act (HIPAA).

"In FY 2017, OCR received approximately 30,166 complaints, a 23 percent increase over the 24,523 complaints received in FY 2016" and its "[c]ase receipts are expected to further rise in FY 2019."[38] The lion's share of complaints received by OCR are for alleged HIPAA violations, but OCR also receives thousands of civil rights complaints each year.

By comparison, "[s]ince the designation of OCR as the agency with authority to enforce Federal health care conscience laws in 2008…. OCR has received on average, only about 1.25 [conscience] complaints per year from the [timeframe of] 2008 until November 2016."[39] OCR has reportedly received 300 provider-conscience complaints recently, but the number of such complaints OCR has ever received still represents a very small fraction of OCR's overall workload.[40] In light of these statistics and HHS's mission, it is crucial that OCR continue to devote sufficient resources to its HIPAA and civil rights functions.

Nor is there any reason to believe that OCR was not already devoting sufficient resources to enforcing provider-conscience laws. In the last ten years, OCR has resolved three sets of complaints filed under provider-conscience laws with written agreements or letters of finding.[41] In one of these instances, a private hospital adopted new policies in response to a complaint alleging that a nurse was forced to participate in an abortion despite her conscience objections;[42] similarly, Vanderbilt University took corrective action when it was alleged that it had coerced applicants for its nurse residency program to agree to assist in abortion procedures.[43] In each of these instances, OCR appropriately investigated and reached resolutions to ensure that the entities took corrective action.[44] Although there has been one instance in which HHS was

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[38] U.S. Dep't of Health and Human Services, *Budget In Brief,* 124 (Feb. 19, 2018), https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf.

[39] *See* 83 Fed. Reg. 3886 (stating that since 2008 OCR has received a total of forty-four complaints, and that prior to the 2016 presidential election, OCR had only received 10 such complaints); *but,* Jesse Hellman, *New HHS office that enforces health workers' religious rights received 300 complaints in a month,* The Hill (Feb. 20, 2018), http://thehill.com/policy/healthcare/374725-hhs-new-office-that-enforces-religious-moral-rights-of-health-workers.

[40] *Id.*

[41] *See* 83 Fed. Reg. 3886 (*citing* OCR Complaint No. 10–109676; OCR Complaint No. 11–122388; OCR Complaint No. 11–122387).

[42] OCR Complaint No. 10–109676.

[43] OCR Complaint No. 11–122388; OCR Complaint No. 11–122387.

[44] *See* 83 Fed. Reg. 3886.

accused of improperly handling conscience protection claims,[45] there is no evidence that those claims, if in fact they were improperly processed, could not be handled under the current regulations governing the provider-conscience laws and without creation of a new division.

We are additionally concerned about the allocation of resources at OCR in light of a future decrease in OCR's budget. In FY 2016, OCR's budget was approximately $38 million. That same year, only 35 percent of "civil rights complaints requiring formal investigation [were] resolved within 365 days."[46] We appreciate that OCR, in response, requested a budget of nearly $43 million dollars for FY 2017, because it expected "complex cases that involve novel issues of law and complicated facts [to] dramatically increase" and that an increased budget would be needed to increase its capacity to handle such.[47] However, under the Consolidated Appropriations Act, 2018, OCR's FY 2018 budget is approximately $39 million.[48] And for FY 2019, HHS is requesting only $31 million for OCR.[49]

As a result, it appears OCR will have to divert substantial resources away from its HIPAA and/or civil rights functions to meet any enhanced budget for enforcing the provider-conscience laws. Moreover, given OCR's ability to appropriately resolve conscience complaints in the past and the agency's budget realities, the economic expenditures associated with this new rule and the creation of OCR's new division appear unjustified. OCR must continue to devote sufficient resources to its core civil rights and HIPAA functions.

## IV. Conclusion

For the foregoing reasons, should OCR choose to issue a Final Rule, we urge OCR to limit it as discussed above, conduct a RIA or otherwise accounts for the impact of the Proposed Rule and any Final Rule has on patients, and to continue to devote sufficient resources to its HIPAA and civil rights functions.

Respectfully Submitted,

[Signatures on next page.]

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[45] *See id.*

[46] *See* U.S. Dep't of Health and Human Services, *Fiscal Year 2017 Office of Civil Rights Justification of Estimates for Appropriations Committee* 9, https://www.hhs.gov/sites/default/files/fy2017-budget-justification-ocr_1.pdf.

[47] *Id.* at 7.

[48] *Consolidated Appropriations Act, 2018*, H.R. 1625, 115th Cong., 919 (2018), https://www.congress.gov/115/bills/hr1625/BILLS-115hr1625eah.pdf.

[49] U.S. Dep't of Health and Human Services, *Budget in Brief,* 124 (Feb. 19, 2018) ("The fiscal year (FY) 2019 Budget request for the Office for Civil Rights (OCR) is $31 million, $8 million below the 2018 Continuing Resolution level"), https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

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No. 16-111

# In The Supreme Court of the United States

MASTERPIECE CAKESHOP, LTD.; AND
JACK C. PHILLIPS,

*Petitioners,*

v.

COLORADO CIVIL RIGHTS COMMISSION; CHARLIE
CRAIG; AND DAVID MULLINS.

*Respondents.*

*ON WRIT OF CERTIORARI TO THE*
*COLORADO COURT OF APPEALS*

## BRIEF OF *AMICI CURIAE* ILAN H. MEYER, PHD, AND OTHER SOCIAL SCIENTISTS AND LEGAL SCHOLARS WHO STUDY THE LGB POPULATION IN SUPPORT OF RESPONDENTS

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## I. INTEREST OF AMICI CURIAE[1]

*Amici* include scholars in public health and social sciences who are recognized experts on the health and well-being of sexual minorities, including lesbians, gay men, and bisexuals ("LGB"). Many of the *amici* have conducted extensive research and authored publications in peer-reviewed academic journals on the effects of discrimination on LGB people. *Amici* also include legal scholars who are recognized experts on law and policy affecting LGB people's health and well-being. The Appendix identifies the individual *amici*.

This Court and other courts have expressly relied on the research of many of the *amici*, and several of the *amici* have served as expert witnesses. *See, e.g.*, *Obergefell v. Hodges*, 135 S. Ct. 2584, 2600 (2015) (citing Brief of Gary J. Gates as *Amicus Curiae*); *Baskin v. Bogan*, 766 F.3d 648, 663, 668 (7th Cir. 2014); *Nungesser v. Columbia Univ.*, 169 F. Supp. 3d 353, 365 n.8 (S.D.N.Y. 2016); *Roberts v. United Parcel Serv. Inc.*, 115 F. Supp. 3d 344, *passim* (E.D.N.Y. 2015); *Stawser v. Strange*, 307 F.R.D. 604, 609 (S.D. Ala. 2015); *Campaign for S. Equality v. Bryant*, 64 F. Supp. 3d 906, 943 n.42 (S.D. Miss.

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[1] As required by Rule 37 of the Rules of this Court, *amici curiae* obtained consent of counsel of record for all parties to file this brief. Blanket permission from petitioners and the Colorado Civil Rights Commission have been filed with the Court. Respondents, Charlie Craig and David Mullins, emailed their permission to *amici*. A copy of which was included with the filing of this brief. *Amici curiae* also represent that no counsel for a party authored this brief in whole or in part, and that no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief.

2014); *DeBoer v. Snyder*, 973 F. Supp. 2d 757, 763-64 (E.D. Mich.), *rev'd*, 772 F.3d 388 (6th Cir. 2014), *rev'd sub nom.*, *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015); *Bassett v. Snyder*, 951 F. Supp. 2d 939, 967 (E.D. Mich. 2013); *Dragovich v. U.S. Dep't of Treasury*, 872 F. Supp. 2d 944, *passim* (N.D. Cal. 2012); *Log Cabin Republicans v. United States*, 716 F. Supp. 2d 884, 917 (C.D. Cal. 2010); *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921, *passim* (N.D. Cal. 2010).

As scholars who specialize in issues related to LGB people, *amici* have a substantial interest in this matter. In this brief, *amici* present public health and social science research relevant to the legal questions before this Court. In particular, *amici* describe the harmful effects on LGB people of stigma- and prejudice-related stress (referred to as "minority stress") when a business or other place of public accommodation discriminates against them on the basis of sexual orientation.[2] Eliminating discrimination against LGB people, and the harms of minority stress to LGB people's health and well-being, are compelling government interests, especially in light of the long history of invidious discrimination that this population has suffered.

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[2] Stigma and prejudice against transgender people leads to minority stress that adversely impacts this population's health and well-being, as well. *See, e.g.*, Bockting *et al.*, *Adult Development and Quality of Life of Transgender and Gender Nonconformity People*, 23 Current Op. Endocrinology, Diabetes & Obesity 188 (Apr. 2016). Because this case concerns sexual orientation discrimination, we do not address the transgender population.

## II. SUMMARY OF ARGUMENT

When a place of public accommodation refuses to serve, or provides lesser services to, LGB people because of their sexual orientation, that experience can have powerful tangible and symbolic effects on them—just as the denial of equal service can adversely impact other minorities. A discriminatory experience can be humiliating and result in harm to health, well-being, and dignity.

After Petitioners rejected the request of Charlie Craig and David Mullins to purchase a wedding cake, Charlie left the bakery shaking, crying, embarrassed, and feeling like a failure before his mother, who witnessed the incident.[3] The symbolic power of such incidents affects not only the LGB person treated unequally but also the larger LGB community, as it becomes aware of the discrimination and fears future such experiences. This Court has recognized that public accommodation antidiscrimination laws protect against these types of harms and, in doing so, "plainly serve[] compelling state interests of the highest order." *Roberts v. United States Jaycees*, 468 U.S. 609, 624 (1984).

The denial of equal service by a bakery or other business to a LGB person because of his or her sexual orientation is an example of what research identifies as a "minority stressor." While everyone has the potential to experience "general stressors"—such as losing a job—LGB people also face minority stressors that stem from anti-LGB stigma and prejudice. A

[3] Munn, *How It Feels When Someone Refuses to Make Your Son a Wedding Cake*, Time (2017), http://time.com/4991839/masterpiece-cakeshop-supreme-court-gay-discrimination/.

large body of research has shown that LGB people, as a group, experience more stress than heterosexuals, and that this excess exposure to stress is caused by anti-LGB stigma and prejudice.[4]

Another minority stressor facing LGB people relates to *expectations* of rejection and discrimination. Because LGB people learn that they may be rejected and discriminated against in society, they come to expect or fear such occurrences in day-to-day social interactions. The expectation of discrimination causes LGB people to be vigilant as they go through life. For example, a same-sex couple walking down the street may reasonably fear that they will be shouted at with homophobic slurs or even assaulted; as a result, the couple may attempt to conceal their LGB identity (such as by not holding hands). This state of vigilance is stressful and can be damaging to LGB people.[5]

Furthermore, if businesses are allowed to discriminate against people because of their sexual orientation, LGB people may reasonably expect discrimination by other businesses and modify their behavior accordingly. This expectation of discrimination can inhibit LGB people's ability to fully participate in the public marketplace. *See, e.g.*, *Washington v. Arlene's Flower's, Inc.*, 389 P.3d 543, 548-49 (Wash. 2017) (same-sex couple abandoned

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[4] *See, e.g.*, Meyer *et al.*, *Social Patterning of Stress and Coping: Does Disadvantaged Social Statuses Confer More Stress and Fewer Coping Resources?*, 3 Soc. Sci. Med. 67 (2008).

[5] *See, e.g.*, Sawyer *et al.*, *Discrimination and the Stress Response: Psychological and Physiological Consequences of Anticipating Prejudice in Interethnic Interactions*, 102 Am. J. Pub. Health 1020 (2012).

plans for a large wedding after being discriminated against by a florist, citing the "emotional toll" of the discrimination and fear of additional discrimination by other vendors, and instead married at home before a small group of people). Antidiscrimination laws exist in part to prevent such market distortions.

Stigma-related minority stress experienced by LGB people has been linked to a disproportionately high prevalence of psychological distress, depression, anxiety, substance-use disorders, and suicidal ideation and attempts—many of which are two to three times greater among sexual minorities than the heterosexual majority.[6] Minority stress may also adversely impact same-sex couples' relationship quality and stability, thereby undercutting one of the advantages of marriage this Court recognized in *Obergefell*, 135 S. Ct. at 2600-01.

Research also has shown that LGB people fare better in regions where social and legal conditions are more hospitable to them.[7] These studies suggest that antidiscrimination laws that prohibit public accommodations from discriminating against LGB people help reduce minority stress and resultant health disparities.

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[6] *See, e.g.*, Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Nat'l Acads. Press 2011).

[7] Hatzenbuehler *et al.*, *State Level Policies and Psychiatric Morbidity in Lesbian, Gay, and Bisexual Populations*, 99 Am. J. Pub. Health 2275 (2009); Hatzenbuehler *et al.*, *The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study*, 100 Am. J. Pub. Health 452 (2010).

Ultimately, *Amici* conclude that the minority stress literature supports a finding that Colorado has a compelling interest in barring public accommodations from discriminating against LGB people. Indeed, this case is not just about a wedding cake. Something much larger is at stake for LGB people: their health, well-being, and dignity. Allowing businesses to avoid their obligations to serve LGB people equally would undercut the "equal dignity" of same-sex couples that this Court has protected. *Obergefell*, 135 S. Ct. at 2608; *see also United States v. Windsor*, 133 S. Ct. 2675, 2692, 2694 (2013); *Lawrence v. Texas*, 539 U.S. 558, 567, 574-75 (2003). Should the Court agree with Petitioners here, LGB people would likely face increased discrimination in a variety of settings, which antidiscrimination laws would not be able to prevent or remedy.

One of Petitioners' *amici* has alleged that the minority stress literature does not apply here, and that the particular incident in question was not stressful. *See* Brief of Amici Curiae Mark Regnerus et al. in Support of Petitioners, *Masterpiece Cakeshop, LTD v. Colorado Civil Rights Commission*, No. 16-111 (filed Sept. 7, 2017) (hereinafter "the Regnerus Brief"). None of the Regnerus Brief's arguments undermines our conclusions in this brief, as we explain below.

## III. ARGUMENT

As Respondents demonstrate, this case involves a discriminatory denial of service; it does not involve any targeting of speech, compelled speech, or regulation of expressive conduct. Respondent Colorado Civil Rights Commission Br. 20-27, 32-44;

Respondents Craig and Mullins Br. 15-28; *R.A.V. v. City of St. Paul,* 505 U.S. 377, 390 (1992) ("acts are not shielded from regulation merely because they express a discriminatory idea or philosophy"); *Rumsfeld v. Forum for Acad. & Institutional Rights, Inc.*, 547 U.S. 47, 62 (2006) (regulation forbidding discrimination against military recruiters did not compel speech endorsing military policy). Even if the Colorado law were deemed to regulate protected expressive conduct, Petitioners' free-speech challenge must fail if the law furthers "an important or substantial governmental interest" that "is unrelated to the suppression of free expression," and "if the incidental restriction on alleged First Amendment freedoms is no greater than is essential to the furtherance of that interest." *United States v. O'Brien*, 391 U.S. 367, 377 (1968). Nor can Petitioners object to a neutral law of general applicability on free-exercise grounds if the law is rationally related to a legitimate government interest. *Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 531 (1993).

