Exhibit 60

CONSORTIUM FOR CITIZENS WITH DISABILITIES

March 27, 2018

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

Re: Comments on HHS proposed rule on Protecting Statutory Conscience Rights in Health Care, HHS–OCR–2018–0002, RIN 0945-ZA03

Dear Secretary Azar:

The co-chairs of the Consortium for Citizens with Disabilities (CCD) Rights Task Force submit these comments in response to HHS's proposed rule interpreting religious refusal laws. CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society.

As advocates for the rights of individuals with disabilities to full and equal participation in all aspects of our society, we have serious concerns about the vagueness and breadth of the proposed rule's provisions and the potential impact that it may have on the application of disability and civil rights laws, such as the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. For example, the proposed provisions at 45 C.F.R. §§ 88.3(a)(2)(v) and 88.3(a)(2)(vi) seem to allow health care providers and staff extremely broad latitude in refusing to perform or assist in the provision of any lawful health service on the ground that doing so would be contrary to his or her religious beliefs. The proposed rule fails to discuss how these broad interpretations of religious refusal laws would interact with civil rights laws. To the extent that its provisions may be interpreted to limit the rights of people with disabilities under the ADA, Section 504, or other civil rights laws to receive health care services, however, we strongly object to them.

Congress provided a "broad mandate" in the ADA and Section 504 "to remedy widespread

discrimination against disabled individuals."[1] The ADA was designed "to provide clear, strong, *consistent, enforceable* standards addressing discrimination against individuals with disabilities."[2] Religious beliefs, regardless of the sincerity with which they are held, cannot be used as a shield for discrimination in contravention of disability rights mandates.

Discrimination in the provision of health care based on religious grounds presents particular concerns for people with disabilities because many people with disabilities rely heavily on religiously affiliated service providers for daily supports. In fact, many people with disabilities have little choice but to receive needed services from such service providers. And those service providers—particularly residential providers—are frequently responsible for assisting with many aspects of a person's life.

People with disabilities have sometimes been excluded from needed services or faced barriers to receiving those services due to service provider objections. For example, group homes have sometimes refused to allow people with disabilities to live with their spouses or romantic partners - even in the case of a heterosexual married couple.[3] Recent federal regulations concerning Medicaid home and community-based services now more clearly require residential service providers for people with disabilities to allow choice of roommate and overnight visitors.[4] Allowing religiously-affiliated service providers to deny residential services to people with disabilities based on a religious objection such as this could dramatically undermine their clients' right to pursue relationships and exercise fundamental rights of association.

The broad language of the proposed rule might also be interpreted to mean that the service providers on whom people with disabilities rely to coordinate necessary services or to provide transportation, personal care services, or other key services could refuse to provide these services, even if the person is entitled to receive them through Medicaid, Medicare, or another program. For example, these provisions might permit a case manager to refuse to set up a medical appointment for a person with a disability to see a gynecologist if contraceptives might be discussed, might permit a personal care services provider to refuse to assist a person with a disability in performing parenting tasks because the person was married to someone of the same gender, might permit a mental health service provider to refuse to provide needed treatment to an individual based on the fact that the individual was transgender, and might permit a sign language interpreter to refuse to help a person communicate with a doctor about sexual health. As these examples demonstrate, a denial of service based on a provider's personal moral

[1] *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 674 (2001).
[2] 42 U.S.C. § 12101(b)(2) (emphasis added). Section 504 contains virtually identical requirements.
[3] *See Forziano v. Independent Grp. Home Livin 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).
[4] 42 C.F.R. §§ 441.710(a)(vi)(B)(2), 441.710(a)(vi)(D).

objection can potentially impact every facet of life for a person with disabilities – including autonomy, parental rights, and access to the community.

In addition, individuals with particular disabilities have historically faced discrimination on the basis of religious beliefs.[5] Cases abound where religious scruples have been invoked to deny services to HIV-infected people; as recently as 2009, pharmacists unsuccessfully challenged a Washington law prohibiting pharmacies from refusing to deliver lawfully prescribed or approved medicines.[6] This is also an extremely relevant issue for the disability community since 4.6 percent of Deaf people are infected with HIV/AIDS, four times the rate for the African-American population,[7] the most at-risk racial group in the U.S.[8]

People with disabilities not only experience health disparities themselves, but those disparities are compounded by the health disparities that they face as members of other demographic groups such as women, people of color, and LGBTQ people. While disability affects people of all races, ethnicities, genders, languages, sexual orientations, and gender identities, disability does not occur uniformly among racial and ethnic groups. Disability prevalence is highest among African Americans, who report disability at 20.5 percent compared to 19.7 percent for non-Hispanic whites, 13.1 percent for Hispanics/Latinos and 12.4 percent of Asian Americans.[9] Disability prevalence among American Indians and Alaskan Natives is 16.3 percent.[10] An Institute of Medicine report has already observed that there are "clear racial differences in medical service utilization rates of people with disabilities that were not explained by socioeconomic variables," and "persistent effects of race/ethnicity [in medical service utilization] could be the result of culture, class, and/or discrimination."[11] These compounded disparities place people with disabilities at greater risk of denials of needed health care.

---

[5] National Women's Law Center, *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.

[6] *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1116 n.7 (9th Cir. 2009)

[7] Disability Policy Consortium, Seth Curtis and Dennis Heaphy, *Disabilities and Disparities: Executive Summary* 3 (March 2009).

[8] *Id*.

[9] U.S. Census Bureau, Matthew Brault, *Americans With Disabilities: 2005, Current Population Reports* 117 (2008). Many of the differences between the disability rates by race and Hispanic origin can be attributed to differences in the age distributions of their populations. For example, Hispanics are predominantly younger than non-Hispanic whites.

[10] U.S. Census Bureau, *2009 American Community Survey, S1810, Disability Characteristics 1 year estimates* (2009) http://factfinder.census.gov/servlet/STTable?_bm=y&¬qr_name=ACS_2009_1YR_G00_S1810&-geo_id=01000US&¬ds_name=ACS_2009_1YR_G00_&-_lang=en&- format=&-CONTEXT=st.

[11] Institute of Medicine, *The Future of Disability in America* 92 (2007).

Finally, we note that Title III of the ADA already exempts from coverage "religious entities or entities controlled by religious organizations, including places of worship."[12] The sweeping language of the proposed rule has the potential to create conflicts with Title III and to preempt enforcement of similar state and local laws protecting people with disabilities.

For the foregoing reasons, we urge you to revise the proposed rule to ensure that the religious refusal provisions are not interpreted to preempt civil rights protections.

Sincerely,

CCD Rights Co-Chairs
On behalf of CCD Rights Task Force

Jennifer Mathis
Bazelon Center for Mental Health Law

Dara Baldwin
National Disability Rights Network

Mark Richert
American Foundation for the Blind

Heather Ansley
Paralyzed Veterans of America

Samantha Crane
Autistic Self Advocacy Network

[12] 42 U.S.C. § 12187.

Exhibit 61

Consumer Health First

Access • Quality • Equity

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 Consumer Health First in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1] Consumer Health First is a statewide, alliance of thousands of individuals and approximately one hundred organizations working to promote health equity through access to comprehensive, high quality and affordable health care for all Marylanders. As such, we represent the communities that would be impacted the most by this rule.

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

Indeed, this proposal runs in the opposite direction of everything the American health system is striving to achieve in the pursuit of "patient-centered care." We urge the

[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].

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

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

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

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

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

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

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

---

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

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

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

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

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

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

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

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

There have been reported instances in which pregnant women suffering medical emergencies—including premature rupture of membranes (PPROM) and ectopic pregnancies[7]—have gone to hospital emergency departments and been denied prompt, medically-indicated care because of institutional religious restrictions.[8] The proposed rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[9] Under EMTALA, every hospital is required to comply – even those that are religiously affiliated.[10] Because the proposed

---

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

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

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

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

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

rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

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

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

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

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

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

[11] The notice requirement is spelled out in section 88.5 of the proposed rule.

[12] *See*, for example, Freedman, Lori R., Luciana E. Hebert, Molly F. Battistelli, and Debra B. Stulberg, *Religious hospital policies on reproductive care: what do patients want to know?* American Journal of Obstetrics & Gynecology 218, no. 2 (2018): 251-e1, accessed here: http://www.ajog.org/article/S0002-9378(17)32444-4/fulltext; also Guiahi, Maryam, Jeanelle Sheeder, and Stephanie Teal, *Are women aware of religious restrictions on reproductive health at Catholic hospitals? A survey of women's expectations and preferences for family planning care*, Contraception and Stulberg, D., et all, accessed here: http://www.contraceptionjournal.org/article/S0010-7824(14)00358-8/fulltext; *Do women know when their hospital is Catholic and how this affects their care? Restrictions in Catholic Hospitals (PARRCH) national survey*, Contraception, Volume 96, Issue 4, 268-269,accessed here: http://www.contraceptionjournal.org/article/S0010-7824(17)30235-4/fulltext; a

[13] 42 U.S.C. § 2000e-2 (1964).

[14] *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

[15] *See id.*

health care employers in the impossible position of being subject to and trying to satisfy both.

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

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. The rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[16]

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

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

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

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

[16] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).
[17] Uttley, L, et all, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.
[18] *See, e.g., supra* note 2.
[19] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[20] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[21] *See* Kira Shepherd, et al., *supra* note 19, at 29.

the procedure.[22] Another woman was sent home by a religiously-affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[23]

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

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[24] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[25] In rural areas there may be no other sources of health and life preserving medical care.[26] When these individuals encounter refusals of care, they may have nowhere else to go.

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

7. The Department is abdicating its responsibility to patients

---

[22] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.

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

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

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

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

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

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

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

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

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

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

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

Conclusion

The proposed pule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The proposed rule is discriminatory, violates multiple federal statutes and the Constitution, fosters confusion, and harms patients. In addition, the proposed rule, runs counter to the Department's stated 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 unerlying medicine, public health, and social services."

For all of these reasons Consumer Health First strongly opposes the proposed rule and calls on the Department to withdraw it in its entirety.

Sincerely,

Kathy Ruben

[30] *See* Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.
[31] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf.
[32] *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, NAT'L GAY AND LESBIAN TASK FORCE & NAT'L CTR. FOR TRANSGENDER EQUALITY, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.
[33] *See, e.g.*, Rule, *Supra* note 1, at 3888-89.

Kathy Ruben, M.S., PhD. - kathyruben@consumerhealthfirst.org

Executive Director

Exhibit 62

Consumers for Affordable Health Care
www.mainecahc.org

Advocating the right to quality, affordable health care for every person in Maine.
Consumer Assistance HelpLine
1-800-965-7476

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:

Consumers for Affordable Health Care ("CAHC") respectfully submits the following comments to the Department of Health and Human Services (HHS), Office for Civil Rights ("OCR") on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1]

CAHC is a nonprofit, nonpartisan organization that advocates for quality, affordable health care for every person in Maine. We administer Maine's Consumer Assistance Helpline, which received over 6,000 calls last year from people seeking assistance in understanding their health coverage options, enrolling in health coverage, or accessing the health care, prescription drugs, medicine, or treatment they needed.

CAHC greatly appreciates the opportunity to provide comments regarding the proposed regulation.

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

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

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

[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].

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

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

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

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

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

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

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

The proposed rule thus could be read as allowing health providers to refuse to inform patients of all potential treatment options. A 2010 publication of the National Health Law Program, "Health Care

---

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

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

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

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

Refusals: Undermining Quality of Care for Women," noted that "refusal clauses and institutional restrictions can operate to deprive patients of the complete and accurate information necessary to give informed consent."[6]

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

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

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

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

---

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

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

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

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

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

[11] The notice requirement is spelled out in section 88.5 of the proposed rule.

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

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

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

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

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. The rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[16]

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

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

---

[12] *See*, for example, Freedman, Lori R., Luciana E. Hebert, Molly F. Battistelli, and Debra B. Stulberg, *Religious hospital policies on reproductive care: what do patients want to know?* American Journal of Obstetrics & Gynecology 218, no. 2 (2018): 251-e1, accessed here: http://www.ajog.org/article/S0002-9378(17)32444-4/fulltext; also Guiahi, Maryam, Jeanelle Sheeder, and Stephanie Teal, *Are women aware of religious restrictions on reproductive health at Catholic hospitals? A survey of women's expectations and preferences for family planning care*, Contraception and Stulberg, D., et all, accessed here: http://www.contraceptionjournal.org/article/S0010-7824(14)00358-8/fulltext; *Do women know when their hospital is Catholic and how this affects their care? Restrictions in Catholic Hospitals (PARRCH) national survey*, Contraception, Volume 96, Issue 4, 268-269,accessed here: http://www.contraceptionjournal.org/article/S0010-7824(17)30235-4/fulltext; a

[13] 42 U.S.C. § 2000e-2 (1964).

[14] *Title VII of the Civil Rights Act of 1964*, U.S. Equal Emp't. Opportunity Comm'n (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

[15] *See id.*

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

[17] Uttley, L, et all, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.

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

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

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

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[24] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[25] In rural areas there may be no other sources of health and life preserving medical care.[26] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that In 19 states, women of color are more likely than white women to give birth in Catholic hospitals.[27] Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provide guidance on a

---

[18] *See, e.g., supra* note 2.

[19] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[20] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[21] *See* Kira Shepherd, et al., *supra* note 19, at 29.

[22] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.

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

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

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

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

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

wide range of hospital matters, including reproductive health care, and can keep providers from offering the standard of care.[28] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[29]

7. The Department is abdicating its responsibility to patients

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

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

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

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

Conclusion

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

Sincerely,

Consumers for Affordable Health Care

---

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

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

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

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

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

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

Exhibit 63

OFFICE OF THE COUNTY COUNSEL
COUNTY OF SANTA CLARA

County Government Center
70 West Hedding Street
East Wing, 9th Floor
San Jose, California 95110-1770

(408) 299-5900
(408) 292-7240 (FAX)

James R. Williams
COUNTY COUNSEL

Greta S. Hansen
CHIEF ASSISTANT COUNTY COUNSEL

Winifred Botha
Robert M. Coelho
Steve Mitra
ASSISTANT COUNTY COUNSEL

March 22, 2018

Submitted electronically through www.regulations.gov

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

Attn: Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)
Re: Protecting Statutory Conscience Rights in Health Care

Dear Secretary Azar:

The County of Santa Clara ("County") submits these comments in response to the Department of Health and Human Services' (HHS) proposed rule, Protecting Statutory Conscience Rights in Health Care.[1]

The County, established in 1850, is a charter county and political subdivision of the State of California. Its mission is to protect the health, safety, and welfare of 1.9 million County residents. The County owns and operates Santa Clara Valley Medical Center ("SCVMC"), a fully integrated and comprehensive public health care delivery system that provides critical health care to residents of Santa Clara County regardless of their ability to pay. SCVMC, which includes a 574-bed tertiary care hospital with a Level 1 trauma center and 11 ambulatory care clinics, is the only public safety-net health care provider in Santa Clara County, and the second largest such provider in California. SCVMC provides the vast majority of the health care services available to poor and underserved patients in the County. The County also owns and operates Valley Health Plan ("VHP"), which participates in California's health insurance marketplace under the Affordable Care Act.

[1] 83 Fed. Reg. 3880 (proposed Jan. 26, 2018).

As set forth below, the proposed regulation: (1) improperly attempts to broaden the substantive scope of statutory conscience-based protections; (2) if adopted, may be improperly interpreted to invite discrimination against patients who face significant barriers to care; and (3) if adopted, will impose unnecessary burdens on safety-net providers such as the County.

A. The Proposed Regulation Improperly Attempts to Broaden the Substantive Scope of Statutory Conscience-Based Protections

Existing law provides an adequate framework for the enforcement of conscience-based protections, which protect under certain circumstances health care workers who refuse to participate in certain procedures or services based on their religious beliefs or "moral convictions." In addition, Title VII of the Civil Rights Act of 1964 provides an employment law framework for religious accommodations. The proposed regulation is not only unnecessary in light of the current framework, but it also improperly attempts to legislate heightened conscience-based protections that Congress has not recognized. Through its "further definition of Federal health care conscience and associated anti-discrimination laws," the proposed regulation seeks to vastly expand the scope of conscience-based protections in a way that substantially increases the likelihood that already-marginalized patients will face additional barriers in accessing health care.[2] Such an effect on patients seeking care undermines HHS's mission "to enhance and protect the health and well-being of all Americans."[3]

1. *The proposed regulation improperly broadens the meaning of "referral or refer for," which may result in health care workers turning patients away from a facility when others at the facility are willing to provide care.*

The proposed regulation's broad definitions of "assist in the performance" and "referral or refer to" in sections 88.3(a)(2)(v) and 88.2 sweep beyond the statutory language and may be improperly interpreted as permitting individual health care workers to turn patients away from a facility, without providing *any* information, when the objected-to services are in fact provided at that facility.[4] The definition in Section 88.2 of "refer or refer to" as including "the provision of any information . . . by any method" goes beyond the County's understanding of what a referral is.[5] The County is concerned that individual health care workers might improperly interpret the proposed regulation as permitting them to refuse *any* form of patient assistance, including notifying them that such services are provided by the County at that facility. For example, a provider might interpret the proposed regulation as allowing her, based on "moral convictions," to turn away, without providing *any* information, a patient at SCVMC experiencing abdominal pain related to an intra-uterine device, when there are many other providers at SCVMC who are

---

[2] *Id.* at 3891.

[3] *Introduction: About HHS*, HHS, https://www.hhs.gov/about/strategic-plan/introduction/index.html, attached as Exhibit 1.

[4] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3925 (§ 88.3(a)(2)(v)); *id.* at 3924 (§ 88.2).

[5] *Id.*

willing to treat that patient. Health care professionals are obligated to provide their patients with complete and accurate information about their treatment options. Failure to do so could result in liability for the providers, incomplete or deficient treatment of patients, and violation of ethical and legal principles.

Nothing in the proposed regulation supports HHS's conclusion that Congress intended such a broad extension of statutory conscience-based protections. HHS contends in the commentary to the proposed regulation that because the statutes use the terms "make arrangements for" and "refer for" services, Congress intended a broad definition of "referrals."[6] But this is not persuasive evidence that Congress intended the definition of "referral or refer to" to be as broad as it is in the proposed regulation: "provision of *any information. . . by any method*."[7] Stating that the County provides the requested services, even if the particular health care worker objects to providing them, is not "making arrangements for" a service that the provider has a religious objection to performing. In particular, the conscience-based protections must be read in light of Congress's robust, generally applicable non-discrimination statutes, including Section 1557 of the Affordable Care Act, Titles II and III of the Americans with Disabilities Act, and Title VI of the Civil Rights Act of 1964, that apply in certain health care settings.

Although HHS states that its proposed definition of "referral or refer to" will "address confusion the Department perceives among the public about what sorts of actions may be properly regarded as referrals for the purposes of protecting rights of conscience under the statutes at issue in this proposed rule,"[8] the substantive rewriting of statutory rights will result in greater confusion, because patients will not know whether they are getting complete information or a full range of treatment options. In delegating to the Office of Civil Rights (OCR) enforcement authority over the conscience-based protection statutes, Congress did not delegate the authority to transform the statutes into a broad license to discriminate and to provide patients with incomplete, deficient, or no treatment options based on a boundless array of "moral convictions," some of which may be contrary to non-discrimination statutes, and many more of which may conflict with HHS's mission to improve the health care of *all* Americans.

2. *The proposed regulation's reinterpretation of the Weldon Amendment is likely to limit access to comprehensive health insurance options.*

As applied to the Weldon Amendment,[9] the proposed regulation's definition of "health care entity" is likely to create additional barriers to accessing care, because it will likely limit

---

[6] *Id.* at 3895.

[7] *Id.* (emphasis added).

[8] *Id.*

[9] The Weldon Amendment, incorporated in the HHS appropriations acts, provides that "[n]one of the funds made available in this Act may be made available to a Federal agency or program, or to a state or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."

access to health insurance with comprehensive coverage of reproductive services. The proposed regulation adds "a plan sponsor" to the definition of "health care entity" under the Weldon Amendment.[10] This would greatly expand the universe of entities permitted to challenge a state's requirement to "provide, pay for, provide coverage of, or refer for, abortion."[11] HHS's proposed justification for expanding the definition of "health care entity"—that "[t]he amendment's broad and non-exhaustive definition indicates that the amendment takes an inclusive approach with respect to the health care entities it protects and should not be interpreted narrowly,"[12]—is not based on any legislative history, nor is it a license to go beyond the plain meaning of the statute. Congress did not delegate authority to HHS to expand the scope of the Weldon Amendment.

It is even more problematic that the proposed regulation attempts to reinterpret the Weldon Amendment to broadly allow health care entities to refuse to "provide, pay for, provide coverage of, or refer for abortions,"[13] regardless of whether entities have a conscience-based objection to doing so. HHS offers no evidence that refusals unrelated to conscience-based objections—such as financial or operational motivations—are intended to be protected under the Weldon Amendment. Rather, both the legislative history of the Weldon Amendment, and judicial interpretations of it, compel the contrary conclusion.[14] And even though economically or operationally driven refusals to provide abortion-related services or referrals have nothing to do with civil rights, the proposed regulation would make OCR's enforcement authority available to entities that merely have an economic or operational objection to providing such services. Contrary to HHS's mission, such a delegation would likely serve only to decrease the availability of health insurance options that provide comprehensive coverage of reproductive services.

B. The Proposed Regulation, If Adopted, May Be Improperly Interpreted as Inviting Discrimination Against Patients Who Already Face Significant Barriers to Care

If adopted, the proposed regulation will likely invite discrimination against patients who already face significant barriers to accessing care, such as lesbian, gay, bisexual, transgender, or queer (LGBTQ) people. Although a full discussion of the myriad of health care consumers who may be affected by the proposed regulation is beyond the scope of this comment, the proposed

---

Consolidated Appropriations Act, 2017, Public Law 115-31, § 507(d)(1), 131 Stat. 135. It defines "health care entity" to include "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." *Id.* at § 507(d)(2).

[10] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3890–91, 3924 (§ 88.2).

[11] *Id.* at 3925–26 (§ 88.3(c)(2)).

[12] *Id.* at 3890.

[13] *Id.* at 3925–26 (§ 88.3(c)(2)).

[14] *See* Letter from Jocelyn Samuels, Director, OCR, to Catherine W. Short, Vice President, Life Legal Def. Found., et al. (June 21, 2016) (citing *California ex rel. Lockyer v. United States*, 450 F.3d 436, 441 (9th Cir. 2006); 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004)).

regulation's likely effect on LGBTQ people, who frequently encounter discrimination and other barriers to accessing medical care, serves as an example of the harmful impact the regulation is likely to have.

Discrimination against LGBTQ people in health care settings is well documented. In one study, more than half of all respondents had experienced at least one of the following when seeking health care: refusals of needed care, providers refusing to touch them or using excessive precautions, harsh or abusive language, providers blaming them for their health status, or physically rough or abusive conduct.[15] In that study, eight percent of lesbian, gay, or bisexual respondents reported they had been refused needed health care because of their sexual orientation, and nearly 27 percent of transgender respondents reported being refused care because of their transgender status.[16] The percentages of LGBT people of color and low-income LGBT people who reported being refused care are much higher than the percentages for survey respondents as a whole.[17]

One respondent to a survey of transgender people reported, "I have been refused emergency room treatment even when delivered to the hospital by ambulance with numerous broken bones and wounds."[18] Another study, based on a review of complaints filed with OCR, describes a situation in which a transgender woman was recovering from an appendectomy, and the treating doctor, who "does not deal with 'these kinds' of patients," refused to call her by the correct pronouns.[19] Some medical providers have explicitly asserted religious-based reasons for denying care to LGBTQ people or their families, such as a pediatrician who refused to treat the newborn daughter of a lesbian couple.[20]

---

[15] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 10 (2010), *available at* https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf, attached as Exhibit 2.

[16] *Id.*

[17] *Id.* at 12. The County generally uses the acronym LGBTQ but uses "LGBT" when referring to the cited study, which uses that acronym.

[18] Jaime Grant et al., Nat'l Center for Transgender Equality & Nat'l Gay and Lesbian Task Force, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* 73 (2011), *available at* http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf, excerpt attached as Exhibit 3.

[19] Sharita Gruberg & Frank J. Bewkes, Ctr. for Am. Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (Mar. 7, 2018), *available at* https://cdn.americanprogress.org/content/uploads/2018/03/06122027/ACAnondiscrimination-brief2.pdf, attached as Exhibit 4.

[20] Abby Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents and There's Nothing Illegal about It*, Washington Post (Feb. 19, 2015), https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it/?utm_term=.a59cf2f3df0a, attached as Exhibit 5.

Refusing to provide medical care to consumers based on sex, sexual orientation, or gender identity is a form of sex discrimination prohibited by federal law. As an entity covered by the Affordable Care Act, the County complies with the ACA's non-discrimination protections in Section 1557, 42 U.S.C. § 18116(a), which prohibits discrimination based on sex and other protected characteristics in health programs and activities. In addition, as a local government that seeks to ensure the health, safety, and welfare of its 1.9 million residents, the County has a significant interest in eliminating discrimination and barriers to health care for *all* of its residents. To understand the health needs of the County's LGBTQ residents, the County's Public Health Department performed an LGBTQ Health Assessment in 2013.[21] Among other things, the study showed that 12 percent of LGBTQ survey respondents were "denied or given lower quality health care" in the 12 months preceding the survey due to their sexual orientation and/or gender identity.[22]

The County is concerned that the proposed regulation, if adopted, will invite medical providers to discriminate against LGBTQ health care consumers, among others, in violation of federal non-discrimination law. Not only does the proposed regulation appear to invite discriminatory conduct by expanding the reach of statutory conscience-based protections as discussed above, but it also oversimplifies them in the language it proposes to use to raise awareness among providers. The Notice in Appendix A tells providers they "have the right to decline to participate in, refer for, undergo, or pay for certain health care-related treatments, research, or services . . . which violate your conscience, religious beliefs, or moral convictions under Federal law."[23] This is not limited to the types of procedures contemplated in the statutory provisions discussed in the proposed rule. Such notice might encourage a provider, for example, to refuse to treat a transgender patient who comes to the emergency room seeking care for a broken arm based on the provider's "moral convictions," even though such refusal of service would violate federal non-discrimination law and the Emergency Medical Treatment and Labor Act.[24] And, if the notice is seen by a patient, this might discourage open communication with the provider, for fear that services will be denied. If HHS adopts the proposed regulation, it must address the empirical evidence which strongly suggests that marginalized patients will face heightened barriers in accessing care. And the notice must be compliant with all other applicable laws.

---

[21] Santa Clara Cnty Pub. Health Dep't, *Status of LGBTQ Health: Santa Clara County 2013* (2013), *available at* https://www.sccgov.org/sites/phd/hi/hd/Documents/LGBTQ%20Report%202012/LGBT%20Health%20Assessment.pdf, attached as Exhibit 6.

[22] *Id.*

[23] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3931.

[24] 42 U.S.C. § 18116(a); 42 U.S.C. § 1395dd.

C. The Proposed Regulation, If Adopted, Would Be an Unnecessary Burden to Safety-Net Providers Such as the County of Santa Clara

The proposed regulation's projected costs, which HHS states will be $815 million over the course of five years, far outweigh any expected benefits that could possibly stem from the expected increase in the supply of health care providers who maintain conscience-based objections. As a result, the proposed regulation, if adopted, would be an unnecessary burden to safety-net providers such as the County, which rely on limited public funds to provide essential health care services to *all* patients on a non-discriminatory basis. As illustrated above, an effect of the proposed regulation will likely be increased discrimination against patients who already face barriers in accessing care.

The proposed regulation's discussion of "ancillary benefits for patients," such as "assist[ing] patients in seeking counselors who share their deepest held convictions,"[25] ignores the much more substantial harm that the proposed regulation will likely cause to patients who are refused medical services, referrals to services, information about such services or referrals, or even information about where such information might be obtained, based on the religious beliefs or "moral convictions" of providers. The proposed regulation asserts that "[f]acilitating open communication between providers and their patients also helps to eliminate barriers to care, particularly for minorities."[26] But providers may interpret the regulation as allowing them to refuse to communicate *any* information to patients based on the provider's "moral convictions."

Surprisingly, the proposed regulation's cost-benefit analysis does *not* consider the potential impact or costs directly impacting patients, including costs resulting from "health outcomes or other effects of protecting conscience rights."[27] Studies show that discrimination, and the potential for discrimination, deter marginalized populations such as LGBTQ people from seeking medical care.[28] And discrimination negatively impacts health outcomes. As HHS's HealthyPeople 2020 initiative has noted, LGBTQ people "face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[29]

In addition, the proposed regulation vastly underestimates the costs of compliance for safety-net providers such as the County. Because the proposed regulation vastly expands the

---

[25] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3916–17.

[26] *Id.* at 3917.

[27] *Id.* at 3916, 3918.

[28] Shabab Ahmed Mirza & Caitlin Rooney, Ctr. for Am. Progress, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018), *available at* https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/, attached as Exhibit 7.

[29] HHS Office of Disease Prevention & Health Promotion, *Lesbian, Gay, Bisexual, and Transgender Health*, HealthyPeople 2020, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, attached as Exhibit 8.

substantive scope of statutory conscience-based protections, the projected estimate of *one* attorney hour to review the final rule[30] grossly underestimates the time that would be required to fully examine the rule's implications for existing County policies and practices related to conscience-based protections, as well as applicable non-discrimination policies at the federal, state, and local level. Similarly, the projected estimate for time required to post approximately five notices[31] ignores the reality of large health and hospital systems like the one operated by the County, which encompasses many facilities in many locations. The burden of this requirement is particularly unnecessary for entities like the County, which already ensures that employees are provided notice of their right to assert conscience-based protections through robust policies that allow employees to opt-out of participation in certain services in advance if those services conflict with a staff member's cultural values, ethics, or religious beliefs.[32]

D. Conclusion

As discussed above, the proposed regulation is an unlawful and unnecessary burden on providers and may invite discrimination against vulnerable populations who already face barriers to health care. The County urges HHS to rescind the proposed regulation.

Very truly yours,

JAMES R. WILLIAMS
County Counsel

Julie Wilensky
Deputy County Counsel

Adriana Benedict
Social Justice and Impact Litigation Fellow

1741533

[30] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3912.

[31] *Id.* at 3914.

[32] *See, e.g.*, Memorandum from Paul Lorenz to SCVMC Employees, Non-Participation in Certain Patient Care (Aug. 9, 2017); Memorandum from Paul Lorenz to SCVMC Employees, Medically Ineffective Interventions, Requests Concerning (May 8, 2015); Agreement Between Cnty. of Santa Clara & Registered Nurses Prof'l Ass'n (Nov. 10, 2014 through Oct. 20, 2019).

Exhibit 64

CATHOLICS COMMITTED TO LGBTQI EQUALITY
DignityUSA
JUBILEE 2019

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

RE: Docket HHS-OCR-2018-002

To the Department of Health and Human Services:

I am writing on behalf of DignityUSA, the organization of Catholics committed to justice, equality and full inclusion of lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) people in our church and in society. Our organization represents the majority of the more than 70 million Catholics in the United States who believe that people should not suffer discrimination due to their gender identity or sexual orientation. We support religious liberty for all people, no matter where they work, where they receive their healthcare or what they believe. We also believe that all people have the right to appropriate, respectful, comprehensive medical care, and that this right should be respected, not trumped by their healthcare provider's religious objections.

We believe that the Department of Health and Human Services is granting extreme exemptions that will imperil access to healthcare for many in the LGBTQI community and beyond. This new rule both expands the type of care an individual provider or an entity may refuse as well as broadening the scope of those eligible to refuse in the first place. No person should be denied critical healthcare such as HIV & AIDS treatment and prevention, reproductive assistance, gender confirmation services, access to contraception, or any other service because their provider has personal objections to that care. No one should be denied care because of who they are or whom they love. That is not protecting conscience—it is discrimination, plain and simple. This is an affront to our deeply held respect for conscience and the values of dignity, respect and autonomy that our Catholic faith compels us to uphold.

This kind of broad authorization to discriminate validates an illegitimate claim to religious liberty for institutions while distorting true religious liberty and denying the healthcare needs of individuals. It dangerously allows providers to keep their patients in the dark about why they are being refused care and will allow providers and entities to refuse to even provide referrals to other institutions where people can find the care they need. Patients will suffer because of this policy. It will only increase, not decrease, the burden of many rural and low-income patients who may not have access to another provider or healthcare institution.

As Catholics, our organization believes that HHS has a duty to protect people's health and that the federal government should safeguard the religious liberty of people seeking services or healthcare, not

PO Box 376, Medford, MA 02155
800.877.8797 202.861.0017 info@dignityusa.org www.dignityusa.org @dignityusa

champion rules that amount to government-sanctioned discrimination. We believe that the government does not have the right to impose burdens on some people, in this case LGBTQI people, and particularly those with the fewest resources and the least access to healthcare, that others do not face. We believe these rules will compromise the lives, health, and equal treatment of LGBTQI people.

We are aware that the US Conference of Catholic Bishops (USCCB) is supporting these proposed rules. Let me be clear that, although USCCB officials may speak on behalf of that organization, they do not represent the views of US Catholics on this matter.

I urge the department to return to its mission of fostering people's health and wellbeing rather than undermining access to healthcare and warping religious liberty. I ask you to represent the vast majority of Catholics and non-Catholics alike in this country who reject religion being used as a tool for discrimination. I urge you to reconsider these harsh new regulations.