Regardless of whether the governmental interest need be legitimate, substantial, or compelling, that requirement is clearly met by the Colorado law. Protecting the dignity of, and eradicating discrimination against, LGB people is a compelling state interest, for "eliminating discrimination and assuring its citizens equal access to publicly available goods and services . . . , which is unrelated to the suppression of expression, plainly serves compelling state interests of the highest order." *Roberts*, 468 U.S. at 624; *see also Bd. of Dirs. of Rotary Int'l v. Rotary Club*, 481 U.S. 537, 549 (1987). In a similar

vein, this Court, in upholding the public accommodations provision of the 1964 Civil Rights Act, recognized Congress's power to "vindicate the deprivation of personal dignity that surely accompanies denials of equal access to public establishments." *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 250 (1964) (internal quotation marks omitted); *see also id.* at 291-92 (Goldberg, J., concurring); *Bob Jones Univ. v. United States*, 461 U.S. 574, 604 (1983) (government's compelling interest in eradicating race discrimination in education overrode burden on religious exercise).

Consistent with this line of cases, this Court has repeatedly made clear that our Constitution protects and ensures the "equal dignity" of individuals in same-sex couples and LGB people more broadly. *Obergefell*, 135 S. Ct. at 2608; *see also Windsor*, 133 S. Ct. at 2692, 2694; *Lawrence*, 539 U.S. at 567, 574-75; *Romer v. Evans*, 517 U.S. 620, 634-35 (1996).

Just as this Court's jurisprudence protects same-sex couples and LGB people from discriminatory state action, Colorado prohibits its places of public accommodation from discriminating based on sexual orientation, among other personal characteristics. Colorado Rev. Stat. § 24-34-601(2)(a) (2017). The purpose of Colorado's antidiscrimination law is to "eradicate the underlying causes of discrimination and halt discriminatory practices" that stigmatize and make second-class citizens of many Coloradans. *Red Seal Potato Chip Co. v. Colo. Civil Rights Comm'n*, 618 P.2d 697, 700 (Colo. Ct. App. 1980). *See generally* Sepper, *The Role of Religion in State Public Accommodation Laws*, 60 St. Louis Univ. L.J. 631, 663-67 (2016) (public accommodation anti-

discrimination laws "vindicate individual and societal interests in material, dignitary, and expressive terms").

Although this Court has already stated that prevention of exclusion and stigmatization is a compelling interest in the public accommodations context, *amici* write to provide the Court with relevant research that finds that LGB people are subject to "minority stress" due to anti-LGB stigma and prejudice. *Amici* describe how being refused service by a business due to stigma and prejudice against LGB people is a minority stressor. Thus, public-accommodation discrimination leads to dignitary harm and can cause adverse outcomes for health and well-being for LGB people. In addition, should this Court accept Petitioners' claims, widespread discrimination could ensue, leading LGB people to reasonably expect discrimination, which, in turn, increases the risk that they will not fully participate in the marketplace. Minority stress may also negatively impact same-sex couples' relationship quality and stability. In contrast, research shows that where social and legal conditions are more hospitable to LGB people, the health of sexual minorities improves, and health disparities between LGB people and heterosexuals are reduced.

## A. LGB People Face Discrimination and Other Minority Stressors Stemming From Anti-LGB Stigma

### 1. LGB people have long endured discrimination.

LGB people have faced a long, painful history of public and private discrimination in the United States. In *Obergefell*, this Court observed that gays and lesbians have been "prohibited from most government employment, barred from military services, excluded under immigration laws, targeted by police, and burdened in their rights to associate." 135 S. Ct. at 2596; *see also Windsor*, 133 S. Ct. at 2693 ("The avowed purpose and practical effect of the law here in question are to impose a disadvantage, a separate status, and so a stigma upon all who enter into same-sex marriages made lawful by the unquestioned authority of the States."); *Lawrence*, 539 U.S. at 575 (discussing stigmatization from criminal sodomy statutes); *Romer*, 517 U.S. at 632 (discussing animus in anti-LGB legislation). Speaking to both public and private discrimination, the Seventh Circuit has explained that "homosexuals are among the most stigmatized, misunderstood, and discriminated-against minorities in the history of the world, the disparagement of their sexual orientation, implicit in the denial of marriage rights to same-sex couples, is a source of continuing pain to the homosexual community." *Baskin v. Bogan*, 766 F.3d 648, 658, 663 (7th Cir. 2014); *accord Windsor v. United States*, 699 F.3d 169, 182 (2d Cir. 2012) ("It is easy to conclude that homosexuals have suffered a

history of discrimination."), *aff'd*, 133 S. Ct. 2675 (2013).

Despite advances that LGB people have made to protect their autonomy and equality under the Constitution and some state and local laws, research finds evidence of persistent and pervasive discrimination against LGB people in employment,[8] education,[9] housing,[10] and public accommodations,[11] as well as widespread stigma, prejudice, and

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[8] *See, e.g.*, Pizer *et al.*, *Evidence of Persistent and Pervasive Workplace Discrimination Against LGBT People*, 45 Loy. L.A. L. Rev. 715, 721-728 (2012); Tilcsik, *Pride and Prejudice: Employment Discrimination Against Openly Gay Men in the United States*, 117 Am. J. Sociology 586, 586-626 (2011).

[9] *See, e.g.*, Kosciw *et al.*, GLSEN, *The 2015 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools* (2016); Wolff *et al.*, *Sexual Minority Students in Non-Affirming Religious Higher Education: Mental Health, Outness, and Identity*, 3 Psychol. Sexual Orientation & Gender Diversity 201 (2016).

[10] *See, e.g.*, Levy *et al.*, Urban Institute, *A Paired-Tested Pilot Study of Housing Discrimination Against Same-Sex Couples and Transgender Individuals* (2017).

[11] *See, e.g.*, Badgett *et al.*, Williams Institute, *Bias in the Workplace: Consistent Evidence of Sexual Orientation and Gender Identity Discrimination* 19-20 (2007); Mallory *et al.*, Williams Institute, *The Impact of Stigma and Discrimination against LGBT People in Florida* 30-32 (2017); Mallory *et al.*, Williams Institute, *The Impact of Stigma and Discrimination Against LGBT People in Georgia* 27-28 (2017); Mallory *et al.*, Williams Institute, *The Impact of Stigma and Discrimination Against LGBT People in Texas* 29-31(2017); Mallory & Sears, Williams Institute, *Evidence of Discrimination in Public Accommodations Based on Sexual Orientation and Gender Identity: An Analysis of Complaints Filed with State Enforcement Agencies, 2008-2014* (2016).

violence.[12] With respect to public accommodations specifically, 31% of gay men, 29% of lesbians, and 15% of bisexual men and women respondents to a national survey conducted by the Pew Research Center in 2013 reported that they had "received poor service at a restaurant, hotel, or other place of business."[13]

### 2. LGB People Face Minority Stressors Stemming from Anti-LGB Stigma and Prejudice

Experiences of discrimination are among other significant minority stressors that adversely impact LGB people's health and well-being. Stress is "any condition having the potential to arouse the adaptive machinery of the individual."[14] Using engineering analysis, stress can be described as the load relative to supportive surface.[15] Like a surface that may break when load weight exceeds its capacity to withstand the load, so too has stress been described as reaching a breaking point beyond which an organism may reach "exhaustion" and even death.[16] Stress is

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[12] *See, e.g.*, *infra* nn. 65-68 and accompanying text.

[13] Pew Research Center, *A Survey of LGBT Americans: Attitudes, Experiences and Values in Changing Times* 41 (2013).

[14] Pearlin *et al.*, *Stress and Mental Health: A Conceptual Overview, in A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* 161, 175 (Cambridge Univ. Press 1999).

[15] Wheaton *et al.*, *The Nature of Stressors, in A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* 176-97 (Cambridge Univ. Press 1999)

[16] Selye, *History and Present Status of the Stress Concept, in Handbook of Stress: Theoretical and Clinical Aspect* 7-17 (Goldbeger & Breznitz eds., Free Press 2nd ed. 1993).

detrimental because it requires an adaptation effort by the individual exposed to stress.[17] Research over more than 40 years has shown that stress causes mental and physical disorders.[18]

LGB people are exposed to stressors that researchers refer to as "minority stressors" that stem from anti-LGB stigma and prejudice.[19] In addition, all people (including LGB people) are exposed to "general stressors," which do not stem from stigma and prejudice.[20]

Exposure to minority stress is chronic, in that it is attached to persistent social processes characterized by anti-LGB stigma and prejudice. Similarly, because it relates to stigma and prejudice against LGB people, minority stress refers to *excess* exposure of LGB people to stress as compared with heterosexuals.[21] Thus, minority stress requires

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[17] *Id.*; Pearlin *et al.* (1999), *supra*.

[18] Thoits, *Stress and Health: Major Findings and Policy Implications*, 51(S) J. Health & Soc. Behav. S41 (2010).

[19] Stigma is "a function of having an attribute that conveys a devalued social identity in a particular context." Crocker *et al.*, *Social Stigma, in* 4 *The Handbook of Social Psychology* 506 (Gilbert *et al.*, eds., McGraw-Hill 1998).

[20] Meyer, *Minority Stress and Mental Health in Gay Men*, 36:1 J. Health & Behav. 38 (1995); Meyer, *Prejudice, Social Stress and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence*, 129:5 Psychol. Bull. 674-697 (2003); Meyer *et al.* (2008), *supra*.

[21] Meyer *et al.* (2008), *supra*; Herek, *Sexual Stigma and Sexual Prejudice in the United States: A Conceptual Framework, in Contemporary Perspectives on Lesbian, Gay, and Bisexual Identities* 65-111 (D. A. Hope ed., 2009); Springer & Herek, *Hate Crimes and Stigma-Related Experiences Among Sexual Minority Adults in the United States: Prevalence Estimates from a*

special adaptation by LGB individuals but not by non-LGB individuals.[22] Because stress can cause mental and physical disorders, the excess exposure to minority stress among LGB people, as compared with heterosexuals, confers an excess risk for diseases that are caused by stress.[23]

Minority stress is defined by specific stress processes, including "prejudice events" and "expectations of rejection and discrimination," among others.[24] "Prejudice events" refers to events that stem from societal anti-LGB stigma and prejudice. Thus, being fired from a job is a general stressor that could affect any person, but it is classified as a prejudice event—a minority stressor—when it is motivated by discrimination against LGB people.

Structural exclusion from resources and advantages available to heterosexuals—such as (1) the historical exclusion of LGB people from the institution of marriage prior to *Obergefell*, (2) the historical exclusion of gay men and lesbians from federal civilian and military employment, and (3) and the current omission of express protections against sexual orientation discrimination in Titles II and VII of 1964 Civil Rights Act, among other federal antidiscrimination laws—leads to prejudice events. Prejudice events also include interpersonal events, perpetrated by individuals acting either in violation

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*National Probability Sample*, 24:1 J. Interpersonal Violence 54-74 (2009); Meyer (2003), *supra*.

[22] Frost & Meyer, *Internalized Homophobia and Relationship Quality Among Lesbians, Gay Men, and Bisexuals*, 59 J. Counseling Psychol. 97-109 (2009).

[23] Meyer *et al.* (2008), *supra*.

[24] Meyer (2003), *supra*.

of the law (e.g., hate crimes) or within the law (e.g., lawful but discriminatory employment practices).

A prejudice event may be perpetrated by one person, but it carries a symbolic message of social disapprobation. The added symbolic value makes a prejudice event more damaging to the victim's psychological health than a similar event not motivated by prejudice.[25] This exemplifies an important quality of minority stress: Prejudice events have a powerful impact because they convey deep cultural meaning.[26] Even "a seemingly minor event, such as a slur directed at a gay man, may evoke deep feelings of rejection and fears of violence [seemingly] disproportionate to the event that precipitated them."[27] Therefore, assessment of stressors related to stigma and prejudice must consider not only the tangible impact of stress—typically defined as the amount of adaptation required by the event—but also the symbolic meaning within the social context.

In sum, stressors are ubiquitous in our society and experienced by LGB and heterosexual people alike. But the quality of stressors the two populations experience differ in that LGB people are uniquely exposed to minority stressors that stem from stigma and prejudice toward them. This added source of stress experiences exposes LGB people to excess stress compared with heterosexuals and leads to

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[25] Frost *et al., Minority Stress and Physical Health Among Sexual Minority Individuals*, 38 J. Behav. Med. 1 (2015); Herek *et al.*, *Psychological Sequelae of Hate-Crime Victimization Among Lesbian, Gay, and Bisexual Adults*, 57:6 J. Consult. & Clin. Psychol. 945 (1999).

[26] Meyer (1995), *supra.*

[27] *Id.*

excess adverse health outcomes in LGB as compared with heterosexual populations. *See infra* Part III.C.

### B. Exclusion From a Public Accommodation is a Prejudice Event and Increases Expectations of Rejection and Discrimination

Based on the large body of research on minority stress, *amici* conclude that when a baker refuses to sell a wedding cake to a LGB person, it is a prejudice event, a type of minority stress, which has both tangible and symbolic impacts on the LGB customer. From a practical perspective, the rejected customer is faced with an additional adaptational task—a concrete problem to resolve: finding a replacement for the needed service or good (here, a wedding cake). This demonstrates the basic premise of minority stress as an *excess* stress: the extra burden of finding an alternative provider adds to the stress of planning a wedding compared with heterosexual couples not affected by such discrimination. This added burden is unique to the class of customers who are shunned by the baker because of their same-sex fiancés.

While the couple here was able to procure another cake, the rejected customer may not always have the ability or time to find a replacement because an alternative business may not be available or because of the immediacy of the need. *See, e.g.*, First Amended Complaint, *Zawadski v. Brewer Funeral Services, Inc.*, No. 55CI1:17-cv-00019-CM (Miss. Cir. Ct., filed Mar. 7, 2017) (widow alleging funeral home refused to transport and cremate deceased same-sex spouse because of their sexual orientation, leaving the decedent's body without proper storage for hours and

the family scrambling to find alternative funeral services).

In addition to such tangible challenges, being rejected by a business for one's sexual orientation underscores the stigmatization that LGB people face. Here, the baker's rejection of a same-sex couple amplifies social rejection and reiterates decades-old stigma and prejudice. In the context of marriage, this is an especially powerful rejection because it relates to the couple's relationship, which inherently embodies their sexual orientation. *See also Obergefell*, 135 S. Ct. at 2600 ("'[W]hen sexuality finds overt expression in intimate conduct with another person, the conduct can be but one element in a personal bond that is more enduring.'" (quoting *Lawrence*, 539 U.S. at 567)). Being rejected by a business is a stark reminder to same-sex couples that even after this Court concluded that their relationships and dignity are protected by the U.S. Constitution, *Obergefell*, 135 S. Ct. at 2608; *Windsor*, 133 S. Ct. at 2692, 2694; *Lawrence*, 539 U.S. at 567, 574-75, they may continue to experience rejection and discrimination in the public marketplace.

Being rejected—and even the threat of rejection—in public accommodations will also increase expectations of future rejection and discrimination among LGB people. This is another form of minority stress.[28] An expectation of rejection and discrimination is a stressor because it requires vigilance by members of minority groups to defend themselves against potential rejection,

[28] Meyer (2003), *supra.*

discrimination, or violence.[29] Unlike prejudice events, which entail concrete events, expectations of rejection and discrimination are stressful even in the absence of a specific prejudice event because the expectation is based on what has been learned from repeated exposure to a stigmatizing social environment.[30] For example, gay couples must remain vigilant when walking in a public space, especially if they demonstrate affection, such as by holding hands, for fear of harassment or violence. The vigilance required in such a state is similar to the classic example of stress experienced by a person in a flight-or-fight stress response, which brings about biophysiological changes that can be harmful to one's health.[31]

Furthermore, it is reasonable to conclude that rejection by a baker or other business will reproduce expectations of rejection and may lead LGB people not to fully participate in the marketplace. For example, in *Washington v. Arlene's Flowers*, the Washington Supreme Court observed that after a florist turned the same-sex couple away, the couple abandoned plans for a large, 100-guest wedding. 389 P.3d at 548. The "emotional toll" of the incident and fear being of denied service by other vendors prompted the couple to forego their plans and marry at home in front of 11 guests. *Id.* at 549.