Sincerely,

Marianne Duddy-Burke

Marianne Duddy-Burke
Executive Director

Exhibit 65

Disability Rights Education & Defense Fund

DREDF

March 27, 2018 *Via Electronic Submission* (www.regulations.gov)

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

Re: Comments on HHS proposed rule on Protecting Statutory Conscience Rights in Health Care, HHS–OCR–2018–0002, RIN 0945-ZA03

Dear Secretary Azar:

Disability Rights Education and Defense Fund (DREDF) thanks you for the opportunity to submit comments on the Department of Health and Human Services' proposed rule on Protecting Statutory Conscience Rights in Health Care (proposed rule). DREDF is a national cross-disability law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. We are committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives.

Healthcare is not simply a consumer good. Everyone needs some degree of healthcare at some point in their lives. Disabilities and health conditions that affect functional ability arise from every facet of human interaction, or the mere reality of aging. People with disabilities and chronic conditions require equal access to quality healthcare in their communities to exercise their civil right to fully participate in all aspects of American society. As longtime advocates for the disability community in the arena of healthcare, we are alarmed by the vagueness and potential reach of the proposed rule's provisions as they intersect with civil rights laws including the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504), and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557). The proposed broadly requirements and prohibitions of 45 C.F.R. § 88.3 prioritize the rights of personnel and entities involved with any health-related service, from research to insurance to third-party administration, to refuse to perform or assist with any lawful health service for "religious, moral, ethical or other reasons."

DREDF appreciates the proposed rule's argument on behalf of the conscience rights of

3075 Adeline Street, Suite 210 • Berkeley, CA 94703 • 510.644.2555 • 510.841.8645
fax/tty • www.dredf.org
Doing disability justice

healthcare entities, but emphasizes that those rights must be read in concert with this country's commitment to the right of people with disabilities, across a full range of race, ethnicity, age, sexual orientation and gender identity, to receive health care services free of discrimination. Congress provided a "broad mandate" in the ADA and Section 504 "to remedy widespread discrimination against disabled individuals."[1] The ADA was designed "to provide clear, strong, *consistent, enforceable* standards addressing discrimination against individuals with disabilities."[2] The ADA unquestionably applies to the private offices of healthcare provides, hospitals, and any state or locally operated healthcare entity, and Section 504 applies to all entities that receive federal financial assistance or are federally operated. Section 1557 broadly extended Section 504's non-discrimination mandate to private insurers. Conscience rights, regardless of the sincerity with which they are held, cannot be used as a shield for discrimination that would deprive people with disabilities of equal access to healthcare.

Discrimination in the provision of health care based on religious grounds presents particular concerns for people with disabilities for both historic and practical reasons. Historically, people with disabilities have been subject to many stereotypes including religious beliefs that disability arises from demonic possession or a curse.[3] Those early stereotypes gave way to assumptions eugenic assumptions about who was "fit" to reproduce and many state laws that sterilized people with disabilities without their consent; California's eugenics laws stayed on the books until 1979.[4] While hopefully few current healthcare providers may hold overt beliefs about demonic possession or eugenics, different religious beliefs can easily influence assumptions about the "childlike nature" and capacities of people with disabilities, their quality of life, their ambitions, and their freedom and capacity to make autonomous choices and take risks.

Practically, people with disabilities as a group are subject to higher unemployment and lower socio-economic status. Many people with disabilities rely heavily on religiously affiliated service providers for daily supports as well as ongoing healthcare services. In fact, many people with disabilities have little choice but to receive needed services from such service providers. And those service providers—particularly residential providers—are frequently responsible for assisting with many aspects of a person's life and the activities to which they have access.

People with disabilities have sometimes been excluded from needed services or faced barriers to receiving those services due to service provider objections. For example, group homes have sometimes refused to allow people with disabilities to live with their spouses or romantic partners - even in the case of a heterosexual married couple.[5] Recent federal regulations concerning Medicaid home and community-based services now more clearly require residential service providers for people with disabilities that

---

[1] *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 674 (2001).
[2] 42 U.S.C. § 12101(b)(2) (emphasis added). Section 504 contains virtually identical requirements.
[3] Chomba Wa Munyi, "Past and Present Perceptions Towards Disability: A Historical Perspective," Disability Studies Quarterly 32:2 (2012), available at: http://dsq-sds.org/article/view/3197/3068.
[4] A. M. Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America*, American Crossroads (2015).
[5] *See Forziano v. Independent Grp. Home Livin 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).

receive federal funds to allow choice of roommate and overnight visitors.[6] Allowing religiously-affiliated service providers to deny residential services to people with disabilities based on a religious objection such as this could dramatically undermine their clients' right to pursue relationships and exercise fundamental rights of association.

The breadth of application of the proposed rule might also be interpreted to mean that the service providers on whom people with disabilities rely to coordinate necessary services or to provide transportation, personal care services, or other key services could refuse to provide these services, even if the person is entitled to receive them through Medicaid, Medicare, or another program. For example, these provisions might permit a case manager to refuse to set up a medical appointment for a person with a disability to see a gynecologist if contraceptives might be discussed, might permit a personal care services provider to refuse to assist a person with a disability in performing parenting tasks because the person was married to someone of the same gender, might permit a mental health service provider to refuse to provide needed treatment to an individual based on the fact that the individual was transgender, and might permit a sign language interpreter to refuse to help a person communicate with a doctor about sexual health. As these examples demonstrate, a denial of service based on a provider's personal moral objection can potentially impact every facet of life for a person with disabilities – including autonomy, parental rights, and access to the community.

Since the proposed rule encompasses referral and the giving of information, people with disabilities can be denied both the option of assistance finding needed healthcare services somewhere else, or left not even knowing that they have been given incomplete information. In many rural areas, and even in some urban areas of the country that have a very high cost of living, it can be extremely difficult for people with disabilities to find personal care assistants. Will a personal care assistant, or a care agency, with sincerely held religious beliefs be able to refuse to assist their client with activities that the assistant disapproves of, such as watching certain movies or meeting with certain friends because they believe such activities are morally wrong? If a person with a disability attempts to find another care assistant, can the current assistant choose to simply not communicate the fact that other applicants are seeking the position? The department's failure to specify in the proposed rule that healthcare entities cannot exercise their conscience rights over a disabled person's right to receive healthcare services free of discrimination leaves people with disabilities in an extremely vulnerable situation, potentially unable to rely on the very agency, HHS Office for Civil Rights,that should be protecting them from discrimination.

In addition, individuals with particular disabilities have historically faced particular discrimination on the basis of religious beliefs.[7] Cases abound where religious scruples have been invoked to deny services to HIV-infected people; as recently as 2009, pharmacists unsuccessfully challenged a Washington law prohibiting pharmacies from refusing to deliver lawfully prescribed or approved medicines.[8] This is also an extremely

---

[6] 42 C.F.R. §§ 441.710(a)(vi)(B)(2), 441.710(a)(vi)(D).
[7] National Women's Law Center, *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.
[8] *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1116 n.7 (9th Cir. 2009)

relevant issue for the disability community since 4.6 percent of Deaf people are infected with HIV/AIDS, four times the rate for the African-American population,[9] the most at-risk racial group in the U.S.[10]

People with disabilities not only experience health disparities themselves, but those disparities are compounded by the health disparities that they face as members of other demographic groups such as women, people of color, and LGBTQ people. While disability affects people of all races, ethnicities, genders, languages, sexual orientations, and gender identities, disability does not occur uniformly among racial and ethnic groups. Disability prevalence is highest among African Americans, who report disability at 20.5 percent compared to 19.7 percent for non-Hispanic whites, 13.1 percent for Hispanics/Latinos and 12.4 percent of Asian Americans.[11] Disability prevalence among American Indians and Alaskan Natives is 16.3 percent.[12] One Institute of Medicine report has already observed that there are "clear racial differences in medical service utilization rates of people with disabilities that were not explained by socioeconomic variables," and "persistent effects of race/ethnicity [in medical service utilization] could be the result of culture, class, and/or discrimination."[13] Another recent paper commissioned by the National Academies of Sciences, Engineering and Medicine found that "[c]onscious and unconscious biases and stereotypes among health care providers and public health practitioners about specific racial and ethnic groups, and people with disabilities, contribute to observable differences in the quality of health care and adverse health outcomes among individual within those groups."[14] These compounded disparities place people with disabilities at greater risk of denials of needed health care.

Title III of the ADA already exempts from coverage "religious entities or entities controlled by religious organizations, including places of worship."[15] The sweeping language of the proposed rule has the potential to create conflicts with Title III and to preempt enforcement of similar state and local laws protecting people with disabilities.

Finally, we note that the proposed rule provides HHS OCR with the following authority:

> (c) Periodic compliance reviews. OCR may from time to time conduct compliance reviews or use other similar procedures as necessary to permit OCR to

---

[9] Disability Policy Consortium, Seth Curtis and Dennis Heaphy, *Disabilities and Disparities: Executive Summary* 3 (March 2009).
[10] *Id.*
[11] U.S. Census Bureau, Matthew Brault, *Americans With Disabilities: 2005, Current Population Reports* 117 (2008). Many of the differences between the disability rates by race and Hispanic origin can be attributed to differences in the age distributions of their populations. For example, Hispanics are predominantly younger than non-Hispanic whites.
[12] U.S. Census Bureau, *2009 American Community Survey, S1810, Disability Characteristics 1 year estimates* (2009) http://factfinder.census.gov/servlet/STTable?_bm=y&¬qr_name=ACS_2009_1YR_G00_S1810&-geo_id=01000US&¬ds_name=ACS_2009_1YR_G00_&-_lang=en&- format=&-CONTEXT=st.
[13] Institute of Medicine, *The Future of Disability in America* 92 (2007).
[14] S. Yee, M. L. Breslin, T. D. Goode, S.M. Havercamp, W. Horner-Johnson, L. I. Iezzoni, G. Krahn, *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*; commissioned by the National Academy of Medicine of the National Academies of Sciences, Engineering and Medicine (2017).
[15] 42 U.S.C. § 12187.

> investigate and review the practices of the Department, Department components, recipients, and subrecipients to determine whether they are complying with Federal health care conscience and associated antidiscrimination laws and this part. OCR may conduct these reviews in the absence of a complaint.

DREDF strongly submits that that HHS OCR's authority to conduct compliance reviews in the absence of a complaint must be available not only when OCR enforces conscience rights on behalf of providers and other healthcare entities, but equally available to those groups which are protected from non-discrimination in healthcare, including people with disabilities.

For the foregoing reasons, DREDF urges you to revise the proposed rule to ensure that the religious refusal provisions are not interpreted to preempt civil rights protections. Please feel free to contact me if you have any questions or comments concerning the above.

Sincerely,

Silvia Yee
Senior Staff Attorney

Exhibit 66

Duke Legal Clinics | Health Justice Clinic

NCAIDSACTION NETWORK

March 27, 2018

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

Re: Conscience NPRM, RIN 0945-ZA03

Dear Mr. Severino:

The Duke Health Justice Clinic and North Carolina AIDS Action Network (NCAAN) appreciate the opportunity to provide comments to the proposed Department of Health and Human Services' rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.

The Duke Health Justice Clinic provides free legal services and policy advocacy on behalf of people living with HIV in North Carolina. NCAAN is a statewide advocacy organization that aims to improve the lives of people living with HIV/AIDS and affected communities. We write on behalf of the 34,187 individuals living with HIV in North Carolina as well as the organizations listed at the end of these comments.

We strongly urge the Department of Health and Human Services to not adopt the proposed rule. The rule should not be adopted because:

1. It is unnecessary. Federal law already reasonably protects health care workers in North Carolina from religious discrimination by their employer.
2. It would encourage more health care providers to discriminate against LGBT North Carolinians and North Carolinians living with HIV.
3. It would restrict health care access, reduce health care quality, and lead to worse health care outcomes for LBGT individuals and people living with HIV in North Carolina.

1. Federal law already reasonably protects health care workers from religious discrimination by their employer.

The federal employment nondiscrimination law, Title VII of the Civil Rights Act of the 1964, and the current federal provider conscience regulation, 45 CFR Part 88, ensure that the religious liberties of health care workers are protected without sacrificing the right of patients to access care. The current law protects religious and conscience objections of health care providers *without* imposing an undue hardship on hospitals and other health care organizations that must balance many competing demands in providing health care to their communities. Given the reasonableness of the current approach, the proposed rule is unnecessary.

Title VII ensures that health care employers must reasonably accommodate the religious needs of their employees. Under Title VII, health care employers must accommodate the religious needs of their employees unless accommodation would place an undue hardship on the employer's business.[1] The undue hardship standard ensures that health care providers do not have to accommodate requests that would hinder their ability to provide care to patients,[2] but also protects employees' religious concerns when that can be done without unduly disrupting the employer's business. A court allowed a claim of religious discrimination to proceed when a pharmacist refused to provide condoms.[3] Although we find this employee's actions distressing, Title VII provided protection for his objections. The current Title VII standard appropriately protects employers from costs and burdens that would interfere with a health care organization's important mission of providing health care. Employers are required to attempt to accommodate employee religious beliefs, but the law appropriately recognizes limitations when accommodation is not reasonably possible.

In addition to the protections of Title VII, the current provider conscience regulation, which implements the Church, Weldon, and Section 245 of the Public Health Service Act, also provides an adequate, additional layer of protection for health care workers from religious discrimination by their employer. Under this regulation, a health care worker can file a complaint with the Department of Health and Human Services asserting that their employer violated one of the federal provider conscience statutes. If their complaint is found to be valid, the regulation provides the Department with the means to protect the employee's religious beliefs. The Department can cut off federal funding for any health care entity that violates the existing provider conscience statutes.

Further, unlike the proposed rule, the current regulation protects a patient's right to treatment. The current regulation does not appear to give health care providers the right to refuse to provide medical care to entire groups of people or types of treatment they find objectionable. Thus, providers are less likely to believe that they can wholesale refuse to provide care to vulnerable

---

[1] 29 CFR 1605.2 (stating the "undue hardship" standard).
[2] *See e.g.*, *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 226 (3d Cir. 2000) (rejecting a Title VII claim of a nurse who refused to assist in an emergency surgery due to her religious beliefs.)
[3] *Hellinger v. Eckerd Corp.*, 67 F. Support.2d 1359, 1361 (S.D. Fla. 1999).

groups. As a result, if the Department maintains the existing regulation in place, patients will maintain access health care services.

In sum, the current legal framework already strongly protects the religious concerns of health care workers. The proposed rule, therefore, is not needed to protect these rights. The additional protection it provides will come at the expense of greater discrimination against patients and reduced health care access.

2. The proposed rule would encourage health care providers to discriminate against LGBT North Carolinians, and North Carolinians living with HIV.

Some health care providers will interpret the proposed rule as an invitation to refuse medical care to LBGT North Carolinians and North Carolinians living with HIV. Although courts may later rule that these discriminatory actions are improper, patients would suffer needlessly and often irreparably in the meantime.

Refusals to provide treatment to patients violate professional ethics standards and anti-discrimination laws. The American Medical Association's national ethical guidelines prohibit discrimination against patients due to their disability (such as HIV/AIDS) or sexual orientation.[4] Federal law ensures that North Carolinians living with HIV, and gay and transgender North Carolinians are protected against discrimination. Under the Americans with Disabilities Act, health care providers cannot refuse to provide medical care to an individual living with HIV because she has HIV.[5] Section 1557 of the Affordable Care Act prohibits health care providers from refusing to provide treatment based on sexual orientation.

Despite being illegal, healthcare discrimination against LBGT individuals and people living with HIV remains a major problem. In a 2017 national survey, eight percent of gay individuals and 29% of transgender individuals reported having been denied health care coverage by a provider who morally objected to their lifestyle.[6] Another recent national survey reported that 20% of individuals living with HIV stated that they had been denied care because of their condition.[7] A few recent examples of discrimination in North Carolina include:

---

[4] AMA Code of Medical Ethics 1.1.2 (stating that "physicians may not decline to accept a patient for reasons that would constitute discrimination against a class or category of patient").

[5] See e.g., *Abbott v. Bragdon*, 163 F.3d 87 (1st Cir. 1998) (upholding ADA claim when individual was refused treatment by a dentist because she had HIV)

[6] Lambda Legal, *When Health Care Isn't Caring: Survey on Discrimination against LGBT People and People Living with HIV*, 2010, accessed at <https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf>

[7] Center for American Progress, *Discrimination Prevents LGBTQ People from Accessing Health Care*, 2018 <https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/ >

- A Charlotte fertility center that declined to provide in-vitro fertility services to same-sex couples seeking to start a family.[8]
- A Fayetteville provider who refused to treat a car crash victim for back pain because of she had HIV.[9]

The proposed rule seeks to implement and enforce the federal provider conscience laws, including the Church Amendment.[10] The proposed rule's interpretation of the Church Amendment appears to permit health care providers to discriminate against LBGT North Carolinians and North Carolinians living with HIV. The rule interprets paragraphs (c)(2) and (d) of the Church Amendment to state that health care employers that receive certain federal funds cannot take adverse workplace actions against a health care worker because the worker "refused to perform or assist in the performance" of any health-care related activity because of a moral or religious objection. Under this interpretation, a health care provider may believe they can refuse to provide a health care service to an LBGT individual or a person living with HIV because of moral or religious objections to their "lifestyle." This provides a far greater shield for religious refusals than Title VII's reasonable and balanced approach. As result, more providers are likely to discriminate against these groups in North Carolina. In particular, we are concerned that this additional encouragement would result in some providers refusing to provide HIV treatment and prevention, including pre-exposure prophylaxis for HIV ("PrEP"), a highly effective means of HIV prevention that can reduce the risk of infection by 92%.

Although patients can seek legal redress for their discrimination, no legal remedy can undo the indignity and stigma resulting from discrimination by a health care provider in whom the patient entrusted his or her life. And some patients may be unable to access appropriate care.

3. The proposed rule would restrict health care access, reduce health care quality, and lead to worse health outcomes for LBGT individuals and people living with HIV.

As a result of the refusals of care that the proposed rule will encourage, more LBGT North Carolinians and North Carolinians living with HIV will lack access to care, receive inadequate care, and suffer poor health outcomes. Additionally, refusals to provide HIV care and prevention, including refusal of PrEP, will undermine the public health and result in new HIV infections that could have been avoided.

As more providers refuse to provide health care to these groups, these North Carolinians will have fewer providers available for them in their communities, especially in the rural areas of the state. Recently enacted state provider conscience laws in the South have resulted in restricted

---

[8] Sandhya Somashekhar, "Lesbians sue N.C. after being turned away from fertility clinic", *Washington Post*, 2016, < https://www.washingtonpost.com/news/post-nation/wp/2016/04/21/lesbians-sue-n-c-after-being-turned-away-from-fertility-clinic/>

[9] U.S Department of Justice, *Fayetteville Pain Center Settles HIV Discrimination Case*, 2014, < https://www.justice.gov/usao-ednc/pr/fayetteville-pain-center-settles-hiv-discrimination-case >

[10] 42 U.S. Code § 300a–7

health care access in rural areas.[11] For example, Tennessee recently enacted a provider conscience statute that appeared to permit mental health counselors to refuse to treat gay and transgender individuals due to moral objections.[12] As a result, LBGT individuals in rural Tennessee have had a hard time accessing mental health services.[13] Some gay and transgender Tennesseans reported having to travel over two hours to see therapists willing to treat them. [14]

More North Carolinians will also receive inadequate care. As result of this rule, more LBGT North Carolinians and North Carolinians living with or at risk of HIV will fear discrimination in the health care setting. Studies have shown that when LBGT individuals and people living with HIV are worried about facing discrimination, they often fail to disclose their sexual or health status with their doctors.[15] As a result, providers are less likely to be fully informed about their medical history and needs, which impacts the provider's ability to make a proper diagnosis and to prescribe the right treatment.

Additionally, the rule appears to allow providers to take actions that will result in inadequate care. The rule permits practitioners to refuse "to assist the performance" of any health-care related activity. Under the rule's broad definition of "assist in performance", a worker can refuse to provide counseling regarding a treatment if he has a moral objection to providing these services. Thus, although it is medically unethical [16] and illegal[17] to withhold treatment options from patients, some providers will interpret the rule as permitting them to withhold information about treatment options they find to be morally objectionable. For example, under the rule, a provider may choose not to inform a patient at risk of HIV about PrEP, based on the belief that PrEP will encourage immoral behavior. Some LBGT patients will receive inadequate care because they will not be fully informed of their treatment options, and thus unable to obtain the treatment and prevention services that best meets their needs. Refusals to provide PrEP would result in new HIV infections that could have been avoided, undermining the health of both the individual and the public.

---

[11] Human Rights Watch, *Religious Exemptions and Discrimination against LGBT People in the United States.*, February 2018, <https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people>

[12] 2016 Tenn. Pub. Acts 926 (stating that "[n]o counselor or therapist providing counseling or therapy services shall be required to counsel or serve a client as to goals, outcomes, or behaviors that conflict with a sincerely held religious belief of the counselor or therapist")

[13] Human Rights Watch, *Religious Exemptions and Discrimination against LGBT People in the United States.*

[14] *Id.*

[15] *See e.g.*, Jillson IA. "Opening closed doors: Improving access to quality health services for LGBT populations". *Clinical Research and Regulatory Affairs*. 2002;19(2–3):153–190

[16] AMA Code of Medical Ethics Opinion 2.1.1 (asserting that "informed consent is fundamental in medical ethics and law").

[17] *See e.g., McPherson v. Ellis*, 305 N.C. 266, 270, 287 S.E.2d 892 (holding that "consent to a proposed medical procedure is meaningless if given without adequate information and understanding of the risks involved".)

Increased denials of medically necessary care and inadequate care will result in more LBGT North Carolinians and North Carolinians living with HIV suffering worse health care outcomes, including death.

***

To ensure that gay and transgender North Carolinians and North Carolinians living with HIV are not discriminated against, we urge the Department of Health and Human Services to withdraw the proposed rule.

Respectfully submitted,

Allison Rice & Alex Lewis
Duke Health Justice Clinic

Lee Storrow
North Carolina AIDS Action Network

Ballantyne Family Medicine
East Carolina University Brody School of Medicine Infectious Diseases Clinic
Equality North Carolina
LGBT Center of Raleigh
RAIN
Southern AIDS Coalition
Warren-Vance Community Health Center
WE Team of the East

Exhibit 67

EmblemHealth

55 Water Street, New York, New York 10041-8190 www.emblemhealth.com

Submitted electronically at www.regulations.gov.

March 27, 2018

Re: HHS–OCR–2018–0002.

On behalf of EmblemHealth and our partner organizations ConnectiCare and AdvantageCare Physicians of New York (ACPNY), we are writing in response to the proposed rule issued by the Office of Civil Rights (OCR) at the Department of Health and Human Services entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" published in the *Federal Register* on January 26, 2018 (83 FR 3880). EmblemHealth is the largest community-based nonprofit health plan in the country, and with our partner ConnectiCare, serves approximately 3.1 million individuals who live in New York, Connecticut, New Jersey, and Massachusetts.

EmblemHealth is unique among health plans because of our close working relationship with ACPNY, one of the largest medical groups in the New York City area, serving approximately 500,000 patients with 36 offices across Manhattan, Brooklyn, Queens, Staten Island, and Long Island. We also operate in New York City, perhaps the most socially, ethnically, and racially diverse city in the world and take pride in our commitment to ensuring all the individuals we serve receive the health care services they need. Our suggestions below reflect this perspective.

GENERAL COMMENT

EmblemHealth and our partners have always taken our obligations to serve the diverse needs of our enrollees while respecting the beliefs of our employees and provider partners extremely seriously. Our organizational culture requires a respect for one another and for the individuals we serve, regardless of their personal beliefs, racial or ethnic makeup, gender, gender identity, sexual orientation, or religion.

Our culture also demands we remain vigilant in ensuring compliance with statutory and regulatory requirements that affect our activities. Those laws include the requirements this proposed rule intends to enforce and federal and state statutes prohibiting discrimination against the individuals we serve. We are concerned certain sections of the proposed rule could be considered in conflict with those laws and our principles. Below, we suggest solutions that would allow us to meet these obligations and ensure both the belief systems of our employees and network providers and the needs of our enrollees are respected.

SPECIFIC COMMENTS

- **§ 88.2 Definitions: Definition of Referral or Refer** – The proposed rule's definition of "refer" goes beyond a direct referral to a provider or specialist who would be able to perform the requested procedure. It also includes "directions that could provide ***any assistance*** in a person obtaining, assisting, training in, funding, financing, or performing a particular health care service, activity, or procedure." (emphasis added) The definition would therefore seem to prevent a health plan from directing a customer service representative receiving questions about services to which s/he objects to suggest the enrollee speak with the person's supervisor about getting coverage, or a clinician in a similar situation to direct the individual to the plan's provider relations staff. This could leave the health plan at risk of being out of compliance with federal and state antidiscrimination laws and coverage requirements and our responsibilities to serve all of our enrollees with equality and respect.

  We strongly urge OCR to clarify how health plans can meet these responsibilities within the context of this definition or change it to be more consistent with our understanding of the statutory requirements. In principle and in practice, EmblemHealth, ConnectiCare, and ACPNY treat all employees, providers, enrollees, and others with whom we work the same. We do not discriminate or show favoritism based on personal beliefs or lifestyles. Any new interpretation of the conscience requirements that jeopardizes these practices is likely in conflict with other federal and state laws and should be changed to ensure conscience protections do not violate an individual's right to receive covered benefits under our plan.

- **§ 88.5 Notice Requirement** – The proposed rule would require covered entities including health plans to post notice of compliance with the rule on its website and on prominent display by April 26, 2018. OCR also notes it will take other factors into account when assessing compliance, including whether the organization puts the notice in employee handbooks or "applications for membership in the recipient's workforce." We have two concerns with this section of the proposed rule:

  - Timeframe: The proposed compliance date is less than one month after the end of the comment period for this rule. Health plans and other entities will need to make systems changes to be in full compliance that include reissuing employee handbooks and assessing employment applications and notices. OCR should make these notice requirements effective no sooner than six months after the publication of the final rule to ensure plans have sufficient time to understand and implement the new regulation.

  - Content of the Notice: The proposed Notice Concerning Federal Health Care Conscience and Associated Anti-Discrimination Protections in Appendix I of the proposed rule includes the following sentence: "You have the right to decline to participate in, refer for, undergo, or pay for certain health care-related treatments, research, or services… which violate your conscience, religious beliefs, or moral convictions under Federal law." As noted above, we are concerned this language

in combination with the new definition of "refer" is inconsistent with other federal and state laws prohibiting discrimination of enrollees requesting coverage for the services we provide. The statement should permit health plans to add a sentence to the end of the first paragraph in the notices to employees and providers stating that individuals with conscientious objections should direct the enrollee to their supervisors or health plan's provider relations staff without fear of discrimination, retaliation, or intimidation.

- **Implications for Providers Serving Enrollees with Conscientious Objections to Medical Services.** The proposed rule is unclear whether it would permit a physician or other clinician to redirect individuals with conscientious objections to medical treatments to others who would be better able to advise them. We have had experience with patients who refuse services, including vaccinations or other procedures, determined by their physician's best medical judgement to be in their interests. In these cases, it is extremely difficult for clinicians to effectively address their patients' needs without violating their ethical standards in the practice of their profession. We request clarification to ensure physicians who refer these patients to others and decide to no longer treat them are not in violation of the proposed rule.

We have appreciated the opportunity to comment on this proposed rule. Please contact Howard Weiss at 646-447-1074 or hweiss@EmblemHealth.com if you would like to discuss the issues we have raised.

Exhibit 68

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:

Empire Justice Center provides the following public comments regarding the proposed rule, "Protecting Statutory Conscience Rights in Health Care", published January 26.

Empire Justice Center is a statewide legal services organization with offices in Albany, Rochester, Westchester and Central Islip (Long Island). Empire Justice provides support and training to legal services and other community based organizations, undertakes policy research and analysis, and engages in legislative and administrative advocacy. We also represent low income individuals, as well as classes of New Yorkers, in a wide range of areas including health, immigration, public assistance, domestic violence, and SSI/SSD benefits.

Daily in the United States, LGBTQ people experience discrimination and other barriers to accessing health care. While discrimination and access barriers harm every member of the community, the barriers that transgender patients experience are especially pronounced. The proposed regulation ignores this widespread practice of discrimination and damage, and will undoubtedly lead to increased discrimination and denials of care for far too many people. This proposed rule threatens the rights to life, liberty, and self-determination that are bedrock values of our nation. Access to health care is a matter of life and death for all Americans.

1. LGBTQ individuals already face significant barriers to accessing health care services.

LGBTQ people, women, and other vulnerable groups around the country face enormous barriers to receiving necessary health care.[1] This challenge is compounded for those living in areas with

[1] *See, e.g.,* Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx; Sandy E. James et al., *The Report of the U.S. Transgender Survey* 93–126 (2016), www.ustranssurvey.org/report; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010),

already limited access to health providers. The proposed regulation will reduce access to care where it is already limited, and will eliminate it entirely in some places.

Patients living in rural areas already face many barriers to care, including lower access to health insurance coverage, lower incomes, and lower rates of paid sick leave. In upstate New York (outside of New York City), 24% of LGBTQ upstate New Yorkers reported inadequate health insurance as a barrier to care, 39% reported inadequate financial resources as a barrier to care, and 20% reported long distances to travel to providers as a barrier to care. 10% reported being denied care entirely due to being LGBTQ.[2] These numbers all jump up significantly for transgender New Yorkers, who are disproportionately affected by discrimination, harassment, and poverty. 66% of transgender New Yorkers reported that personal financial resources were a barrier to accessing transition-related health care, and 61% said that their insurance did not cover their transition-related care.[3]

This is in addition to the costs of transportation, unpaid leave, and other incidentals that accompany obtaining care in the first place. For many, the distance to a healthcare facility alone 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.[4] Patients seeking specialized care such as 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.[5]

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

---

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] Somjen Frazer and Erin Howe, *LGBT Health and Human Services Needs in New York State: A Report from the 2015 LGBT Health and Human Services Needs Assessment* (2016), http://strengthinnumbersconsulting.com/wp-content/uploads/2017/07/Needs-Assessment-WEB.pdf

[3] Somjen Frazer and Erin Howe, *Transgender Health and Economic Insecurity: A Report from the 2015 LGBT Health and Human Services Needs Assessment Survey* (2015), http://strengthinnumbersconsulting.com/wp-content/uploads/2017/06/TG-health-and-economic-insecurity-report-FINAL.pdf

[4] 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.

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

it would be very difficult or impossible to find an alternative provider.[6] 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 proposed regulation would broaden religious exemptions in a way that is likely to reduce access to medically necessary health care services for LGBTQ individuals.

The proposed 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 proposed 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.[7] In New York State, one in three transgender people reported having at least one negative experience with a provider related to being transgender, including verbal harassment, physical or sexual assault, or being refused treatment entirely.[8]

Due to the ambiguity created by the proposed rule, 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.[9] In fact, medical staff may interpret the regulation to indicate that they can not only refuse, but decline to tell the

---

[6] 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.

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

[8] Sandy E. James et al., New York State Report of the U.S. Transgender Survey (2016) http://www.transequality.org/sites/default/files/USTS%20NY%20State%20Report%20%281017%29.pdf

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

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. This ambiguity 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 proposed 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. 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 or broadened to include treatments that have simply an incidental effect on fertility, as the vague and sweeping language of this rule encourages, providers will be emboldened to refuse services in situations that go even further beyond what federal law allows. The proposed regulation 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 broadly to refuse care to patients based on the providers' religious or moral beliefs, the proposed rule conflicts with hundreds of state and local nondiscrimination laws around the country that apply to health care. The conflicts that will be created by the proposed rule will have to be litigated at great expense to patients, health care providers, and taxpayers.

It is, therefore, 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 broad 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 continue to be adequately and safely addressed, and that they are able to receive both accurate information and quality health services.

Indeed, the First Amendment's Establishment Clause, and subsequent jurisprudence, 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 it 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 only 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, and appears to have been developed in a rushed and arbitrary manner. Most importantly, it will put the health and potentially even the lives of patients at risk. We urge the Department to withdraw the proposed rule.

Exhibit 69

ESPERANZA
health centers

Comments from Esperanza Health Centers on proposed rule "Protecting Statutory Conscience Rights in Health Care; Delegations in Authority"

March 22nd, 2017
Submitted online via Regulations.gov to docket HHS-OCR-2018-0002

To whom it may concern at the Department of Health and Human Services,

At Esperanza Health Centers, we are extremely alarmed by the proposed rules "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority". As a Federally Qualified Health Center providing care to Chicago's underserved communities, we know there is a great need to address the many barriers people face in accessing care through the health care system, from language differences and a lack of available providers, to discrimination and denial of services. That is why it is imperative that we speak forcefully against efforts that seek to erect further barriers for patients, endangering their autonomy and health. Any effort that claims to protect providers who put their own opinions above the needs of their patients has no place in the United States.

No provider should be able to refuse to make referrals to other providers who do not have the same moral or religious objections to delivering care. We recommend the words in Section 88.2 "counseling, referral, training and other arrangements for the procedure, health service, or research activity" be removed from the definition of "assist in the performance". This rule gives providers license to discriminate against people based who they are, whom they love, and the care they need. It is unconscionable to allow a provider to use their moral or religious beliefs to manipulate patient decision-making, shame people and deny access to care. These actions will turn people away from seeking medical care, destroy provider and patient relationships, ruin efforts to prioritize prevention, and harm patients' mental and physical health. Providers should be using evidence-based clinical standards, not their religious beliefs to provide care to patients. Patients, above everyone else, should be at the center of decision-making and be fully informed of their treatment options.

This rule should not be finalized without clear and measurable benefits to the public, and a robust analysis of its costs. The cost of this rule greatly exceeds the stated benefits included in the Regulatory Impact Analysis section, which are vague and not supported with evidence. The proposed rule fails to provide any quantifiable benefit to the public, yet would spend $692.1 million dollars over 5 years to implement it. We recommend that the rule include an analysis of quantifiable benefits, as well as an analysis of the costs of the rule, including estimates of discrimination complaints from patients that would result from it.