Should this Court conclude that the First Amendment protects Petitioners' actions here, an

[29] *Id.*

[30] Crocker, *Social Stigma and Self-Esteem: Situational Construction of Self-Worth*, 35:1 J. Experimental Soc. Psychol. 89-107 (1999).

[31] Selye, *The General Adaptation Syndrome and the Diseases of Adaptation*, 6:2 J. Clin. Endocrinology 117 (1946).

untold number of businesses may turn away LGB people. As a result, in order to ensure they will not be refused service when they need it, LGB customers would experience an additional burden of having to come out as LGB in advance of seeking services or goods, or face the risk of being turned away too late. If a same-sex couple getting married doesn't come out to, for example, an event space where they are planning their wedding party, they may find out at the last minute that the event space will not host them. Or, if planning a honeymoon at an inn, LGB customers would have to inquire in advance whether the inn-keeper would accommodate them, lest they arrive only to find out too late that they are not welcome. If the business rejects the LGB customer when he or she comes out, the LGB person must undertake the additional burden of trying to find an alternative provider, if such an alternative provider even exists or is available in the locale.

These experiences inflict dignitary harms on LGB people and are stressful, as they require LGB people to expend greater effort and expense to arrive at the same services or goods provided to non-LGB people with less effort and expense.[32] Moreover, the possibility of public rejection from services and goods creates a stigmatizing social environment. As we discuss next, a stigmatizing social environment and

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[32] Comparisons of LGB and heterosexual people throughout our analysis assume everything else being equal in terms of other sources of potential discrimination, such as minority racial/ethnic identity. Of course, other forms of discrimination would similarly apply to LGB people and heterosexuals. Thus racist discrimination would apply equally to Black heterosexual and LGB people, but only the LGB people would experience the additional anti-LGB discrimination.

minority stress adversely impact LGB people's health and well-being.

### C. Minority Stress Adversely Affects the Health and Well-Being of LGB People and May Impact Relationship Quality and Stability

#### 1. Minority Stress Negatively Impacts the Health and Well-Being of the LGB People

Stigma is a "fundamental social cause" of disease, in that it influences multiple disease outcomes through multiple risk factors across a widespread population.[33] This makes stigma "a central driver of morbidity and mortality at a population level."[34] Stigma leads to poor health outcomes by blocking resources "of money, knowledge, power, prestige, and beneficial social connections," increasing social isolation and limiting social support, and increasing stress.[35]

To date, hundreds of peer-reviewed research articles have reported on studies using the minority stress framework. By and large, this body of work shows that exposure to minority stress has a negative impact on the health and well-being of LGB people. This has led the Institute of Medicine (now called The National Academies of Sciences, Engineering, and Medicine), which operates under a congressional

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[33] Hatzenbuehler *et al.*, *Stigma As a Fundamental Cause of Population Health Inequalities*, 103:5 Am. J. Pub. Health 813, 813 (2013).

[34] *Id.* at 813.

[35] *Id.* at 814.

charter and provides independent, objective analysis of scientific research, to determine that minority stress is a core perspective for understanding LGB health and disparities in health between LGB and heterosexual people.[36]

Other leading public-health authorities have also recognized health disparities of LGB as compared with heterosexual populations. In Healthy People 2010 and Healthy People 2020, which set health priorities for the United States, the Department of Health and Human Services (HHS) identified the LGB population as having disparities in health outcomes, faring worse than heterosexuals.[37] In explaining why the LGB population required special public-health attention, HHS provided a minority stress explanation, noting that "[p]ersonal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals."[38]

This burden has most clearly been articulated in the minority stress literature.[39] Studies have concluded that minority stress processes are related to an array of mental health problems, including depressive symptoms, substance use, and suicide

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[36] Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Nat'l Acads. Press 2011).

[37] *See* United States Dep't of Health & Human Services, Office of Disease Prevention and Health Promotion, Healthy People, *Lesbian, Gay, Bisexual, and Transgender Health*, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

[38] *Id.* (citing Healthy People 2010).

[39] Institute of Medicine (2011), *supra*.

ideation and attempts.[40] LGB individuals also have lower levels of social well-being, which reflects a person's acceptance by his or her social environment,[41] than heterosexual people because of exposure to minority stress.[42]

Minority stress is also associated with a higher incidence of reported suicide attempts among LGB individuals than heterosexuals (especially in youth, when sexual identity is first disclosed to friends and family).[43] The higher prevalence of suicide attempts

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[40] Mays & Cochran, *Mental Health Correlates of Perceived Discrimination Among Lesbian, Gay, and Bisexual Adults in the United States*, 91:11 Am. J. Pub. Health 1869-76 (2001); Herek *et al.*, *Sexual Orientation and Mental Health*, Ann. Rev. Clin. Psychol. 3 (2007); King *et al.*, *A Systematic Review of Mental Disorder, Suicide, and Deliberate Self Harm in Lesbian, Gay and Bisexual People*, 70 BMC Psychiatry 8 (2008); Meyer (2003), *supra*; Cochran & Mays, *Sexual Orientation and Mental Health, in Handbook of Psychology and Sexual Orientation*, 204-22 (Oxford Univ. Press 2013).

[41] Kertzner *et al.*, *Social and Psychological Well-Being in Lesbians, Gay Men, and Bisexuals: The Effects of Race, Gender, Age, and Sexual Identity*, 79:4 Am. J. Orthopsychiatry 500 (2009).

[42] Kertzner *et al.*, *Psychological Well-Being in Midlife and Older Gay Men, Gay and Lesbian Aging: Research and Future Directions* 97-115 (2004); Riggle *et al.*, *LGB Identity and Eudaimonic Well Being in Midlife*, 56:6 J. Homosexuality 786 (2009).

[43] *E.g.*, Cochran & Mays, *Lifetime Prevalence of Suicide Symptoms and Affective Disorders Among Men Reporting Same-Sex Sexual Partners: Results From NHANES III*, 90:4 Am. J. Pub. Health 573 (2000); Gilman *et al.*, *Risk of Psychiatric Disorders Among Individuals Reporting Same-Sex Sexual Partners in the National Comorbidity Survey*, 91:6 Am. J. Pub. Health 933 (2001); Herrell *et al.*, *Sexual Orientation and Suicidality: A Co-Twin Control Study in Adult Men*, 56:10 Arch. Gen. Psychiatry 867 (1999); Friedman *et al.*, *A Meta-Analysis of*

among LGB youth is influenced by minority stress encountered by youths, for example, experiencing rejection by their family.[44]

Minority stressors stemming from social structural discrimination have serious negative consequences on mental health. For example, LGB people who live in states without laws that extend protections to sexual minorities (e.g., job discrimination or hate crimes) demonstrate higher levels of mental health problems compared to those living in states with laws that provide such protections.[45] Furthermore, the denial of marriage rights for same-sex couples had a demonstrated negative effect on the mental health of lesbians and gay men, regardless of their relationship status.[46]

Several studies have also demonstrated links between minority stress factors and some physical

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*Disparities in Childhood Sexual Abuse, Parental Physical Abuse, and Peer Victimization Among Sexual Minority and Sexual Nonminority Individuals*, 8 Am. J. Pub. Health 101 (2011); Meyer *et al.*, *Lifetime Prevalence of Mental Disorders and Suicide Attempts in Diverse Lesbian, Gay, and Bisexual Populations,* 6 Am. J. Pub. Health 98 (2008); Safren & Heimberg, *Depression, Hopelessness, Suicidality, and Related Factors in Sexual Minority and Heterosexual Adolescents*, 67:6 J. Consult. Clin. Psychol. 859 (1999).

[44] Ryan *et al.*, *Family Rejection As a Predictor of Negative Health Outcomes, in White and Latino Lesbian, Gay, and Bisexual Young Adults*, 1 Pediatrics 123 (2009).

[45] Hatzenbuehler *et al.* (2009), *supra.*

[46] Riggle *et al.*, *Psychological Distress, Well-Being, and Legal Recognition in Same-Sex Couple Relationships*, 1 J. Fam. Psychol. 24 (2010); Rostosky *et al.*, *Marriage Amendments and Psychological Distress in Lesbian, Gay, and Bisexual (LGB) Adults*, 1 J. Counseling Psychol. 56 (2009); Hatzenbuehler *et al.* (2010), *supra.*

health problems. For example, one study found that LGB people who had experienced a prejudice-related stressful life event were about three times more likely than those who did not experience a prejudice-related life event to have suffered a serious physical health problem over a one-year period.[47] This effect remained statistically significant, even after controlling for the experience of other non-prejudicial stress events and other factors known to affect physical health. Thus, prejudice-related stressful life events were more damaging to the physical health of LGB people than general stressful life events that did not involve prejudice. In another study, exposure to discrimination at work was related to an increased number of sick days and physician visits among LGB people.[48]

### 2. Minority Stress May Adversely Impact Same-Sex Couples' Relationship Quality and Stability

LGB people have the same aspirations for achieving intimate relationships as heterosexuals, but they face greater social barriers to maintaining long-term relationships.[49] This Court's decisions in *Lawrence*, *Windsor*, and *Obergefell* have helped remove some major barriers. Indeed, emerging evidence suggests "that legal relationship recognition

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[47] Frost *et al.* (2015), *supra.*

[48] Huebner & Davis, *Perceived Antigay Discrimination and Physical Health Outcomes*, 5 Health Psychol. 26 (2007);

[49] Frost, *Similarities and Differences in the Pursuit of Intimacy Among Sexual Minority and Heterosexual Individuals: A Personal Projects Analysis*, 67:2 J. Soc. Issues 282 (2011).

and parenting may act as stabilizing factors for [both same-sex and different-sex] couples."[50]

But minority stress remains a burden for same-sex partners.[51] Some studies indicate that minority stress in LGB people's lives may negatively affect couples' relationship quality and stability.[52] Consistently, some findings suggest that social approval and support appears to be important to couple stability.[53]

While different-sex and same-sex couples all experience general stressors—such as stresses related to finances or household chores—same-sex couples experience additional minority stressors that stem from the stigmatization of same-sex

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[50] Rostosky & Riggle, *What Makes Same-Sex Relationships Endure? in LGBTQ Divorce and Relationship Dissolution: Psychological and Legal Perspectives and Implications for Practice* (Goldberg & Romero, eds., Oxford Univ. Press forthcoming 2018) (on file with counsel).

[51] Clark *et al.*, *Windsor and Perry: Reactions of Siblings in Same-Sex and Heterosexual Couples*, 62:8 J. Homosexuality 993 (2015).

[52] Doyle & Molix, *Social Stigma and Sexual Minorities' Romantic Relationship Functioning: A Meta-Analytic Review*, 41:10 Pers. Soc. Psychol. Bull. 1363 (2015); Rostosky & Riggle, *Same-Sex Relationships and Minority Stress*, 13 Current Opinion Psychol. 29 (2017); Frost & LeBlanc, *Stress in the Lives of Same-Sex Couples: Implications for Relationship Dissolution and Divorce, in LGBTQ Divorce and Relationship Dissolution: Psychological and Legal Perspectives and Implications for Practice* (Goldberg & Romero, eds., Oxford Univ. Press, forthcoming 2018) (on file with counsel).

[53] Lehmiller & Agnew, *Perceived Marginalization and the Prediction of Romantic Relationship Stability*, 69:4 J. Marriage & Family 1036 (2007).

relationships.[54] Societal stigma surrounding same-sex relationships can also be uniquely internalized, contributing to feelings of internalized homophobia among people in same-sex relationships,[55] which has been shown to be detrimental to relationship quality among sexual minority individuals.[56] Moreover, societal stigma of same-sex relationships can lead to adverse mental health effects among LGB individuals, which create the potential for mental health problems in the couple (e.g., depression) that jeopardize the relationship.[57]

### D. Better Social and Legal Conditions are Associated with Fewer Adverse Effects of Minority Stress

Research has shown that in U.S. regions where LGB people have better social and legal conditions, they also have better health and lesser health disparities compared with heterosexuals.[58] Because minority stress stems from societal stigma, its root

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[54] Frost, *Stigma and Intimacy in Same-Sex Relationships: A Narrative Approach*, 25:1 J. Fam. Psychol. 1 (2011); Frost & LeBlanc (forthcoming 2018), *supra*; LeBlanc *et al.*, *Similar Others in Same-Sex Couples' Social Networks*, 62:11 J. Homosexuality 1599 (2015); Meyer (2003), *supra*.

[55] Frost & Meyer (2009), *supra*.

[56] Balsam & Szymanski, *Relationship Quality and Domestic Violence in Women's Same-Sex Relationships: The Role of Minority Stress,* 29:3 Psychol. Women Q. 258 (2005); Edwards *et al.*, *The Perpetration of Intimate Partner Violence Among LGBTQ College Youth: The Role of Minority Stress*, 42:11 J. of Youth & Adolescence 1721 (2013).

[57] Rostosky & Riggle (forthcoming 2018), *supra*; Frost & LeBlanc (forthcoming 2018), *supra*.

[58] Hatzenbuehler *et al.* (2009), *supra*; Hatzenbuehler *et al.* (2010), *supra*.

can only be eliminated through social and structural intervention.[59] Antidiscrimination laws that prohibit public accommodations from discriminating against LGB people would propel improved social and legal conditions. Indeed, as this Court has recognized, public accommodations laws "protect[] the State's citizenry from a number of serious social and personal harms" by ensuring that members of historically disadvantaged groups can participate as full members of civic society. *Roberts*, 468 U.S. at 625.

But just as laws can help eradicate and dismantle stigma and enhance a nation's health, laws can "be a part of the problem by enforcing stigma."[60] Indeed, the role of law in shaping stigma is so clear to public health professionals that they explicitly debate the ethics of using law to promote stigma, for example, related to smoking, even when such laws have undeniable benefits to the public's health by preventing morbidity and mortality.[61]

If this Court accepts Petitioners' arguments here, then future denial of service to LGB customers would be enshrined in the authority of the U.S. Constitution—leading to greater stigmatization of LGB people and same-sex relationships. At the same time, LGB people would feel less protected by the

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[59] Meyer & Frost, *Minority Stress and the Health of Sexual Minorities, in Handbook of Psychology and Sexual Orientation* 252-66 (Oxford Univ. Press 2013).

[60] Burris, *Stigma and the Law*, 367 Lancet 529 (2006); Link & Hatzenbuehler, *Stigma as an Unrecognized Determinant of Population Health: Research and Policy Implications*, 41 J. Health Politics, Policy, & Law 653 (2016).

[61] Bayer, *Stigma and the Ethics of Public Health: Not Can We But Should We*, 67:3 Soc. Sci. & Med. 463 (2008).

state than their heterosexual counterparts, and would need to be increasingly vigilant to secure their families' well-being.

### E. Regnerus *Amici* Brief Does Not Undermine the Significance of the Minority Stress Literature to this Case

One of Petitioners' *amici* briefs (the "Regnerus Brief," *supra*) asserts a variety of arguments that purport to undermine the significance of minority stress to the issues before the Court. Contrary to the claims made by the Regnerus Brief, none of the arguments therein undermines our arguments and conclusions here.