Any rule governing the actions of the Department of Health and Human Services should advance its mission and devote resources to end discrimination against patients, not

ESPERANZA
health centers

encourage it. The proposed rule fails to advance HHS's mission to enhance and protect the health and well-being of all Americans. The OCR should remain within its historical activities, which have been to protect the civil rights and privacy of patients. We recommend that the statement in section 88.8 "The proposed rule does not relieve OCR of its obligation to enforce other civil rights authorities, such as..." also include section 1557 of the Affordable Care Act, which prohibits discrimination along with other civil rights authorities.

We appreciate the opportunity to provide public input. We encourage the Office of Civil Rights reject this rule and share in our commitment to serve and protect all people regardless of gender identity and expression, sexual orientation, national origin, immigration status, race, ethnicity, age, and disability.

Please do not hesitate to contact us with questions regarding these comments.

Sincerely,

Dan Fulwiler
Chief Executive Officer
Esperanza Health Centers
2001 S. California Avenue, Suite 100
Chicago, IL 60608
(773) 584-6130

Exhibit 70

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

The below 41 public and professional health organizations and 116 individual medical professionals respectfully submit the following comment regarding the proposed rule referenced above, as published in the Federal Register. We are concerned that the rule could put people and communities at serious risk based on potential misinterpretations by citizens and/or frontline officials. Specifically, while the Department intends to respect state law, we are concerned that some may try and use the rule to challenge existing state school immunization requirements, undermining a state's autonomy to protect public health according to its assessment of local conditions. We are also concerned that some will interpret the rule, incorrectly, as prohibiting private practices – business owners – from choosing their own clientele. And we are concerned that explicitly naming vaccine administration and reception as a category of discrimination may encourage healthcare workers to act in ways that put others at risk.

We are requesting that the Department:

1. Clarify that the rule is not aimed at, and will not be used for, interfering in existing state legislation that does not currently violate federal law, such as school immunization requirements or state vaccination mandates for healthcare workers.

2. Clarify that the rule is not intended to limit the freedom of independent health care providers to choose which patients to accept or reject, as long as the criteria for such choices are aimed solely at protecting the population they serve and are not religiously motivated.

3. Remove the language that indicates health care providers "being required to administer or receive certain vaccinations derived from aborted fetal tissues as a condition of work or receipt of educational services" is religious discrimination, since refusal to vaccinate in these circumstances can put others – patients and the communities – at risk.

Overview of the Intersection of Vaccines and Religion

Freedom to practice religion is a fundamental right in the U.S., guaranteed by the very first Amendment to our Constitution. However, no right is absolute. If compelling reasons exist to limit this right, we must seriously consider their potential impact.

From smallpox to chicken pox, our nation has successfully protected those in the U.S. from deadly infectious diseases. Vaccines given to children born between 1994 and 2016 will prevent an estimated 381 million illnesses, 24.5 million hospitalizations, 855,000 deaths, and $1.65 trillion in total societal costs.[i] To give two examples, the *Haemophilus influenzae* type b (Hib) vaccine prevents over 20,000 cases of serious disease and a thousand deaths each year,[ii] while the rubella vaccine prevents tens of

thousands of miscarriages, stillbirths, and cases of birth defects that used to result from rubella (German measles) infection during pregnancy.[iii]

While freedom to practice religion – including which medical services to receive – is a fundamental right in this country, it is less certain whether religion and vaccination are truly in conflict. Few, if any, organized religions are opposed to vaccination. Below is an overview of several major religions' positions on immunization:

- While a minority of **Amish** parents do not vaccinate their children, vaccination is not prohibited by their religion.[iv]

- The **Church of Jesus Christ of Latter-day Saints** has supported childhood vaccination for over 30 years. In July 1978 they stated, "We urge members of The Church of Jesus Christ of Latter-day Saints to protect their own children through immunization. Then they may wish to join other public-spirited citizens in efforts to eradicate ignorance and apathy that have caused the disturbingly low levels of childhood immunization."[v]

- Many imams and other **Islamic** leaders have issued clear statements commenting that vaccination is consistent with Islamic principles.[vi, vii, viii] In particular, a 1995 conference of Islamic scholars concluded, "The transformation of pork products into gelatin alters them sufficiently to make it permissible for observant Muslims to receive vaccines containing pork gelatin."[ix]

- According to The Watch Tower Bible and Tract Society of Pennsylvania, the main legal entity that organizes worldwide activities by **Jehovah's Witnesses**, "We have no objection to vaccines in general."[x]

- While there is no single voice for **Jewish** communities, many rabbis have spoken out in favor of vaccinations noting the importance of preserving life (*pikuakh nefesh*) and that, according to Jewish law, there is no objection to porcine or other animal-derived ingredients in vaccines.[xi]

- The **Roman Catholic Church** recognizes the importance of vaccinations and their use in the fight against infectious disease to protect both individuals and the larger community. It advocates use of alternatives, if available, of certain viral vaccines manufactured in cell lines with remote fetal origins. However, "as regards the vaccines without an alternative, the need to contest so that others may be prepared must be reaffirmed, as should be the lawfulness of using the former in the meantime insomuch as is necessary in order to avoid a serious risk not only for one's own children but also, and perhaps more specifically, for the health conditions of the population as a whole - especially for pregnant women; the lawfulness of the use of these vaccines should not be misinterpreted as a declaration of the lawfulness of their production, marketing and use, but is to be understood as being a passive material cooperation and, in its mildest and remotest sense, also active, morally justified as an extrema ratio due to the necessity to provide for the good of one's children and of the people who come in contact with the children (pregnant women)." [xii]

Additional opinions on vaccines from organized religious groups can be found in the Appendix of this comment.

Respecting State Jurisdiction

These are just a few examples of the views of organized religions. Most states recognize individuals may hold religious beliefs that do not perfectly align with an organized religion. Therefore, all but three states in the U.S. – California, Mississippi and West Virginia – allow individuals to refuse immunizations for religious and/or philosophical reasons.

National and even state-wide immunization rates only tell part of the story. In reality, disease outbreaks occur at the community level where vaccination rates have fallen below the thresholds needed to prevent disease. For example, this past spring, Minnesota experienced a major outbreak of measles. In one community in Minnesota, measles vaccination rates had dropped to 42 percent among a group of preschool-aged children, despite a state-wide immunization rate of 93 percent.[xiii] As a result, 8,000 people were exposed to measles, 79 contracted the disease, and 22 were hospitalized. It is therefore critical that states be able to pursue policies and laws that best protect their populations as they know the situations their residents are facing best.

The proposed rule makes it clear in multiple places that its intent is not to interfere in state law. For example, the rule says that, "The proposed rule makes clear that it is not intended to interfere with the operation of State law, except as required by existing Federal health conscience protections." There is, however, no federal law addressing school immunization requirements. We request that the Department clarify that the rule is not intended to be used against schools following state laws in this matter by adding the following language to section 88.8: "Nothing in this part shall be construed as preempting or interfering with existing and valid state law, for example, state school immunization requirements."

Allowing Health Care Providers the Freedom to Accept or Reject Patients

Just as states are in the best position to create vaccination laws and policies that protect their residents, health care providers are in the best position to determine what is best for their patients. Standards are set by national and state law as well as by recommendations from professional medical societies, but within those guidelines there exists some leeway for health care providers to create policies for their practices, including which patients to accept.

Unfortunately, we know that when children are exempt from immunizations, they are at higher risk of deadly infectious diseases. For example:

- Children exempt from vaccination requirements are **more than 35 times more likely to contract measles**[xiv] and **nearly 6 times more likely to contract pertussis**,[xv] compared to vaccinated children.
- **States with loose exemption policies had approximately 50% more cases of whooping cough compared to states with stricter policies** in a 2006 study.[xvi]

Vaccines protect both the individuals vaccinated and those around them from dangerous diseases (a concept known as "community immunity"). Most vaccine-preventable diseases are transmitted from person to person, so if a high proportion of the population is vaccinated and immune, then the chain of transmission is broken. For example, a child can be protected against measles or whooping cough, even

if they have not yet reached the recommended age for vaccination, if enough people around them have been vaccinated and are less likely to carry or transmit the disease. Conversely, if not enough individuals are vaccinated, diseases can once again spread through a community, affecting even those who were vaccinated. Thus, the medical community strongly supports vaccination according the U.S. Centers for Disease Control and Prevention's recommended immunization schedule.

Outbreaks have been started in doctors' offices by unvaccinated children in the past. A 2008 measles outbreak sparked in a San Diego pediatric clinic waiting room is a case in point.[xvii] An unvaccinated child returned from a vacation in Switzerland with measles, leading to the exposure of 839 people, 11 additional cases (all in unvaccinated children), and the hospitalization of an infant below the age measles vaccine is recommended. It is important to provide all children with medical care, but providers are best placed to assess the risks in their community and decide which risks they are willing to take.

It is therefore quite reasonable that some health care providers would have policies that do not allow voluntarily unimmunized children to join their practices out of concern for their other patients. The Department should make it clear that such general and legal policies adopted for reasons that have nothing to do with religion is not discriminatory when applied to all patients equally.

Placing Patient Health First

While 20 percent of the population lives in rural areas, fewer than 10 percent of physicians practice in rural areas.[xviii] According to Georgetown University's Public Health Institute:

> The Department of Health and Human Services recommends a provider-to-patient ratio of one primary care physician to every 2,000 individuals. Over 20 million rural Americans live in areas that have a provider-to-patient ratio of 1 to 3,500 or less and are federally designated as health professional shortage areas (HPSAs). More than 2,200 physicians are needed to remove the HPSA designation from all rural areas, but more than twice that number is needed to achieve the recommended ratio of 1 to 2,000 in these areas.[xix]

As a result, many individuals across the U.S. have limited options to receive medical care, including vaccinations. If the only provider in an area does not administer vaccines because it against his or her personal religious beliefs, then entire communities could be left vulnerable to devastating infectious diseases.

If providers in rural, urban, or suburban areas begin to pick and choose which vaccines to administer to their patients, the resulting patchwork of immunization coverage would make it difficult for patients and parents to become fully vaccinated against dangerous diseases. Few people know which vaccines they have or have not received and may not understand a provider has failed to provide them with one or two crucial immunizations.

In addition, practices and institutions must maintain the ability to require their providers and staff to be vaccinated. Providers and staff have a responsibility not to spread disease among their patients. An unvaccinated provider or staff member in any area, whether rural, suburban or urban, would be in a prime position to spread vaccine-preventable diseases throughout a clinic, hospital system, nursing home, or entire community.

The proposed rule specifically refers to providers who do not support the use of fetal cells in vaccines. According to The National Catholic Bioethics Center: "One is morally free to use the vaccine regardless of its historical association with abortion. The reason is that the risk to public health, if one chooses not to vaccinate, outweighs the legitimate concern about the origins of the vaccine. This is especially important for parents, who have a moral obligation to protect the life and health of their children and those around them." [xx]

Allowing a disease such as rubella, which can cause miscarriages, stillbirths, and birth defects when contracted by pregnant women, to ravage a community due to the personal religious beliefs of a single provider would violate both the Hippocratic Oath as well as religious doctrine.

We therefore ask that the department delete this language in the proposed rule from its final version: "being required to administer or receive certain vaccinations derived from aborted fetal tissues as a condition of work or receipt of educational services. "

Preserving religious freedom in the U.S. is important, but so is keeping our people free from deadly, vaccine-preventable diseases. We hope the Department will consider our requested changes.

Sincerely,

Organizations, Practices, & Clinics

Alliance for Aging Research
Asian Pacific Community in Action
Association of Immunization Managers
California Immunization Coalition
Central Oklahoma Immunization Coalition
Colorado Children's Immunization Coalition
Community Health Alliance, Reno, Nevada
EverThrive Illinois
Every Child By Two
Families Fighting Flu
Hep B United
Hep Free Hawaii
Hepatitis B Foundation
Ithaca is Immunized
Immunization Action Coalition
Immunize Nevada
Indiana Immunization Coalition
Kelsey-Seybold Clinic
Kimberly Coffey Foundation
Massachusetts Chapter of the American Academy of Pediatrics
MassGeneral Hospital for Children
Minnesota Chapter of the American Academy of Pediatrics
Minnesota Childhood Immunization Coalition
National Foundation for Infectious Diseases
Nurses Who Vaccinate

Oregon Pediatric Society, the Oregon Chapter of the American Academy of Pediatrics
Pediatric Nurse Practitioner House Calls, Massapequa Park, NY
Planned Parenthood Mar Monte
San Francisco Immunization Coalition
SC Parents for Vaccines
Southeast Minnesota Immunization Connection
Texas Pediatric Society, the Texas Chapter of the American Academy of Pediatrics
The Immunization Partnership
The Taskforce for Global Health
Thinking Person's Guide to Autism
University of Louisville Global Health Center
Vaccinate California
Vaccine Education Center at Children's Hospital of Philadelphia
Voices for Vaccines
West Virginia Chapter of the American Academy of Pediatrics
West Virginia Immunization Network, a program of The Center for Rural Health Development, Inc.