The Regnerus Brief asserts some methodological objections to studies on minority stress. But these methodological challenges are not unique to the minority stress literature and are routinely handled by scientists, who are trained to discern the implications of these challenges.

In generating knowledge, scientists generally rely on theory, hypotheses posed based on theory, and empirical evidence that enables them to assess these hypotheses using quantitative and qualitative methods. To collect and assess evidence, scientists use conventions and rules about causal inference developed over decades of methodological writings. These are the same processes that were used by scientists studying the incidence and impact of minority stress, and their conclusions are no less worthy of respect than scientific conclusions drawn in other contexts.

Moreover, in all fields of inquiry, no one research article is determinative, and all studies have methodological limitations. Indeed, a good scientific article provides the reader with a thorough review of the study's limitations, as well as suggestions for further study that may address limitations. The mere existence of methodological limitations in any one study, or even in a group of studies, does not by itself discredit the study or area of investigation. Relying on conventions of scientific research methodology and causal inference, a scientist uses his or her expertise and judgment about the significance and potential impact of the limitations in any particular study or group of studies to form conclusions about the questions under study.

First, the Regnerus Brief raises a host of alleged methodological limitations that the authors erroneously claim invalidate minority stress research and conclusions. But none of these alone or together invalidate minority stress research and conclusions, or disqualify the weight of scientific findings we discuss. For example, contrary to the Regnerus Brief, the fact that research evidence on minority stress stems from hundreds of independent research studies, done with varying methodologies, and using a variety of measures is a *strength* of this body of work. Indeed, an established method to assess the validity of scientific findings relies on the assessment of *convergences* of results across *divergent* methods. To the extent that convergences are shown from different studies leading to the same conclusions, this provides evidence that the findings are not

singularly, and spuriously, confounded by a particular method or measure.[62]

Second, the Regnerus Brief alleges that the literature conflates causation and association, but discusses only one study to demonstrate this, and, even then, does not actually describe the purported error of this study's causal inference. Instead, the Regnerus Brief addresses some limitations that do not go to causality. In fact, the one study mentioned is perfectly suited for testing causal relationships in that it is longitudinal and carefully measured and tracked instances of the minority stressor as a cause and its health effect.[63]

In any event, this Court has never required in public accommodations cases that the government must prove that a specific exclusion *caused* the various harms that antidiscrimination laws aim to ameliorate, contrary to the Regnerus Brief's assertion. Regnerus Br. at 1 & 15 (citing *Brown* v. *Entertainment Merchants Ass'n*, 564 U.S. 786 (2011)). Rather, in *Roberts*, for example, it was nothing less than obvious to the Court that discrimination by public accommodations causes dignitary, economic, and other harms. 468 U.S. at 625. Furthermore, this is not a case like *Brown*, cited by the Regnerus Brief, in which the government was attempting to ban protected speech because of harms caused by the speech.

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[62] Campbell & Fiske, *Convergent and Discriminant Validation by the Multitrait-Multimethod Matrix*, 56 Psychol. Bull. 81 (1959).

[63] Frost *et al.* (2015), *supra*.

Third, the Regnerus Brief critiques some studies assessing minority stress that use non-probability, or non-random, samples. But the Regnerus Brief's blanket statement that "[t]hat is not how research on populations ought to be conducted," Regnerus Br. 23, is wrong and contrary to scientific method. Clearly, studies that use non-probability samples differ from studies that use probability (representative) samples, but both types of studies are appropriately utilized by scientists.[64] Probability samples are required to make unbiased population estimates about statistics, such as prevalence of a disorder in a population. But non-probability samples provide insight into studied phenomena and often are preferred for assessing causal relationships. Indeed, one of the definitive textbooks on scientific causal inference describes numerous considerations for causal inference that do not rely on probability samples.[65]

Fourth, the Regnerus Brief argues that some of the data on minority stress are too old to be relevant today because of "recent changes in societal norms and increasing acceptance of LGB persons." Regnerus Br. 4. But evidence from recent studies suggests that improvements in societal norms have not been far-reaching enough to weaken our arguments here. For example, recent data on youth in U.S. high schools—perhaps the population most likely to have adopted more-accepting norms—shows that LGB youth continue to be disproportionally targeted for harassment. The survey of high school students

[64] Meyer & Wilson, *Sampling Lesbian, Gay, and Bisexual Populations*, 56:1 J. Counseling Psychol. 23, 23-31 (2009).

[65] Shadis *et al.*, *Experimental and Quasi-Experimental Designs for Generalized Causal Inference.* (Houghton Mifflin Co. 2002).

conducted in 2015 by the Centers for Disease Control and Prevention (CDC) uses a national probability sample of youth in high schools and therefore is representative of all U.S. youth in high schools. As reported by the CDC, results of the survey showed, among other findings, that 10% of LGB students, compared with 5% of heterosexual students, reported being threatened or injured with a weapon on school property, and 34% of LGB students, compared with 19% of heterosexual students, reported being bullied on school property.[66] And consistent with minority stress explanations, the LGB students were more likely to report being sad or hopeless (60% of LGB versus 26% of heterosexual students), seriously considered attempting suicide (43% of LGB versus 15% of heterosexual students), and actually attempted suicide (29% of LGB versus 6% of heterosexual students).[67] Similarly, the number of anti-LGB bias crimes reported to the FBI in the country has been steady for the past decade. For example, in 2005, 1,213 victims of crimes stemming from sexual-orientation bias were reported to the FBI; in 2015, 1,263 victims of these crimes were reported to the FBI.[68]

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[66] Kann *et al.*, *Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9-12—United States and Selected Sites, 2015*, 65 Morbidity & Mortality Weekly Report 1 (Aug. 12, 2016).

[67] *Id.*

[68] United States Dep't of Justice, Federal Bureau of Investigation, *Hate Crime Statistics 2005*, *Victims*, https://www2.fbi.gov/ucr/hc2005/victims.htm; United States Dep't of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division, *2015 Hate Crime Statistics*, *Victims*, https://ucr.fbi.gov/hate-crime/2015/topic-

Thus, contrary to the Regnerus Brief, despite the increase in social acceptance of LGB people in today's society, stigma, prejudice, and discrimination persist.[69] *See supra* Part III.A.1.

Fifth, the Regnerus Brief notes that minority stress research describes some LGB people as resilient in the face of adversity. Regnerus Br. 9. While research has found that some LGB people are resilient in the face of adversity, others succumb to adverse health effects of minority stress. And, that some people may be able to rebound from adversity does not justify placing adversity in their path. In fact, one of the purposes of antidiscrimination law is to clear discriminatory obstacles in people's paths.

The Regnerus Brief suggests that the issue at stake here is a minor experience that could be "waved off by the plaintiffs as 'Oh well, we realize some people aren't on board with same-sex marriage.'" (Br. 10). The Regnerus Brief misconstrues minority stress writings to claim that this experience does not represent minority stress because the actions of Petitioners were not chronic or acute. In fact, minority stress is chronic not because each stressful event is chronic, but because LGB people repeatedly encounter such events. As we have explained here, the issue at stake is greater than the one-time interaction of the parties to this case. If this Court

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pages/victims_final; *see also* Park & Mykhyalyshyn, *L.G.B.T. People Are More Likely Targets of Hate Crimes Than Any Other Minority Group*, N.Y. Times, June 16, 2016, https://www.nytimes.com/interactive /2016/06/16/us/hate-crimes-against-lgbt.html?_r=0.

[69] Meyer, *The Elusive Promise of LGBT Equality*, 106:8 Am. J. Pub. Health 1356 (2016).

accepts Petitioners' arguments and allows for exemptions to antidiscrimination laws, it would change the social environment of LGB people for the worse, leading to repeated and acute experiences of being rejected from businesses and to expectations of such rejection and discrimination in LGB people's daily interactions within the public marketplace.

Finally, we are compelled to address the Regnerus Brief's false claim that "politics have crowded out sound scientific methodology" in research on minority stress. (Br. 21.). The studies we rely on herein—and many others in this body of research that we do not have room to cite—meet established standards for scientific rigor, as evidenced by their publication in demanding peer-reviewed journals. Furthermore, the Regnerus Brief's assertion about politics is incredible given that a federal court has already found that Mark Regnerus himself conducted results-oriented research in order to "oblige" a politically-driven funder. *DeBoer v. Snyder,* 973 F. Supp. 2d 757, 766 (E.D. Mich.), *rev'd*, 772 F.3d 388 (6th Cir. 2014), *rev'd sub nom.*, *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015).[70]

In the end, the Regnerus Brief does not successfully dispute that a stigmatizing social

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[70] Indeed, the court concluded that Regnerus's testimony was "entirely unbelievable and not worthy of serious consideration." *DeBoer*, 973 F. Supp. 2d at 766. The court also concluded that Regnerus had "fringe viewpoints," *id.* at 768, which is underscored by the fact that Regnerus's own academic colleagues at his university took the extraordinary step of publicly distancing themselves from his findings. *Id.* at 766; UT Austin College of Liberal Arts, *Statement Regarding Sociology Professor Mark Regnerus* (2014), https://liberalarts.utexas.edu/public-affairs/news/7531.

environment damages the health of LGB people by bringing about life events and other conditions that are stressful. It is an environment that demands vigilance of its LGB citizens as they watch to protect themselves from potential discrimination and violence. It is an environment where, in an attempt to protect themselves from the stress of anti-LGB stigma, LGB people are moved to conceal their sexual identity. And it is an environment where stigma and stereotypes are internalized by both heterosexual and LGB people. Each of these stressors causes serious injury in the form of psychological distress, physical and mental health problems, suicide, and lowered sense of well-being. These stressors also negatively impact same-sex couples' relationship quality and stability.

## IV. CONCLUSION

The minority stress literature converges on one conclusion: that when a place of public accommodation refuses to serve, or provides lesser services to, LGB people because of their sexual orientation, that experience can have powerful tangible and symbolic effects on LGB people, which adversely impact their health and well-being. Because of the power of law, if this Court countenances such discrimination, our Constitution will be a source of stigma rather than dignity for LGB people. For the foregoing reasons, the Court should affirm.

Respectfully submitted,

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# APPENDIX

## APPENDIX:
## LIST OF *AMICI* SCHOLARS

1. **Ilan H. Meyer**, Ph.D., is Distinguished Senior Scholar for Public Policy at the Williams Institute, UCLA School of Law, and Professor Emeritus of Sociomedical Sciences at Columbia University. Dr. Meyer studies public health issues related to minority health, including stress and illness in minority populations, in particular, the relationship of minority status, minority identity, prejudice and discrimination and health outcomes in sexual minorities and the intersection of minority stressors related to sexual orientation, race/ethnicity, and gender. In several highly cited papers, Dr. Meyer has developed a model of minority stress that describes the relationship of social stressors and adverse health outcomes and helps to explain LGBT health disparities. The model has guided his and other investigators' population research on lesbian, gay, bisexual, and transgender health disparities by identifying the mechanisms by which social stressors impact health and by describing the harm to LGBT people from prejudice and stigma. For this work, Dr. Meyer received the Outstanding Achievement Award from the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns of the American Psychological Association (APA) and Distinguished Scientific Contribution award from the APA's Division 44. Dr. Meyer has served as an expert in several court cases and hearings, including *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921 (N.D. Cal. 2010); United States Commission on Civil Rights briefing on peer-to-peer violence and bullying in K-12 public schools (2011); *Garden State Equality v. Doe* (N.J. Sup. Ct. 2013);

*Bayev v. Russia* (European Court of Human Rights 2014); and *Sexual Minorities Uganda v. Scott Lively* (D. Mass. 2016). Dr. Meyer has been a principal investigator for over 20 research projects and is currently the principal investigator of two important National Institutes of Health funded studies, the *Generations Study*, a study of stress, identity, health, and health care utilization across three cohorts of lesbians, gay men, and bisexuals; and the TransPoP study, the first national probability sample of transgender individuals, both in the United States.

2. **M. V. Lee Badgett**, Ph.D., is a Professor of Economics at the University of Massachusetts Amherst and a Williams Distinguished Scholar at the Williams Institute, UCLA School of Law. Her current research focuses on poverty in the LGBT community, employment discrimination against LGBT people in the U.S., and the cost of homophobia and transphobia in global economies. Dr. Badgett's latest book is *The Public Professor: How to Use Your Research to Change the World*. Her book, *When Gay People Get Married: What Happens When Societies Legalize Same-Sex Marriage*, analyzes the positive U.S. and European experiences with marriage equality for gay couples. Her first book, *Money, Myths, and Change: The Economic Lives of Lesbians and Gay Men*, presented her groundbreaking work debunking the myth of gay affluence. Dr. Badgett's work includes testifying as an expert witness in legislative matters and litigation (including as an expert witness in California's Prop 8 case), consulting with development agencies (World Bank and UNDP), analyzing public policies, consulting with regulatory

bodies, briefing policymakers, writing op-ed pieces, speaking with journalists, and advising businesses.

3. **Juan Battle**, Ph.D., is a Professor of Sociology, Public Health, & Urban Education and the Coordinator of the Africana Studies Certificate Program at the Graduate Center of the City University of New York (CUNY). His research focuses on race, sexuality, and social justice. Dr. Battle has over 75 grants and publications, including books, book chapters, academic articles, and encyclopedia entries. In addition to having delivered lectures at a multitude of academic institutions, community-based organizations, and funding agencies throughout the world, Dr. Battle's scholarship has included work throughout North America, South America, Africa, Asia, and Europe. Among his current projects, he is heading the Social Justice Sexuality initiative—a project exploring the lived experiences of Black, Latina/o, and Asian lesbian, gay, bisexual, and transgender (LGBT) people in the United States and Puerto Rico. He is also heading a project examining LGBT poverty in New York City. Dr. Battle is a Fulbright Senior Specialist and was the Fulbright Distinguished Chair of Gender Studies at the University of Klagenfurt, Austria and was an Affiliate Faculty of the Institute for Gender and Development Studies (IGDS), The University of the West Indies, St. Augustine, Trinidad and Tobago.

4. **Stuart Biegel**, J.D., has been a longtime member of the faculty at both the UCLA School of Law and the UCLA Graduate School of Education and Information Studies. He has served as Director of Teacher Education at UCLA, Special Counsel for the California Department of Education, and the Consent

Decree Monitor for the federal court in the San Francisco school desegregation case. Professor Biegel is the original author of the West casebook *Education and the Law* (4th ed. 2016), which focuses on both K-12 and higher education communities, and also includes major coverage of technology issues, privacy law issues, and disability rights. Among many other publications, his scholarship includes *The Right to Be Out: Sexual Orientation and Gender Identity in America's Public Schools* (University of Minnesota Press, 2d ed. forthcoming 2018) and *Unfinished Business: The Employment Non-Discrimination Act (ENDA) and the K-12 Education Community,* 14 *NYU Journal of Legislation & Public Policy* 357 (2011). He has also consulted with the National Education Association and the U.S. Commission on Civil Rights on issues relating to marginalized and disenfranchised youth.

5. **Susan D. Cochran**, Ph.D, M.S., is a Professor of Epidemiology at the UCLA Fielding School of Public Health and a Professor of Statistics, UCLA. Her research focuses on the mechanisms by which social adversity affects health. She has received numerous awards for her research and professional activities including the prestigious 2001 Award for Distinguished Contributions to Research in Public Policy from the American Psychological Association. In 2010, she was a member of the APA Presidential Task Force on "Reducing and preventing discrimination against and enhancing benefits of inclusion of people whose social identities are marginalized in society." Using funding from the National Institute on Drug Abuse, she conducted three large-scale population-based studies of mental

health and substance use concerns among lesbian, gay, and bisexual individuals in California. She is also a member of the World Health Organization ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health. She has served as *Amicus curiae* (*Baehr v. Lewin*, Circuit Court, State of Hawaii, October, 1996; *Baehr v. Lewin*, Appeals Court, State of Hawaii, July, 1997) and provided expert testimony (*Howard v. Arkansas Department of Human Services*, 2004; *Doe v. Doe, Miami-Dade County*, 2008; and *Cole v. Arkansas*, 2010) for LGB-related matters.