Individual Health Care Providers

Carden Johnston
Birmingham, AL

Jacques-Emmanuel Corriveau, MD FAAP
Antioch, CA

Graciela M.G. Wilcox, MD MPH FAAP
Carmel, CA

Nelson Branco, MD FAAP
Larkspur, CA

Robin Horak, MD
Los Angeles, CA

Danica B. Liberman, MD MPH FAAP
Los Angeles, CA

Paula Kuhlman, MD FAAP
Valencia, CA

Sean O'Leary, MD MPH
Aurora, CO

Mike Foulds, MD
Colorado Springs, CO

Jeannie Bergamo, RN
East Lyme, CT

Ashley Sara, RN
Trumbull, CT

Jason B. Hann-Deschaine, MD
Townsend, DE

Allan R. De Jong, MD
Wilmington, DE

Stephen C. Eppes, MD
Wilmington, DE

Darren Franczyk, MD FAAP
Wilmington, DE

Nailah Coleman, MD FAAP FACSM
Washington, DC

Linda Fu, MD MS
Washington, DC

Nazrat Mirza, MD
Washington, DC

Robert Wiskind, MD FAAP
Atlanta, GA

Colleen Kraft, MD FAAP
Itasca, IL

Wayne H. Franklin, MD MPH MMM
Maywood, IL

Nithya Sunder, MD
Naperville, IL

Mary Ian McAteer, MD FAAP
Indianapolis, IN

James P. Bien, MD FAAP
Lafayette, IN

Jennifer Mellick, MD
Overland Park, KS

John Snyder, MD
Amherst, MA

Everett Lamm, MD FAAP
Berkshire County, MA

Kathryn S. Brigham, MD
Boston, MA

Peter T. Greenspan, MD
Boston, MA

Vandana Madhavan, MD MPH
Boston, MA

Sean Palfrey, MD
Boston and Cambridge, MA

Stephen I. Pelton, MD
Boston, MA

Parag M. Amin, MD
Brookline, MA

Marc Grella, MD
Cambridge, MA

Gregory Hagan, MD FAAP
Cambridge, MA

David Link, MD
Cambridge, MA

Ronald Samuels, MD MPH
Cambridge, MA

Michael W. Yogman, MD
Cambridge, MA

Wanda I. Gonzalez, MD
Chelsea, MA

David P. Norton, MD FAAP
Holyoke, MA

Carolyn Sax, MD
Milton, MA

Jonathan Caine, MD
Norwood, MA

Marni Roitfarb, MD
Wayland, MA

Joseph B. Leader, MD
Woburn, MA

Angela Beeler, MD
Worcester, MA

Anna Bottar, MD
Worcester, MA

Leah Evans Wong, MD Med
Worcester, MA

Patricia McQuilkin, MD MS
Worcester, MA

Richard Moriarty, MD FAAP
Worcester, MA

Brad Harris, MD
Baltimore, MD

Gillian A. Stoltman, PhD MPH
Kalamazoo, MI

Patricia A. Vranesich, RN BSN
Michigan

Susan Adams, MD PhD
St. Louis, MO

Lauren S. Wilson, MD
Missoula, MT

Gilbert L. Fuld, MD FAAP
Keene, NH

Gail Schonfeld, MD FAAP
East Hampton, NY

Herschel Lessin, MD
Mid Hudson Valley of NY

Michael Weitzman, MD
New York, NY

Jesse Hackell, MD FAAP
Pomona, NY

Carolyn Cleary, MD
Rochester, NY

Andy Pasternak, MD MS
Reno, NV

David A. Horowitz, MD
Cary, NC

David T. Tayloe, Jr., MD FAAP
Goldsboro, NC

Graham Barden, MD FAAP
New Bern, NC

Christoph R. Diasio, MD FAAP
Southern Pines, NC

Susan Kressly, MD FAAP
Warrington, PA

Patricia Holtz, MD
Willow Grove, PA

Eve H. Switzer, MD FAAP
Enid, OK

Michael F. Stratton, DO FAAP FACOP
Muskogee, OK

Donna Jackson, MD
Norman, OK

Thomas L. Kuhls, MD
Norman, OK

Erika Beard-Irvine, MD FAAP
Bend, OR

Tara Greendyk, MD
Austin, TX

Elizabeth Knapp, MD
Austin, TX

Maria C. Monge, MD
Austin, TX

Anna Schlechter, MD FAAP
Austin, TX

Carl Hubbell, MD
Beaumont, TX

Jennifer Macia, MD MPH
Bellaire, TX

Charles Dunlap, MD
Dallas, TX

Damien Mitchell, MD
Dallas, TX

Diane Arnaout, MD
Fort Worth, TX

Stacey Berry, MD
Fort Worth, TX

Jamye Coffman, MD
Fort Worth, TX

Laurie Gray, MD
Fort Worth, TX

Shelby Jacob, MD
Fort Worth, TX

Emily J. Kirby, MD
Fort Worth, TX

Steve Lemons MD
Fort Worth, TX

Parul V. Martin, MD
Fort Worth, TX

Joyce Mauk, MD
Fort Worth, TX

Bradley Mercer, MD
Fort Worth, TX

Kelly Miller, DO
Fort Worth, TX

Beth Montigue, MD
Fort Worth, TX

Julee S. Morrow, MD
Fort Worth, TX

Catherine Nicholas, MD
Fort Worth, TX

Anish Ray, MD
Fort Worth, TX

Ray N. Rhodes, Jr., MD
Fort Worth, TX

Patricia S. Beach, MD
Galveston, TX

Vincent Iannelli, MD FAAP
Heath, TX

Nick Ettinger, MD PhD CPPS FAAP
Houston, TX

W. Blaine Lapin, MD
Houston, TX

Ashley Lucke, MD
Houston, TX

Melanie Mouzoon, MD FAAP
Houston, TX

Mary E. Paul, MD
Houston, TX

Jason V. Terk, MD
Keller, TX

Linda U. McGee, MD
Pasadena, TX

Héctor L. Hidalgo, MD FAAP
Plano, TX

Patricia Harkins, MD
San Antonio, TX

Jane L. Lynch, MD FAAP
San Antonio, TX

Ryan D. Van Ramhorst, MD FAAP
San Antonio, TX

Miguel L. Knochel, MD FAAP
Salt Lake City, UT

Annika M. Hofstetter, MD PhD MPH
Seattle, WA

Edgar K. Marcuse, MD MPH FPIDS
Seattle, WA

Faith Galderisi, DO
Woodinville, WA

Ted Solari, MD
Beckley, WV

James H. Conway, MD FAAP
Madison, WI

Robert T. Rohloff, MD
Milwaukee, WI

Appendix: Additional Vaccination Beliefs of Organized Religions

- In 2010, Tibetan **Buddhist** spiritual leader and Nobel laureate the Dalai Lama helped vaccinate and launch a polio eradication drive in India.[xxi]

- There are some faith-healing groups—of which the **Church of Christ, Scientist (Christian Science)** is the most prominent—that believe they can heal all things through prayer rather than through medicine. Therefore, many of these worshippers oppose vaccinations.[xxii, , xxiiixxiv]

- There is no formal statement from **Hindu** authorities on vaccination, as Hinduism has several hundreds of sects, each with its own traditions and rules. Many areas of the world with large Hindu populations, such as India, which is 80.5% Hindu, have taken proactive efforts to eradicate vaccine-preventable diseases like polio.[xxv, xxvi]

- There is no official statement on immunization from **Sikh** authorities. But generally, Sikhs do not have religious or societal issues against vaccination.

References

[i] U.S. Centers for Disease Control and Prevention. "How Your Child Care Program Can Support Immunization." April 2017. Accessed 21 December 2017.

[ii] U.S. Centers for Disease Control and Prevention. "Protect Your Child against Hib Disease." *CDC Features.* 13 March 2017. Accessed 26 February 2018. https://www.cdc.gov/features/hibdisease/

[iii] U.S. Centers for Disease Control and Prevention. "Chapter 15: Congenital Rubella Syndrome." *Manual for the Surveillance of Vaccine-Preventable Diseases.* 17 November 2017. Accessed 26 February 2018. https://www.cdc.gov/vaccines/pubs/surv-manual/chpt15-crs.html

[iv] Grens, K. (June 27, 2011). Amish Parents Mirror Wider Concerns over Vaccines. *Reuters Health.* Retreived from http://www.reuters.com/article/2011/06/27/us-amish-parents-idUSTRE75Q5SO20110627

[v] The Church of Jesus Christ of Latter-day Saints. (July 1978). Immunize Children, Leaders Urge. *Liahona*. Retrieved from http://www.lds.org/liahona/1978/07/immunize-children-leaders-urge?lang=eng

[vi] Yahya M. (2006). Polio vaccines—Difficult to Swallow. The Story of a Controversy in Northern Nigeria. Institute of Development Studies. Retrieved from www.ids.ac.uk/files/Wp261.pdf

[vii] Kaufmann, J.R., & Feldbaum, H. (2009). Diplomacy and the Polio Immunization Boycott in Northern Nigeria. *Health Affairs, 28*(July-August)(4):1091-101. Retrieved from http://content.healthaffairs.org/content/28/4/1091.full.html

[viii] Jegede, A.S. (2007). What Led to the Nigerian Boycott of the Polio Vaccination Campaign? *PLoS Med*, 4(Mar):e73. Retrieved from http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0040073

[ix] Institute for Vaccine Safety. (2010). Religious Leaders Approval of Use of Vaccines Containing Porcine Gelatin. Retrieved from http://www.vaccinesafety.edu/Porcine-vaccineapproval.htm

[x] Watch Tower Bible and Tract Society of Pennsylvania. (2012). Our View of Medical Care: Health Choices. Retrieved from http://www.jw-media.org/aboutjw/article02.htm

[xi] Institute for Vaccine Safety. (2010). Religious Leaders Approval of Use of Vaccines Containing Porcine Gelatin. Retrieved from http://www.vaccinesafety.edu/Porcine-vaccineapproval.htm

[xii] Pontifical Academy for Life. (2005) "Moral Reflections on Vaccines Prepared from Cells Derived from Aborted Human Foetutes" Retrieved from http://www.academiavita.org/publications.php

[xiii] Minnesota Department of Health. "Health officials declare end of measles outbreak."25 August 2017. Accessed 8 December 2017. http://www.health.state.mn.us/news/pressrel/2017/measles082517.html.
[xiv] Salmon DA, Haber M, Gangarosa EJ, Phillips L, Smith NJ, Chen RT. Health consequences of religious and philosophical exemptions from immunization laws: individual and societal risk of measles. JAMA.1999;282:47-53.
[xv] Feikin DR, Lezotte DC, Hamman RF, Salmon DA, Chen RT, and Hoffman RE. Individual and Community Risks of Measles and Pertussis Associated With Personal Exemptions to Immunization. JAMA 2007;284:3145-3150.
[xvi] Omer, S.B., Pan, W.K., Halsey, N.A., Stokley, S., Moulton, L.H., Navar, A.M., Pierce, M., & Salmon, D.A. (2006). Nonmedical exemptions to school immunization requirements: secular trends and association of state policies with pertussis incidence. *Journal of the American Medical Association, 296*(14):1757-63. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17032989
[xvii] David E. Sugerman et al. "Measles Outbreak in a Highly Vaccinated Population, San Diego, 2008: Role of the Intentionally Undervaccinated." 125 *Pediatrics* 747 (2010).
[xviii] Stanford University. "Healthcare disparities & barriers to healthcare." Accessed 23 February 2018. http://ruralhealth.stanford.edu/health-pros/factsheets/downloads/rural_fact_sheet_5.pdf.
[xix] Health Policy Institute. "Rural and Urban Health." Georgetown University. Data Profile Number 7, January 2003. Accessed 23 February 2018. https://hpi.georgetown.edu/agingsociety/pubhtml/rural/rural.html.
[xx] The National Catholic Bioethics Center. "FAQ on the Use of Vaccines." 2006. Accessed 27 February 2018. https://www.ncbcenter.org/resources/frequently-asked-questions/use-vaccines/.
[xxi] Reuters. (January 10, 2010). Video: Dalai Lama Launches polio vaccine. Retrieved from http://www.reuters.com/video/2010/01/10/dalai-lama-launches-polio-vaccine?videoId=26160277
[xxii] The College of Physicians of Philadelphia. (2012). Cultural Perspectives on Vaccination. *The History of Vaccines.* Retrieved from http://www.historyofvaccines.org/content/articles/cultural-perspectives-vaccination
[xxiii] *GOOD.is.* (February 3, 2011). Should Parents Be Allowed to Pray Their Children Healthy? Retreived from http://www.good.is/posts/should-families-that-believe-in-faith-healing-be-prosecuted-when-their-children-die
[xxiv] Rodgers, D.V., Gindler, J.S., Atkinson, W.L., & Markowitz L.E. (1993). High Attack Rates and Case Fatality During a Measles Outbreak in Groups with Religious Exemption to Vaccination. *Pediatric Infectious Disease Journal, 12*(4): 288-292. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8483622
[xxv] Memon, A. (September 20, 2012). Opinion: Cross-border Lessons in Saving Lives. *The Hindu*. Retrieved from http://www.thehindu.com/todays-paper/tp-opinion/article3916454.ece
[xxvi] Office of the Registrar General and Census Commissioner, India under Ministry of Home Affairs, Government of India. (2010-2011). Distribution of Population by Religions. Retrieved from http://censusindia.gov.in/Census_And_You/religion.aspx

Exhibit 71

475 Park Avenue South, Suite 2100
New York, NY 10016
tel 646.880.3005
fax 202.697.5058
info@familyequality.org

March 27, 2018

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

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

To Whom it May Concern:

Family Equality Council submits the following comment in response to the request for public comment regarding the proposed rule entitled "Protecting Statutory Conscience Rights in Health Care," published January 26.

Family Equality Council connects, supports, and represents the three million parents who are lesbian, gay, bisexual, transgender and queer (LGBTQ) in this country and their six million children. We are a community of parents and children, grandparents and grandchildren that reaches across this country. For over 30 years we have raised our voices toward fairness for all families.

We thank you for the opportunity to comment on HHS' Proposed Rule, RIN 0945-ZA03, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (Rule).

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 rule ignores the prevalence of discrimination and damage it causes and will undoubtedly lead to increased discrimination and denials of care for some of the most vulnerable members of our community. We deeply value freedom of religion but sweeping exemptions that obstruct access to care are a fundamental distortion of that principle. American patients, particularly those already at heightened

risk for discrimination in health care services as documented by HHS' own Office of Civil Rights, deserve better.[1]

Family Equality Council and partner organizations have documented numerous instances of mistreatment, discrimination and denial of health care services to LGBTQ people and our children in amicus briefs to the Supreme Court and other courts. These stories illustrate not only the discrimination and degrading treatment LGBTQ individuals face when seeking medical care, but also the impact such treatment has on our families:

- Kinsey, a one-week old infant who had a life-threatening reaction to vaccine but was not immediately treated by hospital staff because the lesbian mother who had brought her could not prove she was her "real" mom.[2]
- M.C., a two-year old whose emergency treatment by a pediatric dentist was delayed because, as she was told, "a child cannot have two mothers."[3]
- A.S. and M.S., a married lesbian couple in Tennessee, who were denied service by multiple midwives and a birthing class provider during A.S.' pregnancy.[4]
- K.S., a transgender woman seeking mental health services who was subject to abusive treatment, inappropriate questioning and breaches of confidentiality, and who attempted to commit suicide twice while at the facility.[5]
- M.H., a gay man who checked into a New York City hospital with a severe infection and was treated roughly, called a 'faggot' multiple times, dragged down the hall in an office chair causing him to fall out of chair, and left on the ground where he had a seizure and convulsions.[6]

Expanding religious refusals can exacerbate the barriers to care that LGBTQ individuals and our family members already face.

---

[1] See for example Sharita Gruberg & Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial, 2018* https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/

[2] Brief of Amici Curiae Family Equality Council, Colage, and Kinsey Morrison in Support of Petitioners, Addressing the Merits and Supporting Reversal, *Obergefell v. Hodges*, 135 S. Ct. 2584, 2015, https://www.familyequality.org/_asset/mhfjym/VoCSCOTUS2015.pdf

[3] Brief of Amici Curiae Lambda Legal Defense and Education Fund, Inc., Family Equality Council et al., in Support of Respondents, *Masterpiece Cake Shop v. Colorado Civil Rights Commission*, (S. Ct. 2017), https://www.familyequality.org/_asset/5xtc7j/20171030-LambdaLegal-FamEq-Amicus-Brief-Masterpiece.pdf

[4] Ibid.

[5] Ibid.

[6] Ibid.

Because of the broad language of the rule that goes beyond existing statutes and regulations, we are concerned it could embolden health care providers to claim protections for the kinds of harmful mistreatment and service denials such as those outlined in the examples above.
Nearly 56% of lesbian, gay, and bisexual people have had at least one experience of mistreatment or service denials in health care and 31% of transgender people have faced such discrimination in the last year alone. [7]

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.[8] 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 proposed rule attempts to inappropriately broaden religious exemptions in a way that can lead to dangerous denials of medically necessary treatments.

The rule 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 rule, 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. 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.[9]

---

[7] Movement Advancement Project, *LGBT Policy Spotlight: Public Accommodations Nondiscrimination Laws*, 2018, http://www.lgbtmap.org/file/Spotlight-Public-Accommodations-FINAL.pdf
[8] 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.
[9] Sharita Gruberg & Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial, 2018* https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/

Medical staff may interpret the rule 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 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.

Expanding exemptions undermines the Department's mandate to protect the health and well-being of all Americans.

Reducing discrimination and other barriers to accessing health care services, as well as reducing the accompanying health disparities, is core to the Department's mission and its obligations under laws authorizing its programs. Weakening protections and limiting program access by expanding religion-based exemptions fundamentally runs contrary to this mission.

The Department's core mission is to "enhance and protect the health and well-being of all Americans…by providing for effective health and human services."[10] Ensuring that beneficiaries of Department programs and other patients have fair and equal access to services and reducing barriers to those services is an inseparable and necessary component of this responsibility. The Department's ability to ensure equal, nondiscriminatory access to services would be significantly weakened by the proposed rule. In order to meet its legal obligations and its statutory mission, HHS must prioritize the needs and rights of patients over those of organizations seeking federal funds and individual health

[10] Dep't. of Health & Human Servs., *About HHS*, 2017, https://www.hhs.gov/about/index.html.

care workers. Creating new or expanded exemptions for recipients of federal funds at the cost of patients' access to health services prevents the Department from meeting its responsibilities to HHS program beneficiaries and patients around the country.

The proposed rule undermines 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 inaccurate 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.

Foster children face unique harms due to health care service refusals.
Allowing Such Refusals Undermines States' and Local Governments' Statutorily Required Efforts to Promote Safety, Permanency, and Well-Being of Foster Youth, Including Child-Welfare Specific Nondiscrimination Laws

Foster children, including LGBTQ foster youth, are particularly vulnerable to health care service refusals, and the rule could lead to unlawful service refusals and worsened outcomes for youth in care. The rule could undermine the core statutory objectives of those providing services in the child welfare context, who must act in the best interests of the child, with the objectives of child safety, permanency and well-being. Instead, a health care provider could prioritize personal religious beliefs over the best interests of the child. A broadening of the interpretation of the Church Amendment could lead to a medical professional funded by federal health programs who is providing health care services to foster children, including those in a restricted setting, to feel emboldened to refuse the child a range of services that are in his or her best interests such as reproductive health care for a girl in care, transition related care for a transgender foster youth, or counseling for an LGBTQ-identified foster youth that affirms her or his identity.

Foster children are uniquely dependent on those providing their care, including health care. For example, a child placed in a group home may not have access to the internet, phone service, email, or other means to communicate with health providers other than those entrusted with their care. This means if these children are refused needed health services, it may simply not be possible for them to find a viable alternative.

LGBTQ and female foster youth are particularly vulnerable. HHS-funded research has shown that LGBTQ youth, who comprised 19% of foster youth over 12 in the study of Los Angeles foster care, suffer unacceptably high rates of mistreatment, hospitalizations, placements in group homes (instead of with loving families), serial placements, and homelessness.[11] A study conducted in New York City's child welfare system further found that more than half (56%) of the LGBTQ-identified youth who had been interviewed said that they had chosen living in the streets at one point as they felt safer there than living in group or foster homes.[12] Affirming care that supports LGBTQ foster youths' identities is essential for achieving the child welfare goals of safety, permanency, and well-being. This care includes affirming health care, including reproductive care, transition-related health care for transgender youth, and mental health care that helps LGBTQ foster youth address issues of trauma related to family rejection, violence, harassment, and discrimination due to their sexual orientation or gender identity or expression. Service refusals by medical professionals could greatly exacerbate the trauma these youth have already experienced, particularly as they face few options for accessing alternative providers.

It is impermissible to allow those who care for foster children to deny them access to reproductive health care.