6. **Kerith Conron**, Sc.D., M.P.H., is the Blachford-Cooper Distinguished Scholar and Research Director at the Williams Institute, UCLA School of Law. Dr. Conron earned her doctorate from the Harvard School of Public Health and MPH from the Boston University School of Public Health. She is a social and psychiatric epidemiologist whose work focuses on documenting and reducing health inequities that impact sexual and gender minority populations. Dr. Conron is committed to altering the landscape of adversity and opportunity for the most marginalized lesbian, gay, bisexual, and transgender (LGBT) communities through collaborative activities that impact the social determinants of health. She has been supported by the National Institutes of Health to conduct community-based participatory research with LGBT youth of color and to train scholars in LGBT population health research. Dr. Conron has been active in LGBT health for over 15 years, serving on the first Steering Committee of the National Coalition for LGBT Health and as the first coordinator of the Office of LGBT Health for the City

of Boston. Her current research focuses on socioeconomic status and strategies to reduce poverty and to promote health. Her publications appear in the American Journal of Public Health, Archives of Pediatrics and Adolescent Medicine, and Psychological Medicine. Her expertise and commentary have been featured by major media outlets including the New York Times, the Associated Press, and National Public Radio.

7. **Brian de Vries**, Ph.D., is a (retired) professor of Gerontology at San Francisco State University, with adjunct appointments at both Simon Fraser University (in Vancouver) and the University of Alberta (in Edmonton). Dr. de Vries has been instrumental in guiding his professional associations through his role as fellow of the Gerontological Society of America (GSA), past Board member of the American Society on Aging (ASA), and former co-Chair of the LGBT Aging Issues Network constituent group. Similarly, Dr. de Vries was appointed to the Institute of Medicine's Board on the Health of Select Populations Committee which authored the influential book: *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*. Dr. de Vries has co-edited several professional journals and acclaimed academic books as well as authored or co-authored approximately 100 journal articles and book chapters, and has given over 150 presentations to local, national, and international professional audiences on the social and psychological well-being of midlife and older LGBT persons, among other topics.

8. **Brian Dodge**, Ph.D., is an Associate Professor in the Department of Applied Health Science and Associate Director of the Center for Sexual Health Promotion at the Indiana University School of Public Health-Bloomington. A nationally recognized expert on bisexual health, he is a co-director of the Bisexual Research Collaborative on Health (BiRCH), a partnership of Indiana University, University of Illinois at Chicago, and The Fenway Institute. His research focuses on understanding social and behavioral aspects of sexual health and other aspects of well-being among a variety of understudied and underserved sexual minority communities, with a specific emphasis on the impact of stigma and minority stress on health among bisexual individuals. His work includes some of the first National Institutes of Health-funded studies on health among bisexual men and women, relative to their exclusively heterosexual and homosexual counterparts. He also collaborates on assessments of health among probability samples of sexual minority individuals in the U.S., including as a co-investigator of the ongoing nationally representative National Survey of Sexual Health & Behavior. Dr. Dodge has provided expert legal consultation on bisexuality-related cases for the Maricopa County, Phoenix, Arizona Public Defenders' Office and the U.S. Military.

9. **Jessica N. Fish**, Ph.D., is a Postdoctoral Research Fellow at the University of Texas at Austin Population Research Center and Visiting Assistant Professor in the Department of Family Science at the University of Maryland School of Public Health. Dr. Fish studies the sociocultural factors that shape the

development and health of sexual minorities. Her area of research, in particular, focuses on how prejudice and discrimination influence the prevalence and developmental patterns of substance use and mental health among sexual minority youth and adults. Among other findings, her research demonstrates the deleterious effects of discrimination on sexual minority health across the life course.

10. **Andrew R. Flores**, Ph.D., is Assistant Professor of Political Science in the Public Policy & Political Science Department at the Lorry I. Lokey Graduate School of Business and Public Policy at Mills College and a Visiting Scholar at the Williams Institute, UCLA School of Law. Dr. Flores studies attitude formation and change about marginalized groups, particularly lesbian, gay, bisexual, and transgender people (LGBT); the political behavior of LGBT people with a central focus on the role of linked fate in LGBTQ politics, and research on the demography of LGBT people; and the experiences of LGBT people while incarcerated. Dr. Flores has also analyzed the effects of social attitudes about LGBT populations on the physical and mental health of LGBT populations. Dr. Flores's research has appeared in or are forthcoming in the *American Journal of Public Health*, *Political Psychology*, *Public Opinion Quarterly*; the *Journal of Social Issues*, *Political Research Quarterly*; *Politics, Groups, and Identities*; the *Journal of Youth and Adolescence*; *Aggression and Violent Behavior*; the *International Journal of Public Opinion Research*; *Research and Politics*, *Transgender Studies Quarterly;* and the *Indiana Journal of Law and Social Equality*.

11. **David M. Frost**, Ph.D., is a Senior Lecturer (Associate Professor) in Social Psychology in the Department of Social Science at University College London. His research focuses on close relationships, stress, stigma, and health. His primary line of research examines on how stigma, prejudice, and discrimination constitute minority stress and, as a result, affect the health and well-being of marginalized individuals. He also studies how couples psychologically experience intimacy within long-term romantic relationships and how their experience of intimacy affects their health. These two lines of research combine within recent projects examining same-sex couples' experiences of stigmatization and its resulting impact on their relational, sexual, and mental health. His research has been published in several top tier social science, public health, and policy journals and has been recognized by grants and awards from the U.S. National Institutes of Health, the Society for the Psychological Study of Social Issues, and the New York Academy of Sciences.

12. **Nanette Gartrell**, M.D., is a Visiting Distinguished Scholar at the Williams Institute, UCLA School of Law. She has a Guest Appointment at the University of Amsterdam, and she was formerly on the faculties of Harvard Medical School and UCSF. Dr. Gartrell is a psychiatrist, researcher, and writer whose 48 years of scientific investigations have focused primarily on sexual minority parent families. Dr. Gartrell is the principal investigator of the U.S. National Longitudinal Lesbian Family Study, now in its 31st year. Her research has been cited internationally in litigation and legislation

concerning equality in marriage, foster care, and adoption, and it contributed to the American Academy of Pediatrics' 2013 endorsement of marriage equality. "The U.S. National Longitudinal Lesbian Family Study: Psychological Adjustment of the 17-year-old Adolescents," published in *Pediatrics,* was cited by *Discover Magazine* as one of the top 100 science stories of 2010.

13. **Jeremy Goldbach**, Ph.D., is an Assistant Professor at the University of Southern California Suzanne Dworak-Peck School of Social Work. Dr. Goldbach joined the faculty in 2012 after completing both his master's and doctoral degrees in social work at the University of Texas at Austin. His research is broadly focused on the relationship between social stigma, minority stress, and health among lesbian, gay, bisexual and transgender (LGBT) youth and adults. He has conducted studies in psychometric measurement development and is currently leading one of the first studies to examine how discrimination during adolescence may impact healthy development.

14. **Abbie E. Goldberg**, Ph.D., is an Associate Professor in the Department of Psychology at Clark University in Worcester, Massachusetts. She received her Ph.D. in clinical psychology from the University of Massachusetts Amherst. Her research examines diverse families, including lesbian- and gay-parent families and adoptive-parent families. A particular focus of her research is key life transitions (e.g., the transition to parenthood, the transition to kindergarten, and the transition to divorce) for same-sex couples. She has also studied the experiences of transgender college students, families formed through reproductive technologies, and bisexual

mothers partnered with men. She is the author of over 90 peer-reviewed articles and two books: Gay Dads (NYU Press) and Lesbian- and Gay-Parent Families (APA). She is the co-editor of LGBT-Parent Families: Innovations in Research and Implications for Practice (Springer) and the editor of the Encyclopedia of LGBTQ Studies (Sage). She has received research funding from the American Psychological Association, the Alfred P. Sloan Foundation, the Williams Institute, the Gay and Lesbian Medical Association, the Society for the Psychological Study of Social Issues, the National Institutes of Health, and the Spencer Foundation.

15. **Suzanne B. Goldberg**, J.D., is the Herbert and Doris Wechsler Clinical Professor of Law and founding director of the Sexuality and Gender Law Clinic at Columbia Law School. She also co-directs the Law School's Center for Gender & Sexuality Law. Professor Goldberg has written extensively about discrimination against lesbians, gay men, bisexuals and transgender people and has worked for nearly three decades on efforts to redress this discrimination.

16. **Gary J. Gates**, Ph.D., is a recognized expert on the geography and demography of the lesbian, gay, bisexual, and transgender (LGBT) population. Justice Anthony Kennedy cited his friend-of-the-court brief in his majority opinion in *Obergefell v. Hodges* (2015), holding that same-sex couples have a constitutional right to marriage. Dr. Gates holds a PhD in Public Policy and Management from the Heinz College, Carnegie Mellon University, a Master of Divinity degree from St. Vincent Seminary, and a Bachelor of Science degree in

Computer Science from the University of Pittsburgh at Johnstown. He is co-author of *The Gay and Lesbian Atlas* and publishes extensively on the demographic and economic characteristics of the LGBT population. National and international media outlets regularly feature his work. Dr. Gates is retired as a Distinguished Scholar and Research Director at the Williams Institute, UCLA School of Law. He has also held positions as a Senior Researcher at Gallup, a Research Associate at the Urban Institute in Washington, DC and Director of the AIDS Intervention Project in Altoona, PA.

17. **John C. Gonsiorek**, Ph.D., holds a Diplomate in Clinical Psychology from the American Board of Professional Psychology. He is past president of American Psychological Association Division 44, and has published widely on sexual orientation and identity. He is a fellow of APA Divisions 9, 12, 29, 36, and 44. Until August 2012, he was Professor in the PsyD Program at Argosy University/Twin Cities; and has taught at a number of other institutions. For over 25 years, he had an independent practice of clinical and forensic psychology in Minneapolis, and provided expert witness evaluation and testimony on a number of areas, including sexual orientation. Expert witness testimony regarding sexual orientation has included helping prepare *amicus curiae* briefs for the American Psychological Association; testimony in major cases includes: *Evans et al, v. Romer et al.*, *Equality Foundation et al. v. Cincinnati*, and *Nabozny v. Podlezny et al.* He has been a consulting editor for *Professional Psychology: Research & Practice,* and currently serves as Founding Editor for

*Psychology of Sexual Orientation and Gender Diversity*. His major publications include: Homosexuality: Research implications for public policy, and Homosexuality and psychotherapy: A practitioner's handbook of affirmative models.

18. **Perry N. Halkitis**, Ph.D., M.S., M.P.H., is dean of the Rutgers School of Public Health at Rutgers University–New Brunswick. Previously, he was professor of global public health, applied psychology, and medicine at NYU, where he has focused a significant amount of his research on HIV/AIDS, drug abuse, and mental health disease and how they are impacted by psychiatric and psychosocial factors. Dr. Halkitis also served as senior associate dean of the New York University (NYU) College of Global Public Health; director of NYU's Center for Health, Identity, and Behavior and Prevention Studies; and interim chair of the Department of Biostatistics at the College of Global Public Health. As senior associate dean for academic and faculty affairs at the NYU College of Global Public Health, Dr. Halkitis managed the academic portfolio of the college and administers the curriculum; directed faculty appointments and hiring; and participated in the college's and university's fund-raising efforts. He was NYU's inaugural associate dean for research and doctoral studies from 2005 to 2013 and earlier chaired the NYU Department of Applied Psychology.

19. **Gary W. Harper**, Ph.D., M.P.H., is a Professor of Health Behavior and Health Education, Professor of Global Public Health, and Director of the Office of Undergraduate Education at the School of Public Health at the University of Michigan. Dr.

Harper has conducted extensive research for more than 20 years with sexual minority youth/young adults, and has authored more than 130 publications in peer-reviewed academic journals. His research and community work have focused on the health and well-being of sexual minority youth and young adults, especially gay/bisexual male youth of color. This work includes the development of evidence-based interventions aimed at improving the health and well-being of sexual minority youth and young adults who experience discrimination, prejudice, and stigma. Dr. Harper's health promotion interventions for sexual minority youth are being utilized by community organizations and health centers in various states across the U.S., as well as in Kenya. Dr. Harper has testified as an expert witness in the City and County of San Francisco, California, and was appointed by the 2008 U.S. Secretary of Health and Human Services (under the George W. Bush administration) to serve on the Department of Health and Human Service's Office on AIDS Research Advisory Council.

20. **Amira Hasenbush**, J.D., M.P.H., is the Jim Kepner Law and Policy Fellow at the Williams Institute, UCLA School of Law. She researches discrimination based on sexual orientation and gender identity, family law issues for LGBT parents and children, and the legal needs of people living with HIV. She has completed empirical research on the existence and impact of public accommodations laws at the state and local level.

21. **Mark L. Hatzenbuehler**, Ph.D., is Associate Professor of Sociomedical Sciences and Sociology at Columbia University's Mailman School

of Public Health. Dr. Hatzenbuehler's research examines how structural forms of stigma—including social policies and community-level norms—increase risk for adverse health outcomes among members of stigmatized populations, with a particular focus on lesbian, gay, and bisexual individuals. He also developed a widely cited theoretical model that identifies psychosocial mechanisms linking stigma-related stressors to the development of psychopathology. Dr. Hatzenbuehler has published over 100 peer-reviewed articles and book chapters, and his work has been published in several leading journals, including *American Psychologist, Psychological Bulletin, American Journal of Public Health,* and *JAMA Pediatrics*. In recognition of this work on stigma and health inequalities, Dr. Hatzenbuehler received the 2015 Louise Kidder Early Career Award from the Society for the Psychological Study of Social Issues, the 2016 Early Career Award for Distinguished Contributions to Psychology in the Public Interest from the American Psychological Association, and the 2016 Janet Taylor Spence Award for Transformational Early Career Contributions from the Association for Psychological Science.

22. **Jody L. Herman**, Ph.D., is Scholar of Public Policy at the Williams Institute, UCLA School of Law. Dr. Herman has worked on issues of poverty, women's rights, and anti-discrimination policy development with non-profit research, advocacy, and direct-service organizations in the United States and Mexico. Before joining the Williams Institute, she worked as a research consultant on issues of voting rights in low-income minority communities and gender identity discrimination. She served as a co-

author on the groundbreaking report Injustice at Every Turn, based on the National Transgender Discrimination Survey conducted by the National Gay and Lesbian Task Force and the National Center for Transgender Equality. At the Williams Institute, her work has included research on the fiscal and economic impact of marriage for same-sex couples, the fiscal impact of employment discrimination against people who are transgender, and the development of trans-inclusive questions for population-based surveys. Her main research interests are the impact of gender identity-based discrimination and issues related to gender regulation in public space and the built environment.

23. **Ning Hsieh**, Ph.D., is an assistant professor of sociology at Michigan State University. Dr. Hsieh studies disparities in health outcomes and health care access by sexual orientation. Her research focuses on how sexual minorities' experiences of marginalization, prejudice, and discrimination contribute to their lower access to social, economic, and other coping resources, which eventually leads to poorer mental and physical health. Her recent publications reveal the heterogeneity in health risks among sexual minorities, suggesting that sexual minorities of color and bisexual individuals are particularly disadvantaged in health and healthcare experience.