The government is legally obligated to provide medical care and family planning services to the youth in its care, without exception.[13] Yet, the proposed Rule could allow foster parents and social service agencies that provide services to children and young people to refuse even minor assistance to a young person in foster care who needs reproductive health services, including birth control, testing or treatment for sexually transmitted infection, and abortion care. This means that a social service agency or even just one person at that agency could block a young person in foster care from making an appointment or getting to a doctor's office for reproductive health care. A bus driver who is supposed to take a foster child to a doctor's appointment, for example, could refuse to drive the young person to a family planning clinic, claiming that doing so would "assist in the performance" of providing birth control.

Comprehensive, non-judgmental, and trauma informed reproductive health care is critical for youth in foster care. Girls in foster care are twice as likely as girls not in foster care to have sex and less likely to use birth control when they do have sex.[14] As a result, girls in foster care are more likely to

---

[11] Wilson, B.D.M., Cooper, K., Kastanis, A., & Nezhad, S. (2014). *Sexual and Gender Minority Youth in Foster care: Assessing Disproportionality and Disparities in Los Angeles.* Los Angeles: The Williams Institute, UCLA School of Law.

[12] G.P. Mallon, *We don't exactly get the welcome wagon: The experience of gay and lesbian adolescents in North America's child welfare system*, in Child Welfare League of America Best Practice Guidelines (Child Welfare League of America, 2006).

[13] *Flores v. Reno*, No. CV 85-4544- RJK(Px) (C.D. Cal. Jan. 17, 1997).

[14] Alison Stewart Ng & Kelleen Kaye, The National Campaign to Prevent Teen and Unplanned Pregnancy, *Teen Childbearing and Child Welfare*, 2013, 1, *available at* https://thenationalcampaign.org/sites/default/files/resource-primary-download/childbearing-childwelfare.pdf.

become parents: A national study found that twice as many girls in foster care give birth compared to girls not in foster care.[15]

It is critical, therefore, that young people in foster care be able to access comprehensive reproductive health care and counselling. Girls in foster care also experience higher rates of sexual violence.[16] They are twice as likely as boys to be removed from their homes and placed in foster care because of sexual abuse (6 percent of girls versus 2.9 percent of boys),[17] making it that much more crucial that they are provided timely, unimpeded access to a full range of reproductive health care services in a manner that is both respectful and non-stigmatizing.

Allowing young people to be placed in a setting with caregivers who are unwilling to allow a young person to access reproductive health care services would lead to discriminatory and substandard care. No young person in foster care should be denied access to needed health care services because the people or organizations who are supposed to care for the young person object to the care.

The proposed rule undermines states' and local governments' efforts to protect foster children's health and safety, including their nondiscrimination laws.

The Department claims that its new interpretations of federal law supersede laws passed by state and local governments to ensure patients' access to health care. Yet, by allowing health care providers to refuse care to patients based on the providers' religious or moral beliefs in such a sweeping way, the proposed rule conflicts with state and local nondiscrimination laws, regulations, and policies that provide protections to foster youth.

Thirty-seven states provide protections against discrimination based on sexual orientation for youth receiving foster care and adoption services by law, regulation, or policy, and twenty-four states provide such protections based on gender identity and expression.[18] Further, "all States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have statutes requiring that the child's best interests be considered whenever specified types of decisions are made regarding a child's custody, placement, or other critical life issues." (from HHS Children's Bureau website, with links to all statutes.)[19]

---

[15] Lois Thiessen Love et al., The National Campaign to Prevent Teen Pregnancy, *Fostering Hope: Preventing Teen Pregnancy Among Youth in Foster Care*, 2005, 7, *available at* https://thenationalcampaign.org/sites/default/files/resource-primary-download/FosteringHope_FINAL.pdf.

[16] Karen Banes-Dunning & Karen Worthington, "Responding to the Needs of Girls in Foster Care," *Georgetown Journal on Law & Poverty* 20 no. 2, 2013, 321-49, *available at* http://www.karenworthington.com/uploads/2/8/3/9/2839680/adolescent_girls_in_foster_care.pdf.

[17] National Women's Law Center calculations of unpublished data by National Data Archive on Child Abuse and Neglect.

[18] See https://www.lambdalegal.org/map/child-welfare for a map of sex, sexual orientation, and gender identity anti-discrimination statutes, regulations, and policies in place for foster youth by state.

[19] Available at https://www.childwelfare.gov/pubPDFs/best_interest.pdf

Two examples of state nondiscrimination laws and policies that protect LGBTQ foster youth from discrimination include (emphasis added):

California

Statute: Cal. Welf. & Inst. Code 16001.9
Rights of minors and non-minors in foster care.
"It is the policy of the state that all minors and nonminors in foster care shall have the following rights:
. . .
(23) To have fair and equal access to all available services, placement, **care, treatment, and benefits,** and to not be subjected to discrimination or harassment on the basis of actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, **sex**, **sexual orientation**, **gender identity**, mental or physical disability, or HIV status.

(25) To have caregivers and child welfare personnel who have received instruction on cultural competency and sensitivity training relating to, and best practices for, providing adequate care to **lesbian**, **gay**, **bisexual**, and **transgender** youth in out-of-home care."

Idaho

Policy: Idaho Youth in Care Bill of Rights (Oct. 2015)
"Youth have the right to learn about their **sexuality** in a safe and supportive environment.
. . .
Youth have the most basic right to receive care and services that are free of discrimination based on race, color, national origin, ancestry, **gender**, **gender identity** and **gender expression**, religion, **sexual orientation**, physical and mental disability, and the fact that they are in foster care."

Because of explicit nondiscrimination protections in the provision of care and services to foster youth, including health care services, it is inaccurate 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. In fact, the rule could prove financially burdensome to states attempting to ameliorate the high costs of disproportionately negative outcomes for LGBTQ foster youth. An HHS-funded study found that LGBTQ foster youth had been hospitalized for emotional reasons at three times the rate of non-LGBTQ foster youth, and the report therefor recommended "address[ing] the needs of LGBTQ youth in care so their experience begins to approximate those of their non-LGBTQ counterparts. This will result in much needed cost avoidance for already over-burdened child welfare systems."[20]

[20] Wilson, B.D.M., Cooper, K., Kastanis, A., & Nezhad, S., 2014. *Sexual and Gender Minority Youth in Foster care: Assessing Disproportionality and Disparities in Los Angeles.* Los Angeles: The Williams Institute, UCLA School of Law.

FAMILY EQUALITY COUNCIL

Conclusion

The proposed rule goes far beyond established law, improperly undermines state nondiscrimination laws, and most importantly will put the health and potentially even the lives of some of the most underserved and vulnerable patients at risk. We urge you to withdraw the proposed rule.

Should you have any questions about these comments, I would be happy to visit your offices in Washington, DC to discuss them, or you can reach me via telephone or email at 646.829.9314 or ssloan@familyequality.org.

Sincerely,

Rev. Stan J. Sloan
Chief Executive Officer

Exhibit 72

FAMILY VOICES®
. . . keeping families at the center of children's health care

March 27, 2018

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

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority
RIN 0945-ZA03 Docket ID No. HHS-OCR-2018-0002

Dear Director Severino:

Family Voices is a national, nonprofit, family-led organization promoting quality health care for all children and youth, particularly those with special health care needs. Working with family leaders and professional partners at the local, state, regional, and national levels since 1992, Family Voices has brought a respected family perspective to improving health care programs and policies and ensuring that health care systems include, listen to, and honor the voices of families.

Throughout the US, there are over 14 million children and youth with special health care needs (CYSHCN), constituting over 19 percent of the child population. More than one in five households with children has at least one child with special health care needs.

We are very concerned that the proposed rule would restrict access to medically necessary care for CYSHCN. It is already difficult to find the appropriate pediatric subspecialists and health care facilities for many children with special health care needs, particularly those with rare conditions, and particularly in rural areas. Many families have to travel long distances to obtain the specialized care their children need. If regulations are implemented to make it more acceptable to withhold health care, we fear that it will be even more difficult for CYSHCN to obtain medically necessary services.

There is already discrimination against some children with disabilities or other special health care needs. For example, some providers do not believe it is appropriate to extend certain services to children with intellectual disabilities (e.g., cochlear implants to improve hearing, or an organ transplant to save the life of a child with Down syndrome).

A more dramatic example of such discrimination might be found in a neonatal intensive care unit. Suppose a nurse has a moral conviction that society should not expend resources on children with severe physical or intellectual disabilities. Should he be protected, on the basis of his moral conviction, if he decides not to respond to an alarm signaling a heart problem for an infant born without legs?

Conversely, suppose a nurse held a religious belief that all measures must be taken to preserve life, and therefore resuscitated a terminally ill patient who had a "Do not resuscitate" order in place. Would the nurse's employer be prohibited from taking any disciplinary action against her in such a situation?

Religious beliefs can harm patients in more subtle but harmful ways as well. In a rural community, there may be a single physician. If a teen questioning his or her sexual orientation were to bring up the topic with the physician, and the physician indicated a belief that homosexuality was sinful, the teen ultimately may become depressed, despondent, and even suicidal. If an unmarried teen contracts a sexually transmitted infection, he or she may feel uncomfortable going to a physician who is known to disapprove of premarital sex, thus risking serious complications and the chance of passing the infection to others.

In addition to harming patients' health directly, we are concerned that this proposed rule would hurt families of CYSHCN financially, since it applies to insurers and employers as well as health care professionals and institutions. These entities have a vested interest in denying care in order to save money. This rule could provide them with an excuse to refuse coverage for expensive treatments.

Finally, we think the proposed rule contradicts current antidiscrimination laws and regulations. Will it provide a defense for health care providers or insurers who discriminate against people with disabilities?

The OCR has specifically requested comment on whether this rule would result in unjustified limitation on access to health care or treatments. We submit that it would.

We understand that there are health care professionals and institutions with strong religious or moral convictions that are inconsistent with rendering certain types of care. It is reasonable to accommodate their views, *provided that others are not harmed* in doing so.

At the same time, it is critical to protect patients from discrimination so they can obtain the care they need, particularly in an emergency. If an individual or institution chooses not to provide certain care on the basis of religious beliefs or moral convictions, then that provider should be required to inform prospective or current patients of those limitations in advance or as soon as possible. In addition, the provider should be required to provide information about alternative sources of care in a timely manner, and should be required to provide any treatment needed to stabilize a patient in an emergency situation.

Thank you for your attention to our comments.

Sincerely,

/s/

Nora Wells
Executive Director

Exhibit 73

FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

March 26, 2018

Submitted via the Federal e-Rulemaking Portal

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

RE: HHS-OCR-2018-0002-0001 proposed rule

Dear Mr. Severino:

We are writing on behalf of the HIV Health Care Access Working Group to urge HHS to uphold its duty to "enhance the health and well-being of all Americans" by withdrawing the proposed rule on "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority. " HHCAWG is a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV- and hepatitis C-related health care and support services.

We are deeply concerned that this rule would open the door wider to discrimination by physicians, nurses, and other professionals against people with HIV, people at risk for HIV and LGTBQ individuals. Federal resources must not be used to empower people to deny medical care, especially to those who have few options to obtain it. As HHS acknowledges, current law sufficiently protects the religious rights of providers.

While the stated intent of the proposed rule is to protect health care providers, we are concerned that the ultimate impact of the rule will be to compromise the health of individuals most in need of care, including people at risk for HIV and people living with HIV. Under the guise of civil rights protections, the rule will allow providers to disregard clinical standards of care when it comes to HIV prevention and treatment, putting patient safety and access at risk. Implementing this rule and actively sheltering discriminatory health providers will be a significant setback to progress made in responding to the HIV epidemic.

The stigma and discrimination experienced by people with HIV persists in many facets of their lives including in accessing health care services.[i] Despite the availability of highly effective prevention and treatment tools – 15 percent of people in the U.S. who are living with HIV are undiagnosed and just 50 percent of diagnosed individuals are fully benefiting from treatment (or virally suppressed).[ii] Improving access to effective treatment and increasing the number fully benefiting from treatment is important to

the health of people living with HIV and to reduce the spread of HIV. The risk of transmitting HIV is virtually zero when virally suppressed.

We highlight key areas of concern regarding the potential implications of the proposed rule below.

- **HIV Prevention:** Despite the availability of highly effective prevention tools including pre-exposure prophylaxis or (PrEP) -- a once-a-day pill recommended for individuals at higher risk for HIV – the number of new HIV infections is around 40,000 annually. Allowing providers to ignore CDC clinical guidelines[iii] for use of PrEP and other HIV prevention interventions will hinder our efforts to reduce new HIV infections, particularly for populations most at risk for HIV including gay men and transgender individuals. Individuals who turn to health care providers for HIV and STD testing, PrEP, HIV treatment, or prevention and treatment for any communicable disease, should never be denied access to these services because of a provider's religious beliefs. This is particularly important in underserved areas where health care provider access can be severely limited and travel to other providers can be prohibitive due lack of transportation and/or distance.

- **LGBTQ Care, Particularly Transgender Care**: LGBTQ individuals continue to face significant discrimination and stigma. Ensuring that this population has access to culturally competent and sensitive providers is critical to our efforts to address the HIV-related disparities faced by gay men and transgender individuals.[iv] [v] Transgender individuals in particular are at high risk for HIV and have low rates of health coverage in the U.S.[vi] In many jurisdictions, transgender patients are already denied gender-affirming and medically necessary care. Denying transgender individuals the gender-related medical care they need will lead to fear and distrust of health care providers and of the health care system leaving them even more vulnerable to HIV and less likely to learn they are HIV-positive, to access care, and to effectively manage their HIV. Provider shortages in many areas will leave transgender individuals without viable alternatives for preventive and health care services if their local provider denies care.

- **Women's Health Care**: Women with HIV and all women have a right to reproductive health services including contraception and abortion. Granting health care providers and institutions the right to withhold medical information regarding prevention or treatment options or to deny women these services based on personal religious beliefs puts their health at risk.

For nearly two decades, HHCAWG has been advocating for expanding access to health coverage and health care services for people at risk for HIV and living with HIV to improve their health outcomes and to improve public health. Until recently, many people with HIV and the populations at higher risk for HIV, including gay men and transgender individuals, were denied health care coverage or the coverage available to them was priced out of reach. The Patient Protection and Affordable Care Act's non-discrimination protections (Section 1557) have been critical to improving access to health care coverage and services for people with HIV. However, even with these protections, we continue to see health plans discourage enrollment of people with HIV through discriminatory benefit and formulary designs. These practices have been reported to the HHS Office of Civil Rights (OCR), which is charged with investigating complaints related to these practices. To date, there's little evidence that enforcement of these protections is taking place. We urge OCR to focus its attention on challenging discriminatory practices that are impeding access to health care for people with HIV and others rather than defending health care providers who counter to their pledge to "do no harm" are denying individuals medically appropriate health care services.

We strongly urge HHS not to undermine the current non-discrimination protections that are making a difference in the lives of people at risk for HIV and living with HIV by providing health care providers the license to discriminate against patients based on their religious beliefs. Please withdrawal the proposed rule (HHS-OCR-2018-0002-0001 proposed rule) and commit to monitoring and enforcing existing non-discrimination protections to uphold HHS' mission of improving the health for all Americans, including people living with HIV, LGBT individuals and women.

Should you have any questions or need additional information, please contact HHCAWG co-chairs Robert Greenwald with the Treatment Access Expansion Project at rgreenwa@law.harvard.edu, Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@NASTAD.org, or Andrea Weddle with the HIV Medicine Association at aweddle@hivma.org.

Respectfully submitted by:

ADAP Educational Initiative |AIDS Alabama | AIDS Action Baltimore | AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | AIDS Research Consortium of Atlanta | AIDS United | American Academy of HIV Medicine | APLA Health | AIDS Resource Center of Wisconsin | Bailey House, Inc. | Communities Advocating Emergency AIDS Relief (CAEAR) | Community Access National Network (CANN) | Equality California | Equality Federation |Georgia AIDS Coalition | Harm Reduction Coalition | HealthHIV | HIV Medicine Association| Housing Works | Legal Council for Health Justice | Los Angeles LGBT Center |Michigan Positive Action Coalition | Minnesota AIDS Project | National Alliance of State and Territorial AIDS Directors | National Latino AIDS Action Network | NMAC | Out2Enroll | Positive Women's Network - USA| Project Inform | Rocky Mountain CARES | San Francisco AIDS Foundation | SisterLove | Southern AIDS Coalition | Southern HIV/AIDS Strategy Initiative | The AIDS Institute | Treatment Access Expansion Project | Treatment Action Group |

---

[i] HIV.gov.Activities Combating HIV Stigma and Discrimination. https://www.hiv.gov/federal-response/federal-activities-agencies/activities-combating-hiv-stigma-and-discrimination. Accessed 3/22/18.

[ii] Centers for Disease Control and Prevention. HIV Continuum of Care, U.S.,2014, Overall and by Age, Race/Ethnicity, Transmission Route and Sex. July 2017.

[iii] CDC.Pre-Exposure Prophylaxis For The Prevention of HIV Infection In The United States - 2014 A Clinical Practice Guideline. https://www.cdc.gov/hiv/pdf/prepguidelines2014.pdf.