24. **Laura T. Kessler**, J.D., J.S.D., is a Professor of Law at the University of Utah, S.J. Quinney School of Law. Dr. Kessler studies discrimination and families. Her expertise includes the harms of discrimination with regard to marriage, parentage, child custody, and family leave for LGB

individuals. Professor Kessler has developed a theory of equal citizenship for LGB individuals rooted in their intimate relationships. Her papers document the long and continuing history of disapproval of LGB relationships; how this denial serves to disrespect and subordinate gays and lesbians; and the consequent emotional, political, and expressive significance for LGB individuals of legal recognition of their intimate relationships. Her research is widely cited and recognized as providing rigorous, comprehensive, interdisciplinary analyses of the stubborn problem of discrimination against minority families, including LGB families. She was co-author of Brief of Amici Curiae Family Law Professors in Support of Plaintiffs-Appellees and Affirmance, filed in *Kitchen v. Herbert*, 755 F.3d 1193 (10th Cir. 2014), addressing, among other issues, the harm of the state of Utah's marriage ban to the well-being of different-sex couples and their children.

25. **Suzanne A. Kim**, J.D., is Professor of Law at Rutgers Law School at Rutgers University in Newark. Her research interests include the socio-legal regulation of intimacy; discrimination; intersections of family law with gender, sexuality, culture, and race; critical legal theory; law and social science; and vulnerability and resilience, including as concerning minority stress. Professor Kim has served as Associate Dean for Faculty Development at Rutgers Law. A recipient of the Dream Professor Award from the Association of Black Law Students at Rutgers Law, Professor Kim has been a visiting scholar at Emory University's interdisciplinary Vulnerability and the Human Condition Initiative and Columbia Law School's Center for Gender and

Sexuality Law and has also taught at Fordham Law School. Professor Kim also serves on the Executive Committee of the Institute for Research on Women at Rutgers University.

26. **Nancy J. Knauer**, J.D., is a Professor of Law and Director of the Law & Public Policy Program at Temple University, Beasley School of Law. For the past twenty-five years, Professor Knauer has explored the impact of federal policies on the lives of LGBT people. She is the author of Gay and Lesbian Elders: History, Law and Identity Politics in the US and more than forty academic articles, books, and book chapters. Her most recent scholarship focuses on the challenges faced by LGBT older adults, including health disparities and issues related to minority stress. Professor Knauer has received a Dukeminier Award and the Stu Walter Prize from the Williams Institute for her scholarship on LGBT aging issues. She is the co-founder of the Aging, Law & Society Collaborative Research Network of the Law & Society Association and served on the Executive Committee of the Family Law Institute of the National LGBT Bar Association. Professor Knauer was selected as one of 26 law professors from across the nation to be featured in the book What the Best Law Teachers Do, published by Harvard University Press in 2013.

27. **David J. Lick**, Ph.D., is User Experience Researcher at Facebook. Dr. Lick received his doctorate in Psychology from the University of California, Los Angeles. His research examines a number of issues related to sexual orientation, ranging from the psychological factors that contribute to prejudice against LGBT people to the downstream

health consequences of such prejudice. He recently collaborated on a scientific review that synthesized the growing body of research linking sexual minorities' experiences with prejudice to physical health disparities. He and his colleagues outlined the psychological, physiological, and behavioral pathways through which prejudice could hinder overall health for LGBT people. Dr. Lick has received numerous honors and awards for his work, including funding from the National Science Foundation, American Psychological Association, American Psychological Foundation, and Society for the Psychological Study of Social Issues.

28. **Marguerita Lightfoot**, Ph.D., is Professor of Medicine at the University of California, San Francisco School of Medicine. She is Chief for the Division of Prevention Science, Director of the Center for AIDS Prevention Studies (CAPS), Director of the UCSF Prevention Research Center and she holds the Walter Gray Endowed Chair. As a counseling psychologist, her research focus has been on improving the health and well-being of adolescents and young adults as well as the development of efficacious interventions to reduce health disparities among those populations disproportionately burdened by HIV and poorer mental and physical health outcomes. Her domestic and international research has included developing culturally appropriate interventions for runaway/homeless youth, juvenile justice involved adolescents, youth in medical clinics and settings, youth with a parent living with HIV, youth living with HIV, and LGBT youth, among others. She also studies the factors and approaches that strengthen resilience and mitigate the societal

impacts of stressors among these vulnerable populations of youth.

29. **Christy Mallory**, J.D., is the Director of State & Local Policy at the Williams Institute, UCLA School of Law. She studies the prevalence and impact of discrimination against LGBT people and same-sex couples in areas such as employment, housing, public accommodations, and education. Her work has been published in various journals and books, including *When Mandates Work* (UC Press, 2013), the *Loyola of Los Angeles Law Review*, the *LGBTQ Policy Journal at the Harvard Kennedy School*, and the *Albany Government Law Review*.

30. **Michael P. Marshal**, Ph.D., is an Associate Professor of Psychiatry at the University of Pittsburgh, and a Licensed Clinical Psychologist. Dr. Marshal is also a Standing Member of the "Health Disparities and Equity Promotion" Study Section within the Center for Scientific Review, at the National Institutes of Health (NIH). His expertise includes the investigation of mental health disparities among lesbian, gay, and bisexual (LGB) adolescents, particularly adolescents under the age of 18 years old. Dr. Marshal's program of research has been supported by multiple NIH-funded grants. His peer-reviewed publications have provided strong scientific evidence for the following: (1) On average, compared with heterosexual adolescents, LGB adolescents report higher rates of substance use, depressive symptoms, suicidality, and violent victimization experiences; (2) Mental health disparities among LGBT adolescents persist as they transition into young adulthood; and (3) Consistent with Dr. Ilan Meyer's Minority Stress Model, gay-

related victimization experiences are strongly associated with these disparities.

31. **Miguel Muñoz-Laboy**, Dr.P.H., is an Associate Professor of Social Work at Temple University's College of Public Health. Dr. Muñoz-Laboy conducts studies on: 1) social and cultural factors that impact access to HIV/sexually transmitted infections, mental health, and/or substance abuse treatments in Latino communities in the United States; 2) the roles of acculturative stress and minority stress in the health and well-being for bisexual populations; and 3) linkage and retention in HIV among Latinos(as) with severe opioids use disorder. Drawing on Dr. Ilan Meyer's minority stress model, Muñoz-Laboy published research has documented how sexual minority stress increased the severity of anxiety and depressive symptoms among Latino bisexual men. To support his research program, he has received nine grants by the U.S. National Institutes of Health and private foundations as the Principal Investigator (PI) or co-Principal Investigator (co-PI) and has served as co-Investigator in 11 additional grants. Dr. Muñoz-Laboy has published over 70 articles in peer-reviewed journals, authored 10 chapters in edited books, and co-edited two books.

32. **John Pachankis**, Ph.D., is an Associate Professor of Public Health at Yale University. Dr. Pachankis studies the mental health of sexual and gender minority individuals. He developed a highly-cited model of stigma concealment, which has been used to understand the reasons that people conceal stigmatized identities and the psychological costs of doing so. He also studies the psychological impact of

stigma and discrimination on sexual and gender minority mental health over the lifespan. Drawing on his background as a clinical psychologist, he has translated this research into some of the first evidence-based mental health treatments for LGBT individuals. He has tested the delivery of these treatments via novel technologies (e.g., smartphones), in diverse settings (e.g., Eastern Europe), and with diverse segments of the LGBT community (e.g., rural youth). He is the recipient of the 2017 Distinguished Contributions to Knowledge award of the American Psychological Association's Division 44.

33. **Charlotte J. Patterson**, Ph.D., is a professor of Psychology at the University of Virginia. She is best known for her research on the role of sexual orientation in human development and family lives—specifically for her work on child development in lesbian- and gay-parented families. Patterson's research has been published in the field's top journals and she has co-edited four books on the psychology of sexual orientation. Patterson is a Fellow of the American Psychological Association (APA) and of the Association for Psychological Science (APS) and a past president of the Society for Psychological Study of Lesbian, Gay, and Bisexual Issues. She has won a number of awards, including APA's Distinguished Contributions to Research in Public Policy Award. She also served as a member of the United States Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues, whose 2011 report on LGBT health disparities was instrumental in leading the National Institutes of Health to reorganize research and increase funding for studies in this area.

34. **John L. Peterson**, Ph.D., is emeritus professor of psychology at Georgia State University. Prior to his faculty position at Georgia State, he was on the faculty at the University of California, San Francisco, in the Department of Medicine. Dr. Peterson studies the effects of sexual prejudice and violence toward sexual minorities and psychological issues related to the HIV/AIDS prevention among nonwhite gay and bisexual men. His work has been well cited regarding the interactive effects of sexual prejudice, masculine ideology, and violence toward sexual minorities and the sociocultural and psychological factors associated with HIV risk behavior and the social determinants of racial disparity in HIV infection. Dr. Peterson served on the Institute of Medicine (IOM) Committee on Lesbian, Gay, Bisexual & Transgender Health Issues and Research Gaps at the National Academies.

35. **Nancy Polikoff**, J.D., is Professor of Law at American University Washington College of Law where she teaches Family Law and a seminar on Children of LGBT Parents. She was previously the Visiting McDonald/Wright Chair of Law at UCLA School of Law and Faculty Chair of the Williams Institute. For more than 40 years, she has been writing about, teaching about, and working on litigation and legislation about LGBT families. Among her many publications is the book *Beyond (Straight and Gay) Marriage: Valuing All Families under the Law* (2008). Professor Polikoff was instrumental in the development of the legal theories that support second-parent adoption and custody and visitation rights for legally unrecognized parents. She was successful counsel in *In re M.M.D.*, which

established joint adoption for lesbian, gay, and unmarried couples in DC, and *Boswell v. Boswell*, a Maryland case that overturned restrictions on a gay noncustodial father's visitation rights. From 2007-2009, she played a primary role in the drafting and passage of groundbreaking parentage legislation in DC. She is a former chair of the Association of American Law Schools Section on Sexual Orientation and Gender Identity Issues. In 2011, Professor Polikoff received the Dan Bradley award from the National LGBT Bar Association, the organization's highest honor.

36. **Ellen D.B. Riggle**, Ph.D., is Professor of Political Science and Gender and Women's Studies at the University of Kentucky. Dr. Riggle studies the impact of stigma and identity strengths on the health and well-being of LGBT people and same-sex couples. Her areas of research include the effects of minority stress on LGBT individuals and same-sex couples, how laws and policies affect LGBT individuals' reports of distress and well-being, and the role of positive LGBT identity factors in well-being and resilience. Dr. Riggle is the co-author of A Positive View of LGBTQ: Embracing Identity and Cultivating Well-Being, winner of the 2012 American Psychological Association Division 44 Distinguished Book Award, and Happy Together: Thriving as a Same-Sex Couple in Your Family, Workplace, and Community (published by the American Psychological Association LifeTools series).

37. **Sharon Scales Rostosky**, Ph.D., is Professor and Director of Training in the Counseling Psychology program at the University of Kentucky. She is also a licensed psychologist. Dr. Rostosky uses

qualitative and quantitative methodologies to document the negative psychosocial impacts of prejudice and discrimination against LGB individuals and same-sex relationships that is sourced at all levels of the ecological system (intrapersonal, interpersonal, and socio-cultural). Her research on same-sex couple relationships was first funded by the American Psychological Foundation in 2000 and most recently by NIH in 2017. In addition to over 70 peer-reviewed articles, Dr. Rostosky has co-authored two books based on her research findings: *A Positive View of LGBTQ: Embracing Identity and Cultivating Well-Being* (Riggle & Rostosky, 2012, Rowman & Littlefield; American Psychological Association Division 44 Distinguished Book Award for 2012.), and *Happy Together: Thriving as a Same-Sex Couple in Your Family, Workplace, and Community* (Rostosky & Riggle, 2015, American Psychological Association).

38. **Esther D. Rothblum**, Ph.D., is Professor of Women's Studies at San Diego State University and Visiting Distinguished Scholar at the Williams Institute at UCLA School of Law. She is editor of the Journal of Lesbian Studies, a former president of Division 44 (Society for the Psychological Study of LGBT Issues) of the American Psychological Association, and a Fellow of seven divisions of APA. Her research and writing have focused on LGBT relationships and mental health, focusing on using heterosexual and cisgender siblings as a comparison group. Since 2001 Dr. Rothblum has compared same-sex couples in legal relationships with their heterosexual married siblings. She has edited 27 books and has over 130 publications in academic journals and books.

39. **Jocelyn Samuels**, J.D., is the Executive Director of the Williams Institute with close to three decades of experience in interpretation and enforcement of federal civil rights laws. She has served in numerous roles in the federal government, including as Acting Assistant Attorney General for the Civil Rights Division at the U.S. Department of Justice, and Director of the Office of Civil Rights at the U.S. Department of Health and Human Services. She has deep expertise in issues related to LGBT law and policy, including with respect to barriers that continue to limit access for the LGBT community to services and benefits and the application of existing laws to discrimination based on sexual orientation and gender identity.

40. **R. Bradley Sears**, J.D., is the David Sanders Distinguished Scholar of Law and Policy at the Williams Institute and Associate Dean of Public Interest Law at UCLA School of Law. Over the past two decades, Sears has published a number of research studies and articles, primarily on discrimination against LGBT people in the workplace in the private and public sectors, HIV discrimination by health care providers, the economic and fiscal impact of discrimination against same-sex couples, and the economic and fiscal impact of LGBT health disparities at the state-level.

41. **Ari Ezra Waldman**, J.D., Ph.D., is an Associate Professor of Law at New York Law School. He is the Director of the Innovation Center for Law and Technology and the Founder and Director of the Institute for CyberSafety, a full service academic and direct outreach program that includes, among other things, the first and, to-date, only law school clinic

representing LGBTQ victims of online harassment. Professor Waldman's research focuses, in relevant part, on the frequency and effects of bullying and cyberbullying on marginalized populations; the impact face-to-face and online harassment have on queer youth and adolescent success and health; and how federal, state, and local laws and policies can reduce cybervictimization and improve the lives of members of the LGBTQ community. His work has been published in leading law reviews and his forthcoming work explores nonconsensual image sharing among gay men and the effect of mobile apps on queer social life. He is an internationally sought-after speaker and commentator on privacy and cyberharassment.

42. **Bianca D.M. Wilson**, Ph.D., is a Senior Scholar of Public Policy at the Williams Institute, UCLA School of Law, and affiliated faculty with the UCLA California Center for Population Research. She earned a Ph.D. in Psychology from the Community and Prevention Research program at the University of Illinois at Chicago (UIC) with a minor in Statistics, Methods, and Measurement, and received postdoctoral training at the UCSF Institute for Health Policy Studies and the UCSF Lesbian Health and Research Center through an Agency for Health Research and Quality (AHRQ) postdoctoral fellowship. Her research focuses on the relationships between culture, oppression, and health, with an emphasis on racial and sexual and gender minorities. Her most current work focuses on LGBT economic instabilities and population research among foster youth, homeless youth, and youth in juvenile custody,

with a focus on sampling, data collection, and assessing disproportionality in these systems.

43. **Richard G. Wight**, Ph.D., M.P.H., is a retired Researcher from the Department of Community Health Sciences at the UCLA School of Public Health. For more than two decades, he conducted interdisciplinary research on stress and health experiences of individuals vis-à-vis the people and places around them, and his work has been widely published in the U.S. and internationally. His early publications were among the first to address public health and health policy issues relating to informal AIDS caregiving in the United States and he is an expert on the neighborhood context of health. Wight has developed life course studies that examine aging, minority stress, and health processes among the growing population of midlife and older lesbians and gay men, with a particular focus on the health effects of same-sex legal marriage. His recent work examines minority stress and health experiences of the parents of sexual minorities.

*Institutional affiliations for identification purposes only*

# Exhibit 181

HHS-OCR-2018-0002-0001

The Wisconsin Alliance for Women's Health (WAWH) believes a health care provider's personal beliefs should never determine the care a patient receives. WAWH has an interest in ensuring patients have access to health care in Wisconsin, and that widely accepted standards of medical care, not religious beliefs, dictate patient access to care. That is why we strongly oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule"), which seeks to permit discrimination in all aspects of health care.[1]

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

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

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

[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.

Already existing refusal of care laws are used across the country to deny patients the care they need, including existing Wisconsin state law.[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]

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

[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.
[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.

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] In Milwaukee, Wisconsin, a woman who was 18 weeks pregnant went into premature labor and taken to a Catholic hospital.[14] Her medical condition became dangerous, as she was hemorrhaging and was febrile. As her condition worsened, the patient and her family asked her health care providers to speed up the process of terminating her pregnancy, but her providers were unable to do so because the hospital, because of Catholic health dictates, did not stock mifepristone or perform a dilation and evacuation procedures, which is fastest and safest method for terminating a second trimester pregnancy. Because she was denied access to best medical practices, the patient was forced to labor painfully for more than 24 hours and required a blood transfusion, only to deliver a fetus that had no hope of survival.

Similar incidents have occurred in other states. One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[15] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside

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[10] The doctrine of expression unius est exclusion alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[11] *See* Rule *supra* note 1, at 180.
[12] *Id.*
[13] *See, e.g., supra* note 3.
[14] *See* Amy Littlefield, *Catholic Rules Forced This Doctor to Watch Her Patient Sicken—Now, She's Speaking Out*, Rewire (September 7, 2017), https://rewire.news/article/2017/09/07/catholic-rules-forced-doctor-watch-patient-sicken-now-shes-speaking/

[15] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

Chicago, Illinois.[16] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[17] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[18] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[19]

*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.[20] 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.[21] In rural areas there may be no other sources of health and life preserving medical care.[22] In developing countries where many health systems are weak, health care options and supplies are often unavailable.[23] When these individuals encounter refusals of care, they may have nowhere else to go.

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

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, including Wisconsin, women of color are more likely than white women to give birth in Catholic hospitals.[24] 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.[25] 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.[26] 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.[27]

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.[28]

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."[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,

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[24] *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.
[25] *See id.* at 10-13.
[26] 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/.
[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 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/.
[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.

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 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.[33] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive 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 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 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.[38]

**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,

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[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.

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

[38] *See id.*

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.[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.

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.[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 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.[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 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'

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[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.

[43] 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).

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 not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce.[46] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[47] If finalized, however, the Proposed Rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities. Through robust enforcement of civil rights laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities, segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[48]

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[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. §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.

Nevertheless, there is still work to be done, and the Proposed Rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.[49] And these disparities do not occur in isolation. Black women, for example, are three to four times more likely than white women to die during or after childbirth.[50] Further, the disparity in maternal mortality is growing rather than decreasing,[51] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resulting health disparities. For example, women's pain is routinely undertreated and often dismissed.[52] And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[53] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[54] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[55]

OCR must work to address these disparities, yet the Proposed Rule seeks to prioritize the expansion of existing religious refusal laws beyond their statutory requirements and create new religious exemptions where none had previously existed rather than using already limited resources to protect patient access to health care. The Proposed Rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.[56]

**The Proposed Rule Conflicts with Other Existing Federal Law**

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

For example, the Proposed Rule makes no mention of Title VII,[57] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance

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

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

[51] *See id.*

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

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

[54] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf. A survey examining discrimination against LGBTQ people in health care more than half of respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health care status; or health care professionals being physically rough or abusive.

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

[56] *See supra* note 46.

[57] 42 U.S.C. § 2000e-2 (1964).

on Title VII.[58] With respect to religion, Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[59] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The Proposed Rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both. Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[60]

Furthermore, the language in the Proposed Rule would seem to put health care entities in the position of being forced to hire people who intend to refuse to perform essential elements of a position even though Title VII would not require such an "accommodation." For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling even though the employer would not be required to do so under Title VII.[61] It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

In addition, the Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[62] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[63] Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

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

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[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.
[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).

WAWH is committed to ensuring that all patients in Wisconsin 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.[64] Moreover, the Proposed Rule invites states to further expand refusals of care by making clear that this expansive rule is a floor, and not a ceiling, for religious exemption laws.[65]

**Conclusion**

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

Sincerely,

Sara Finger
Executive Director

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

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# Exhibit 182

# WISCONSIN HOSPITAL ASSOCIATION, INC.

March 26, 2018

Alex Azar
Secretary, Department of Health & Human Services
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

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

Dear Mr. Azar:

The Wisconsin Hospital Association ("WHA") is a statewide nonprofit association with a membership of more than 140 Wisconsin hospital and integrated health systems that includes not only critical access hospitals providing crucial services to their rural communities, but also major academic medical centers providing critical care, research, and training. On behalf of our members, WHA appreciates the opportunity to comment on RIN 0945-ZA03, a proposed rule regarding protection of statutory conscience rights in health care issued by the Department of Health and Human Services ("HHS"), Office for Civil Rights ("OCR").

As is explained in more detail below, WHA offers three primary recommendations with respect to this proposed rule:

- As HHS proceeds with this rulemaking to create a more robust enforcement structure for important statutory protections for health care provider decisions based on religious belief or moral conviction, WHA encourages HHS to do so in such a way that aligns with HHS's and WHA's mutual commitment to combatting patient discrimination and expanding health care access for all patients.
- WHA urges HHS not to finalize the proposal to require health care organizations to report the existence of all filed complaints and of all OCR investigations and compliance because, as written, the proposal (1) unfairly would apply even to organizations that have not violated the law and (2) is inconsistent with the Administration's and WHA's shared interest in reducing regulatory burden.
- WHA urges HHS to establish notice, hearing, and appeal procedures that HHS must follow before it can take remedial action (including termination of Medicare and Medicaid funding) against any health care organization found to have violated a federal health care provider conscience protection law.

5510 Research Park Drive P.O. Box 259038 Madison, WI 53725-9038 P (608.274.1820) F (608.274.8554) wha.org

## I. WHA encourages HHS to align its rulemaking with HHS's and WHA's mutual commitment to expanding health care access for all patients, regardless of race, color, national origin, disability, age, or sex.

WHA and its hospital and health system members are strongly committed to expanding access to high-quality health care for all Wisconsin communities, regardless of any patient's race, color, national origin, disability, age, or sex. At the same time, Wisconsin hospitals and health systems likewise are committed to respecting the personal religious beliefs and moral convictions of their employees and other personnel and to fostering respectful and diverse workplaces.

This goal of a health care system free from discrimination obviously is shared by HHS and OCR, which is the federal agency responsible for enforcing federal statutes that prohibit health care organizations that receive certain federal funds from engaging in discrimination. Specifically, OCR is responsible for enforcing statutes that prohibit discrimination against patients in the delivery of health care. *See, e.g.*, Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq.*, 45 C.F.R. pt. 80; § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 701 *et seq.*, 45 C.F.R. pt. 84; Age Discrimination Act of 1975, 42 U.S.C. § 6101 *et seq.*, 45 C.F.R. pts. 90 & 91; Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116, 45 C.F.R. pts. 92. In addition, OCR is responsible for enforcing what it calls at 45 C.F.R. § 88.1 "federal health care provider conscience protection statutes," *i.e.*, statutes that prohibit discrimination against health care personnel who refuse to perform or assist in performing certain procedures (*e.g.*, abortions, sterilizations, or assisted suicides) due to religious beliefs or moral convictions. *See, e.g.*, Church Amendments, 42 U.S.C. § 300a-7; Coats-Snowe Amendment, 42 U.S.C. § 238n; Section 1553 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18113.

While OCR already has the regulatory authority to enforce and handle complaints filed under these federal health care provider conscience protection statutes, *see* 45 C.F.R. pt. 88, in its proposed rule OCR intends to restate these federal statutes, expand and make more explicit certain regulatory authorities, and place specific regulatory requirements on health care organizations covered under the federal statutes. As HHS proceeds with this rulemaking to create a more robust enforcement structure for important statutory protections for health care provider decisions based on religious belief or moral conviction, WHA encourages HHS to do so in such a way that aligns with HHS's and WHA's mutual commitment to combatting patient discrimination and expanding health care access for all patients.

**II. In order to advance the Administration's and WHA's mutual commitment to reducing regulatory burden, WHA urges HHS not to finalize the proposal to require health care organizations to report the existence of all filed complaints and of all OCR investigations and compliance reviews.**

The Trump Administration often has expressed its support for reducing the burden associated with regulatory compliance. For example, on January 30, 2017, the President issued an Executive Order, "Reducing Regulation & Controlling Regulatory Costs," that stated that "it is essential to manage the costs associated with the governmental imposition of private expenditures required to comply with Federal regulations" and that "it is important that for every one new regulation issued, at least two prior regulations be identified for elimination." Exec. Order No. 13,771, 82 Fed. Reg. 9,339 (Feb. 3, 2017). In addition, on March 5, 2018, in remarks to the Federation of American Hospitals, the HHS Secretary himself identified the following as a "key engine for transformation" of health care: "addressing any government burdens that may be getting in the way of integrated, collaborative, and holistic care for the patient, and of structures that may create new value more generally." Azar, Alex, *Remarks on Value-Based Transformation to the Federation of American Hospitals* (March 5, 2018), https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html.

WHA and its hospital and health system members support the Administration's policy on reducing regulatory burden. Just last fall, WHA submitted comments to the U.S. House of Representatives' Ways & Means Committee in response to the Committee's request for provider feedback on ways to reduce statutory and regulatory burden within Medicare. *See* Wis. Hosp. Ass'n, *Submission to U.S. House, Committee on Ways and Means, Subcommittee on Health* (Aug. 24, 2017), www.wha.org/data/sites/1/pdf/8-24-2017WHAsubmissionWMMedicareRedTapeReview.pdf. WHA's comments identified laws across the health care delivery continuum that Congress and the Administration could address to reduce Medicare's burden on Wisconsin hospitals and health systems.

The proposed rule would impose several additional regulatory requirements on covered hospitals and health systems, including the following:

- Organizations must report the existence of all filed complaints alleging violation of a federal health care provider conscience protection law and of all OCR investigations and compliance reviews, including reviews conducted in the absence of a filed complaint. 83 Fed. Reg. 3,880, 3,930. For reports of filed complaints, the organization must make the report for a duration of *five years* from the date of the complaint. *Id.*
- Organizations must submit written assurances and certifications of compliance with the federal health care provider conscience protection laws as a condition of receiving funding from HHS. *Id.* at 3,928.

- Organizations must post notices to advise persons about their rights and about such organizations' obligations under the federal health care provider conscience protection laws. *Id.* at 3,929.
- Organizations must maintain records evidencing compliance with the federal health care provider conscience protection laws and afford OCR reasonable access to such records. *Id.*
- Organizations must cooperate with OCR investigations and compliance reviews, which cooperation includes producing documents, participating in interviews, responding to data requests, and submitting to on-site inspections. *Id.* at 3,929-30.

WHA urges HHS not to finalize the proposal to require health care organizations to report the existence of all filed complaints and of all OCR investigations and compliance reviews. First, as written, this proposed regulatory requirement would not apply narrowly to organizations that in fact have violated a federal health care provider conscience protection law, but also would apply unfairly to any organization that OCR determines, after investigation, not to have violated such laws. This proposal, therefore, would have the effect of punishing organizations that have complied with all applicable laws. It is especially important not to finalize this proposal because elsewhere the proposed rule allows OCR to conduct a compliance review against organizations *even in the absence of a filed complaint* and allows *any* person to file a complaint, even if the complaint turns out not to have been based on any evidence of an actual legal violation. *See id.* at 3,930.

Second, the proposal as written is inefficient and does not advance the Administration's stated policy of reducing regulatory burden on private organizations. An alternative policy that would create more efficiencies and better align with the Administration's and WHA's commitment to regulatory burden reduction would be for OCR itself to track which organizations OCR has determined to be noncompliant and then report such information directly to HHS. This alternative policy would be more efficient because OCR itself would already have such information in a centralized, internal location and could easily convey such information to HHS for HHS to use in making funding decisions with respect to noncompliant organizations.

**III. WHA urges HHS to establish notice, hearing, and appeal procedures for any remedial action that HHS may take against a noncompliant health care organization, including termination of HHS funds.**

The proposed rule provides that "[i]f there appears to be a failure or threatened failure" of a health care organization to have complied with the federal health care provider conscience protection laws, HHS may terminate all HHS funding, including Medicare and Medicaid. 83 Fed. Reg. 3,880, 3,931. There are no "due process" provisions contained in the proposed rule that establish a specific procedure that HHS must follow before terminating an organization's Medicare and Medicaid funding or that provide the organization an opportunity to have a hearing before or to file an appeal after HHS decides to terminate the organization's funding.

HHS specifically seeks comment on "what administrative procedures or opportunities for due process the Department should, as a matter of policy, or must, as a matter of law, provide," before HHS terminates an organization's HHS funding or otherwise takes remedial action against such organization. *Id.* at 3,898. WHA urges HHS to establish notice, hearing, and appeal procedures for any remedial action, including termination of HHS funds, that HHS may take against a health care organization for noncompliance (or "threatened" noncompliance) with the federal health care provider conscience protection laws. As an analogue for what such procedures might look like, HHS is advised to consult its own regulations implementing Title VI of the Civil Rights Act of 1964, *see* 45 C.F.R. §§ 80.8-80.10, or the Conditions of Participation for Medicare and Medicaid, *see* 42 C.F.R. § 489.53 & pt. 498.

Thank you again for the opportunity to comment. If you have any questions, please contact Andrew Brenton at (608) 274-1820 or abrenton@wha.org, or Jon Hoelter at (608) 274-1820 or jhoelter@wha.org.

Sincerely,

Eric Borgerding

President

# Exhibit 183

# Wisconsin Medical Society

March 27, 2018

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

**RE: RIN 0945-ZA03, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

Dear Secretary Azar:

Comprised of more than 12,500 physicians, residents and medical students, the Wisconsin Medical Society (Society) is the largest association of medical doctors in Wisconsin. It is our mission to improve the health of the people of Wisconsin by supporting and strengthening physicians' ability to practice high-quality patient care in a changing environment.

The Society's membership is diverse, representing the entire spectrum of medical practice, demographics, clinic size, personal beliefs, religion, and communities served. At the core of our efforts at the Society is protecting the sanctity of the physician-patient relationship. It is in this context that we offer comment on RIN 0945-ZA03.

The proposed rule is concerning to us as it expands the Government's role in the delivery of health care and the physician-patient relationship. It also presents some dilemmas for how the medical profession governs itself, while significantly increasing administrative burden. We ask the Department to consider our existing Society policies and recommendations outlined below.