[iv] CDC. HIV Among Gay and Bisexual Men. https://www.cdc.gov/hiv/group/msm/index.html. Accessed 3/22/18.

[v] Trinh, MH, et al. .Health and healthcare disparities among U.S. women and men at the intersection of sexual orientation and race/ethnicity: a nationally representative cross-sectional study. BMC Public Health. 2017 Dec 19;17(1):964.

[vi] CDC.HIV Among Transgender People. https://www.cdc.gov/hiv/group/gender/transgender/index.html. Accessed 3/22/18.

Exhibit 74

FEMINIST MAJORITY FOUNDATION
Working for Women's Equality

Eleanor Smeal
President

Peg Yorkin
Chair of the Board

Katherine Spillar
Executive Director

■ Washington DC
1600 Wilson Blvd
Suite 801
Arlington, VA 22209
703 522 2214
703 522 2219 fax

■ West Coast
433 S. Beverly Dr
Beverly Hills, CA
90212
310 556 2500
310 556 2509 fax

March 24, 2018

VIA ELECTRONIC SUBMISSION

The Honorable Alex M. Azar
Director Roger Severino
U.S. Department of Health and Human Services
Office for Civil Rights
Hubert H. Humphrey Building
200 Independence Avenue SW
Room 415F
Washington, DC 20201

ATTN: Conscience NPRM, RIN 0945—ZA03

Dear Secretary Azar and Director Severino,

The Feminist Majority Foundation (FMF), a national organization dedicated to women's equality, reproductive health, and the empowerment of women and girls in all spheres, writes in response to the Notice of Proposed Rulemaking regarding Protecting Statutory Conscience Rights in Health Care ("the Proposed Rule"), published in the Federal Register on January 26, 2018.[1] FMF strongly opposes this Proposed Rule.

The Proposed Rule would unlawfully expand the reach of refusal laws, undermine access to care, and exacerbate already existing health disparities by allowing government-funded health care entities to impose their religious beliefs and moral convictions onto patients and other service recipients. Although the Department of Health and Human Services ("the Department") claims that the Proposed Rule is necessary to counter discrimination, the rule itself would allow individuals and health care entities who receive federal funding to use religion as a tool to discriminate, particularly against women, LGBTQ individuals, and gender nonconforming people.

For these reasons, the Feminist Majority Foundation calls on the Department and the Office for Civil Rights (OCR) to withdraw the Proposed Rule in its entirety.

The Proposed Rule is Unlawful

The Proposed Rule unlawfully seeks to expand the reach of federal refusal of care laws and create new refusals of care. As such, the Proposed Rule violates the Administrative Procedure Act (APA), which requires agency actions that are "not in accordance with

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) [hereinafter Proposed Rule].

law," "contrary to a constitutional right," or "in excess of statutory jurisdiction," to be set aside.[2]

One such unlawful expansion concerns the Church Amendments. The Church Amendments prevent healthcare personnel employed by federally-funded facilities or programs from being required to perform or "assist in the performance" of sterilization or abortion services to which they have a religious or moral objection.[3] The statute does not contain a definition of "assist in the performance." The Proposed Rule would define this term, but the definition offered goes beyond the intent of the Church Amendments, as stated by Senator Frank Church himself. During debate on the amendments, Senator Church stated:

> The amendment is meant to give protection the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions. So the fact [that] Federal funds may have been extended will not be used as an excuse for requiring physicians, nurses, or institutions to perform abortions or sterilizations that are contrary to their religious precepts. That is the objective of the amendment. *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*.[4]

The Proposed Rule, however, would create a broad definition of "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."[5] It continues, "This includes but is not limited to counseling, referral, training, or other arrangements for the procedure, health service, health program, or research activity."[6] This overly broad definition of "assist in the performance" greatly expands the types of services that can be refused—including making simple "arrangements for the procedure"—no matter how tangential. As a result, individuals who are not "assisting in the performance" of a procedure, under the ordinary meaning of the term, as suggested by Senator Church himself, could assert a new right to refuse, including the hospital room scheduler, the technician assigned to clean surgical instruments, and other hospital employees providing routine hospital services. The use of the term "articulable" does not cabin this overly broad definition; instead, it introduces yet another level of confusion and uncertainty. In defining this term, then, the Department broadened the scope of the Church Amendments far beyond what was envisioned when they were enacted.

The Proposed Rule's definition of "referral" also goes beyond an ordinary understanding of the term, allowing individuals, hospitals, and other health care entities to refuse to provide *any* information that could help an individual get access to care, even if that care is critically-needed.[7] The Department would even allow an individual to refuse to provide any "guidance

---

[2] 5 U.S.C. § 706(2)(A)-(C).
[3] 42 U.S.C. § 300a-7.
[4] 155 Cong. Rec. S9597 (1973) (statement of Sen. Church) (emphasis added).
[5] Proposed Rule, *supra* note 1, at 3923 (emphasis added).
[6] *Id.*
[7] *Id.* at 3895. Note that the Proposed Rule would also appear to conflict with the Emergency Medical Treatment and Active Labor Act (EMTALA) which requires hospitals that have a Medicare provider agreement and an

likely to assist a patient" in obtaining abortion care, including providing information for "a physician or clinic that *may* provide an abortion."[8] Such a broad definition that gives no direction on when information becomes "likely" to assist and provides no limiting principle for denying referrals to a healthcare provider who *may* provide abortion, is an invitation to abuse, potentially at the cost of women's health and lives.

Similarly, the Proposed Rule creates a new definition of the term "health care entity" that appears to be much broader than what is allowed under the Coats and Weldon Amendments.[9] The Department argues that the Weldon Amendment's inclusion of "any other kind of health care facility, organization, or plan," in its definition of "health care entity"[10] justifies the Department's broad definition of the term in the Proposed Rule; however, the Proposed Rule does not set any parameters for its definition at all. In fact, the Department notes that in its attempt to create a definition, it is merely creating an "illustrative" list.[11] Such an approach, which disregards the statutory definitions of the term for an open-ended laundry list, would not only create confusion, it would undermine Congressional intent and not be in accordance with the law, in violation of the APA.

In addition to the Proposed Rule being an unlawful expansion of refusal of care provisions, the rule also conflicts with Title VII of the Civil Rights Act of 1964, which provides the legal framework for religious accommodations in the workplace.[12]

With respect to religion, Title VII requires an employer to provide a reasonable accommodation of an employee's or an applicant's sincerely held religious belief, practice, or observance, unless doing so would pose an undue hardship.[13] In considering whether an accommodation would pose an undue hardship, employers may consider not only the cost of the accommodation, but also the burden it would impose on patients and coworkers and the impact on overall safety. Employers can also consider the type of workplace it runs as well as the nature of the

---

emergency room or department to provide anyone requesting treatment an appropriate medical screening to determine whether an emergency exists, to stabilize the patient, and to determine whether a transfer to another facility is warranted. 42 U.S.C. § 1395dd(a)-(c). Hospitals must comply with the EMTALA, even those who are religiously affiliated. The Proposed Rule, however does not create an exception for emergencies, or even acknowledge EMTALA, suggesting once again, that the Department has engaged in overreach through its Proposed Rule.

[8] *Id* (emphasis added).

[9] *See* 42 U.S.C. § 238n (c)(2) (defining "health care entity" to include "an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions); The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009) (defining "health care entity" to include "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan").

[10] *Id.*

[11] Proposed Rule, *supra* note 1, at 3893.

[12] 42 U.S.C. § 2000e-2.

[13] *Questions and Answers: Religious Discrimination in the Workplace*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (Jan. 31, 2011), https://www.eeoc.gov/policy/docs/qanda_religion.html.

employee's duties to determine whether the accommodation would be an undue hardship.[14] The Proposed Rule, however, not only makes no mention of Title VII, it would appear to conflict with the law in that the Proposed Rule, as written, could require health care entities to hire people, whether or not the applicants' religious or moral objections posed an undue hardship, who intend to refuse to provide services that would otherwise be performed.

To illustrate the problem created by the Proposed Rule, consider a Title X funded health clinic. Title X of the Public Health Service Act is the only domestic federal grant program dedicated solely to providing family planning and related healthcare services. Under the Proposed Rule, the Department would appear to allow a situation in which a Title X grantee could receive federal funds while being exempt from providing necessary services required by law—including the provision of non-directive pregnancy counseling options and referrals, upon request, for a range of services, including pregnancy termination[15]—if the grantee had a religious or moral objection. Even if grantees did generally provide these services, the Proposed Rule offers no guidance on whether it would be impermissible for a Title X funded health clinic *not* to hire a counselor or clinician if that person would refuse to provide these required services, something that Title VII would not mandate.[16] The Proposed Rule is therefore not only at odds with pre-existing legal and regulatory requirements, but it could also undermine the entire purpose of the Title X program, which is to provide low-income people with affordable family planning services and health care information they can use to make the best health care decisions for themselves, free from government interference or coercion.

Finally, the Proposed Rule would also appear to violate the First Amendment. Although the U.S. Constitution recognizes that freedom of religion is a fundamental right, the First Amendment does not allow the government to use religious liberty as a weapon to harm others. To the contrary, the U.S. Constitution forbids the government from creating religious accommodations to generally applicable laws when the accommodation would harm a third party.[17] As the Proposed Rule would allow individuals and health care entities to use their personal religious beliefs or moral convictions—instead of medical standards of care—to dictate patient care, the Proposed Rule, as described in more detail below, would create substantial harm to patients who may be denied care and therefore incur additional economic costs, experience adverse health outcomes, and/or suffer social or emotional harm.

---

[14] *See id.*

[15] *See* Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017); 42 C.F.R. § 59.5(a)(5).

[16] It is also of note that Congress specifically rejected the House Conscience Protection Act in the FY 2018 omnibus spending bill passed on March 23, 2018, which continues to fund Title X programs.

[17] *See e.g., Estate of Thornton v. Caldor*, 472 U.S. 703, 709 (1985) (finding that a Connecticut law that gave workers an absolute and unqualified right not to work on their chosen Sabbath violated the Establishment Clause of the First Amendment because "the State commands that Sabbath religious concerns automatically control over all secular interests at the workplace; the statute takes no account of the convenience or interests of the employer or those of other employees who do not observe a Sabbath. The employer and others must adjust their affairs to the command of the State whenever the statute is invoked by an employee.").

The Proposed Rule Will Impose Substantial Harm to Patients & Exacerbate Health Disparities

Far from improving access to health care and expanding care and service options, when healthcare providers are allowed to let religion or moral convictions dictate care, patients often have fewer options, resulting in poorer health outcomes that can have devastating and long-lasting consequences. Religious directives, for example, have led certain hospitals to refuse to provide appropriate, life-saving treatment to women following miscarriage, putting women at greater risk of death.[18] Not only have women been denied treatment and services—including family planning services and sterilization procedures—women have even been prevented from receiving appropriate referrals or have been outright denied information about their own health condition.[19] Citing religious beliefs and/or moral convictions, medical providers have also denied care to LGBTQ individuals and persons with HIV.[20] Religious and/or moral beliefs could also be used as a license to discriminate against young people seeking sexuality and sexual health information, older adults seeking end-of-life care, and victims of intimate partner violence seeking care and support, among other populations.

Refusals of care can have devastating consequences for patients who are denied access to healthcare information and services. Withholding care during miscarriage, for example, caused women at a religiously-affiliated hospital to suffer from potentially life-threatening infections, including sepsis.[21] This experience mirrors what was learned in a 2008 study in which providers disclosed how some women at Catholic hospitals were being denied care consistent with prevailing medical standards and transferred to other facilities, sometimes at a great distance, thereby delaying care and increasing risks to their health.[22]

Refusals also increase the economic cost of care to patients—sometimes preventing them from accessing health care at all. 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 to travel, or where there is no transportation available, then refusals can amount to an outright bar on access to health care. This is especially true for individuals in rural areas where there may be severely limited healthcare options. Allowing providers and health care entities to discriminate against patients by refusing care therefore exacerbates healthcare disparities for low-income people.

Expanding already harmful refusal laws will also have a substantial impact on women of color who already face increased barriers to access care, generally receive poorer quality care, and

---

[18] *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S LAW CNTR, (Aug. 30, 2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/.

[19] *Id.*

[20] *Id.*

[21] Molly Redden, *Abortion Ban Linked to Dangerous Miscarriages at Catholic Hospital, Report Claims*, THE GUARDIAN (Feb. 18, 2016), https://www.theguardian.com/us-news/2016/feb/18/michigan-catholic-hospital-women-miscarriage-abortion-mercy-health-partners.

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

experience worse health outcomes.[23] For example, Black women in the U.S. are up to four times more likely than white women to die during or after childbirth, a disparity that is growing not decreasing.[24] The shocking rates of maternal mortality for Black women are likely related to discrimination Black women face accessing health care or when interacting with healthcare providers.[25] Creating more opportunities for Black women to be discriminated against or denied information, treatment, or care only adds to these disparities, especially at a time when the Department should be focusing its resources on lowering sky high rates of Black maternal death.

For transgender individuals, refusals can also block access to care with devastating consequences. A recent survey of over 20,000 transgender individuals in the U.S. found that one-third of those who saw a healthcare provider had at least one negative experience related to being transgender, such as being verbally harassed or refused treatment because of their gender identity, with higher rates for people of color and people with disabilities.[26] Additionally, nearly one-quarter of respondents reported that they did not seek the health care they needed in the year prior to completing the survey due to fear of being mistreated as a transgender person.[27] Creating expanded protections for those who would deny health care to transgender individuals based on religious or moral beliefs, would only aggravate these existing problems.

The Proposed Rule also harms patients by threatening informed consent, a bedrock principle of patient-centered decision-making that is a hallmark of the patient-provider relationship. Informed consent requires that a provider give patients relevant and medically accurate information so that patients can make the best healthcare decisions for themselves. Existing refusals of care based on religious or other personal beliefs already undermine open communication between providers and patients. Although the Department argues that the Proposed Rule would improve communication between patients and providers,[28] that argument simply rings hollow. In truth, the Proposed Rule broadens protection for refusals and allows providers, including hospitals and other health care institutions, to refuse to provide patients with information. By its very nature, then, the Proposed Rule allows providers to block information, curtail meaningful communication, and make it impossible for patients to make informed healthcare decisions, undermining their right to dignity and bodily autonomy.

The consequences of undermining informed consent were captured by one woman who, after being denied information and access to care following a miscarriage, reported to a health

---

[23] *See generally*, Petry Ubri and Samantha Artiga, *Disparities in Health Care: Five Key Questions and Answers*, HENRY J. KAISER FAMILY FOUND. (Aug. 12 2016), https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/#endnote_link_195310-17.

[24] *See* Nina Martin and Renee Montagne, *Nothing Protects Black Women from Dying in Childbirth*, PROPUBLICA AND NPR NEWS (Dec. 7, 2017), https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth.

[25] *See id.*

[26] *The Report of the 2015 U.S. Transgender Survey*, NAT'L CTR FOR TRANSGENDER EQUALITY (2015), http://www.ustranssurvey.org/reports.

[27] *Id.*

[28] Proposed Rule, *supra* note 1, at XX.

official "her anger at being given false hope that her infant would survive and at the hospital's decision to risk her life for a pregnancy that staff knew was no longer viable."[29] Had she had all of the facts, this woman may have chosen very different care, but her healthcare providers, acting on religious directives, imposed their religious and moral view onto her and robbed her of all of her choices, without her knowledge.

Conclusion

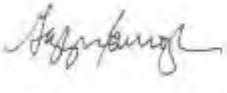
Healthcare providers should not be able to use their own personal religious or moral beliefs to determine the care a person may receive. Moreover, the government has an obligation to prevent its partners from imposing their own religious beliefs onto patients or other service recipients.

If the Department is serious about its mission "to enhance and protect the health and well-being of all Americans," then the Feminist Majority Foundation has grave concerns about the current Proposed Rule. In developing this Proposed Rule, it does not appear that the Department considered how patients denied care—especially those who already face barriers to access, those suffering from large healthcare disparities, or those who live in medically under-served areas—would be able to access the healthcare information and services they need and want. Instead, on its face, the Proposed Rule is specifically designed to expand the category of entities that can deny care to specific populations of people, especially women, LGBTQ people, gender nonconforming people, pregnant people, and the elderly, as well as the categories of care that can be denied. It is a reckless rule that privileges religion and moral convictions over standards of care, public health, and the lives of some of the most vulnerable, not only in the U.S. but also globally as the Proposed Rule also purports to reach global health programs.

As the Proposed Rule is discriminatory, violates multiple statues and the U.S. Constitution, ignores Congressional intent, and would create confusion while harming patients and the public, the Feminist Majority Foundation calls on the Department to withdraw the Proposed Rule in its entirety.

Thank you for your attention to these comments. If you have any questions or need any further information, please email gburroughs@feminist.org.

Sincerely,



Gaylynn Burroughs
Director of Policy and Research

[29] Redden, *supra* note 21.