**1. Existing Society Policy**

The Society's position on public policy matters stems from the input and direction of our members. As illustrated below, many aspects of this proposed rule are included in our existing policy compendium. The policies listed below showcase the breadth of the Society's positions on issues related to ethical and personal beliefs. The Society shares these policies with HHS in the hope that doing so will help inform the Department's decisions and actions regarding respect of beliefs between patients and physicians.

a. **ABO-004**
**Abortion as a Medical Procedure and Providing Abortion-Related Information:**
The Wisconsin Medical Society: 1) supports enactment of appropriate legislation that would acknowledge the right of a physician to perform and to practice this medical procedure as he/she might any other medical procedure or to refuse to perform an abortion according to the dictates of his/her training, experience and conscience; 2) supports the development of guidelines that ensure that abortions be performed only under proper medical circumstances with adequate provision for safeguarding the health of the patient; and 3) although abortion is a contentious issue, it is a legal medical procedure and physicians should be expected to advise their patients of all available options.

b. **WOM-003**
**Emergency Contraception:**
Individuals of childbearing capacity should be provided medically accurate information regarding prophylaxis or pregnancy if the patient requests it or referred to an expert to provide medically accurate information. A victim of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent and consistent with current treatment guidelines. Physicians or hospitals should not be legally mandated to provide emergency prophylaxis to patients in violation of their own conscience, moral beliefs or guiding principles. Physicians and allied health practitioners who find this morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should provide individuals with evidence-based information about such services and where they can be obtained in a timely fashion.

c. **ETH-024**
**Physician Sensitivity to Patient's Religious and Cultural Beliefs in Medical Practice:**
The Wisconsin Medical Society believes that physicians should maintain respect for their patients' beliefs. Therefore, the Society:

- Encourages clinicians to consider the religious and cultural orientation and beliefs of the patients, in interacting with and providing treatment.
- Encourages that interactions with patients be handled with recognition of the patient's vulnerability to the attitudes of the physician and respect for the patient's autonomy.
- Supports the position that medical recommendations that concern a patient's beliefs should be made in a context of empathic respect for the value and meaning of those beliefs.

The Society also believes that physicians should not impose their own religious, anti-religious or ideological systems of beliefs on their patients, nor substitute such beliefs or ritual for accepted diagnostic concepts or therapeutic practice.

d. **ETH-029**
**Process for Resolving Disputes About Life-Sustaining Treatment Decisions:**
The Wisconsin Medical Society supports the following provisions in regard to disputes about life-sustaining treatment decisions:

1. Attending physicians and their patients should have an open and honest dialogue about what is the best treatment available to the patient as well as the goals, benefits, risks and potential outcomes of any prescribed treatment. These conversations should be had between physicians and patients at the beginning of treatment, and any potential problems or disputes addressed as early as possible.
2. In matters relating to life-sustaining treatment, physicians should inform their patients when life-sustaining treatment may no longer be desirable or feasible in the estimation of the attending physician. In such circumstances where a patient, or an individual who has legal

authority to make health care decisions for the patient, disagrees with a physician's decision to withdraw, withhold or reduce life-sustaining treatment, an ethics committee or other institutional resources should be consulted to determine a course of action. Physicians, patients and other relevant parties should be allowed to attend the ethics committee meeting.
3. If either the physician or the patient choose not to accept the determination made by an ethics committee, reasonable efforts should be made by the physician, or physician's facility, to transfer the patient to another physician or facility. The patient would continue to receive all current life-sustaining treatment pending their transfer; however, if transfer is not possible, the physician is under no ethical obligation to continue providing life-sustaining treatment.
4. Disagreements or discussions regarding the medical appropriateness and benefit of life-sustaining treatment should in no way reduce or impact the provision of medically appropriate interventions, including appropriate symptom management and palliative care.
5. The Society encourages physicians to familiarize themselves with the AMA Principles of Medical Ethics 5.5, "Medically Ineffective Interventions."

e. **ETH-036**
**Statewide Effort to Improve Advance Care Planning:**
Advance care planning is an important part of every patient's health care and despite the existence of advance directives, there is a continuing need for improved advance care planning in Wisconsin.

The Wisconsin Medical Society will work to initiate a statewide effort to improve advance care planning through education, community outreach, and pilot programs among physicians and the public. (HOD, 0412)

f. **ETH-042**
**Relation of Laws to Ethics Policy:**
Ethical values and legal principles typically are closely related, but ethical obligations often exceed legal duties. Adherence to ethical values does not ensure legal compliance, and adherence to the law may not be sufficient to ensure ethical conduct.

The Society recognizes that physicians' adherence to the law is essential to maintaining public trust in the medical profession. As such, physicians must respect and abide by applicable law, even if they disagree with it. Physicians should seek to change laws that they believe are contrary to the best interests of the practice of medicine or their patients, but must continue to abide by the law until such time as it is changed. Nothing in the policies of the Society should be interpreted as a suggestion or command that any individual violate any law or legal requirement as it then exists. (HOD, 0416)

g. **HSR-008**
**Discrimination in the Delivery of Health Care:**
The Wisconsin Medical Society opposes any arbitrary, inequitable or discriminatory application of plan benefits or medical care under any state or national health care plan and, further, specifically opposes discriminatory allocation of medical care on the basis of class, means, gender, sexual orientation, gender identity, sex, race, ethnicity, religious beliefs, disabilities, or any other federally protected class of citizens. (HOD, 0417)

**2. Additional Nondiscrimination Protections**
The Department has asked for comment on whether certifications of compliance with nondiscrimination laws should contain additional language. The Society believes the rule also should include explicit

protections for Lesbian, Gay, Bisexual and Transgender (LGBT) patients. Research suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBT people has been associated with high rates of psychiatric disorders, substance abuse, and suicide.[1]

**3. Rationale for Proposed Rule, Compliance and Adding More Administrative Burden on Physicians:**

Included in the proposed rule's narrative is the Department's conclusion that there is significant need to amend the 2011 Rule to ensure knowledge, compliance and enforcement of the Federal health care conscience and associated anti-discrimination laws.

The rule does not address how the Department intends to achieve this; will there be additional administrative burdens placed on providers and their administrative staff? Will there be required training for all covered entities? How will this be coordinated with the appropriate licensing and accrediting bodies in each state? How will physicians attest compliance?

Given the existing complex reporting structure already in place for physicians, we are concerned this rule will add more administrative burden. For every hour physicians provide direct clinical care to patients, they spend nearly two additional hours on electronic health records and related tasks within the clinic day. Outside office hours, physicians spend another one to two hours of personal time each night doing additional computer and other clerical work.[2] Creating additional layers of reporting will exacerbate this well-documented physician burnout problem.

**4. Impact on Licensing, Credentialing and Certification**

The proposed rule in sections 88.3(b)(2)(A) through 88.3(b)(2)(C) could be construed to remove, or at a minimum threaten, the authority of independent institutions to set standards for what/who can be considered an accredited institution, and/or a licensed/certified physician. The rule proposes that individuals should be considered certified/licensed/accredited physicians even though they exempted themselves from mandatory training or education that conflicted with their beliefs. The rule also proposes that established institutional health care entities can't require training or education on specified procedures as a condition of licensure or certification. This presents several issues. It threatens to remove the ability of medical schools to set curriculum and standards, and the ability of national certification and state examining boards to set standards for basic competence.

For specified medical procedures the current rule creates exemptions for religious beliefs and moral reasons. Guidelines and procedures are already in place to address these concerns. However, the new interpretations of the rule threaten, or outright remove, the ability of established health care entities to independently set their own standards. This is inherently problematic and could adversely impact the quality of care medical professionals are able to deliver. We urge HHS to consider amending its position to be more in line with existing policy, which has proven effective and equitable.

**5. Conflicts with State Laws and Medicaid Programs**

Section 88.3(m)(2) prohibits "a State agency that administers a State Medicaid Plan to compel any person to undergo any medical screening, examination, diagnosis, or treatment" for reasons other than discovering or preventing the spread of diseases on religious grounds. This language puts provisions of

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[1] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

[2] http://annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties

Wisconsin's pending 1115 Medicaid waiver into direct conflict with the proposed rule. Aside from the Society's stated position on the parameters of the pending waiver, this proposal also creates a tremendous amount of confusion, bureaucratic conflict, and administrative burden not only for physicians, but for the broader Medicaid program. The layers of administrative interpretation and bureaucracy generated by this proposal would create confusion for patients as well, and the proposal potentially creates scenarios that disrupt the patient-physician relationship as both parties try to comply with conflicting regulations. The Society urges HHS to consider clarifying its language to avoid conflicting with 1115 waivers. The Society also suggests that HHS instruct CMS to offer explicit guidance as to how it will interpret this provision of the proposed rule as it relates to screenings and treatment under a state's 1115 waiver.

**6. Exemptions from State Standards**
Section 88.3(q)(iv)(2)(i) of the proposed rule states that Medicaid must exempt (if requested) "religious nonmedical health care institutions" from:

- State health standards
- Review of the "appropriateness and quality of care and services" for Medicaid recipients as is approved under a state plan amendment (SPA)
- Written plans for those in mental health facilities
- Hospital utilization reviews

Religious Non-Medical Health Care Institutions (formerly known as Christian Science Sanatoriums) provide both hospital and post-discharge skilled nursing facility services. Wisconsin is one of the few states that cover this service under our Medicaid SPA. Exempting these providers from state standards for cleanliness and quality of care potentially threatens the quality of care that patients receive from these providers. The Society supports and respects patients' willingness and wishes to receive care at these facilities and from these providers. However, at a minimum, they should adhere to the same standards as all other skilled nursing facilities and providers. The Society recommends that HHS strike this section from its proposed rule

In conclusion, we encourage the Department to find a balance that protects patients and providers. We believe the suggestions above strike that balance, and are directly derived from physicians. As always, the Society appreciates the opportunity to offer perspective on behalf of our members. We encourage the Department to continue to engage physicians in the development of new proposed regulations that impact the physician-patient relationship.

Sincerely,

Clyde "Bud" Chumbley, MD
CEO Wisconsin Medical Society

# Exhibit 184

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 Women's Health and Family Planning Association of Texas (WHFPT) 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.

WHFPT is a non-profit organization dedicated to ensuring Texans have equal access to high-quality reproductive health services and control over the timing and spacing of their children. As the sole Title X Family Planning Program grantee for the state of Texas, WHFPT funds a diverse network of 28 providers—including federally qualified health centers (FQHCs), public health departments, hospital based clinics, and free-standing family planning clinics—that operates approximately 100 clinic sites throughout Texas and provides critical reproductive health care services to over 180,000 women, men, and young people each year.

WHFPT 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, and puts at risk millions of dollars in federal funding that WHFPT-supported providers currently receive. Without this federal support, WHFPT-supported providers would be forced to drastically scale back the services provided to our patients or to even close completely.

Although this NPRM claims the authority to interpret numerous statutes of concern and interest, WHFPT will limit our comments primarily to the 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 opens the door to undermining the intent and integrity of key HHS programs, including the Title X family planning program, we urge HHS to withdraw the NPRM.

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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.

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 amendments 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. Section 88.3(c) of the NPRM adds new language that applies the Weldon amendment's prohibitions 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 to entities like WHFPT and to funding through any program administered by HHS, neither of which the Weldon amendment statutorily includes. These extensions of Weldon's reach are clearly contrary to both the plain language of the Weldon amendment and to congressional intent.

- Section 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). This overly broad and vague standard is far from reasonable, and would make it exceedingly difficult, if not impossible, for WHFPT-supported providers to interview, hire, or respond to accommodation requests, causing significant harm to their business operations.

- 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. This overly broad 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.

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 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 and unduly punitive.**

We are troubled by some of the new provisions concerning OCR oversight and enforcement authority that appear vague, overly broad, and overly punitive.

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).

When combined with other aspects of the NPRM, concern over the breadth and potential harm of such provisions is even greater. For instance, Section 88.6 of the NPRM includes a 5-year reporting requirement that would require WHFPT to inform any current HHS "funding component" of any OCR compliance review, investigation, or 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 for the federal health care refusal statutes.

Given the lack of 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 and what safeguards exist to prevent abuse.

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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).

Here in Texas, 183,000 women and men received publicly funded contraceptive services from WHFPT-supported providers in fiscal year 2017. The publicly funded family planning and sexual health care WHFPT-supported health care entities provide serves as 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 in the United States than currently occur.

Congress has specifically required that "all pregnancy counseling shall be non-directive" (Public Law 112-74, p. 1066-1067), 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)). 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 like WHFPT 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 WHFPT and other Title X grantees may ensure that the subrecipients we 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 and forces organizations like us to make an impossible choice between violating the Title X statute and regulations or violating the NPRM—both of which could lead to a loss of critical funding.

In addition, the language in the NPRM could put Title X-funded entities like WHFPT 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 like WHFPT are permitted to consider patients' needs when faced with an employee's refusal to provide services.

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.**

The NPRM will have an extremely burdensome effect on the variety of public and private entities awarded federal dollars to provide health services to underserved communities, including WHFPT.

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, WHFPT will likely need to pay for the time of legal counsel to review and consult on how to adjust our 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 WHFPT 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.

In light of these burdens, the substantial costs overlooked by HHS in its NPRM, and the HHS's inability to demonstrate a countervailing need for the rule, WHFPT 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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WHFPT 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 this letter, please contact Kami Geoffray at kami.geoffray@whfpt.org or (512) 448-4857.

Sincerely,

Kami Geoffray
Chief Executive Officer

# Exhibit 185

March 26, 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:

WV FREE, a reproductive health, rights and justice organization founded in 1989, believes a health care provider's personal beliefs should never determine the care a patient receives. In particular, WV FREE has an interest in ensuring patients have access to health care in West Virginia, and that religious beliefs do not dictate patient access to care. That is why we strongly oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule"), which seeks to permit discrimination in all aspects of health care.[1]

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

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

[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 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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*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.

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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

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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.

[6] *Id.* at 180.

"referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information, including location or funding, that could help an individual to get the care they need.[7]

Furthermore, the Proposed Rule's new and unwarranted expanded definitions often exceed, or are not in accordance with, existing definitions contained within the statutes the Proposed Rule seeks to enforce. Specifically, under the Coats and Weldon Amendments "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.[8] The Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term.[9] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but goes directly against congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert.[10]

When these impermissibly broad definitions are combined with the expansive interpretations of the underlying statutes, they work together to further expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, one way the Weldon Amendment is expanded under the Proposed Rule is through the definition of "discrimination."[11] In particular, the Proposed Rule defines "discrimination" against a health care entity broadly to include a number of activities, including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[12] In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is nonsensical and inappropriate. Further such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

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

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

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[7] *Id.* at 183.
[8] The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018).
[9] *See* Rule *supra* note 1, at 182.
[10] The doctrine of expression unius est exclusion alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[11] *See* Rule *supra* note 1, at 180.
[12] *Id.*
[13] *See, e.g., supra* note 3.
[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.

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 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.

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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/.
[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*,

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 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]

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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/.

[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.

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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**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]

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

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[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.

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

[37] *See id.*

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.

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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]

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The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[42] Individuals seeking reproductive health care, regardless of their reasons for needing these services, should be treated with dignity and respect. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them.

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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).

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.

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**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.

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

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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.

[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-

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 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]

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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.

[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.

**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 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

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[56] 42 U.S.C. § 2000e-2 (1964).
[57] *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.
[58] *See id.*
[59] Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.
[60] *See* Rule *supra* note 1, at 180-181.
[61] 42 U.S.C. § 1295dd(a)-(c) (2003).
[62] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); In In re Baby K, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v.*

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**

WV FREE is committed to ensuring that all patients in West Virginia 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]

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**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 WV FREE calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

Margaret Chapman Pomponio

Executive Director

WV FREE

*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.*