Exhibit 88

IVRJ
Interfaith Voices 4 Reproductive Justice

March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attn: Conscience NPRM
RIN 0945-ZA03
Hubert H. Humphrey Building, Room 209F
200 Independent Avenue SW
Washington, DC 20201

Dear Officials:

On behalf of Interfaith Voices for Reproductive Justice (IVRJ), we submit these comments to the federal Department of Health and Human Services ("Department") and its Office for Civil Rights ("OCR") in opposition to the proposed regulation entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (hereinafter 'proposed rule')."[1]

In health care, patients must always come first. The newly established "Division of Conscience and Religious Freedom" under OCR and the accompanying proposed rule to allow health-care providers to refuse care to individuals based on the personal belief of providers, would allow health-care providers to deny care to women, the lesbian, gay, bisexual, transgender, and queer (LBGTQ) communities, and other vulnerable populations. The proposed rule would make it possible for health-care providers to ignore one of the core principles outlined in oaths used in many medical schools today – *respecting the dignity and autonomy of patients*.[2] The proposed rule threatens the health and wellbeing of patients by creating the potential for exposure to medical care that fails to comply with already established medical practice guidelines.

The proposed regulation places a significant burden upon vulnerable populations like people of color, women, people with disabilities, and members of the LBGTQ communities. Members of these communities already face enormous health disparities and discrimination from health-care providers. The proposed regulation will exacerbate those situations, placing many individuals from the above communities at risk of being denied necessary and even life-saving care.

More importantly, the proposed regulation, written under the guise of protecting civil rights, would instead make it possible for individuals to misuse religious freedom to discriminate and deny care to individuals because they disagree with their identity. Denying certain individuals health care is not only discriminatory, but it risks the lives of some of the most disadvantaged populations in the United States. The proposed regulation attempts to preference religious conviction over the human dignity and well-being of patients.

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[1] U.S. Dept. of Health and Human Serv., Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880-3931 (Jan. 26, 2018).
[2] "Medical Students Revise Their Hippocratic Oath to Reflect Modern Values," STAT, September 21, 2016, https://www.statnews.com/2016/09/21/hippocratic-oath-medical-students-doctors/.

IVRJ would like to bring to the Department's attention that one of the core ethics across most of the world religious traditions is an ethic of reciprocity. A golden rule across religious traditions, the ethic of reciprocity is a universal moral code that calls upon us to treat others as one would wish to be treated. The proposed regulation violates that ethic of reciprocity by creating potential conditions for patients to be treated unfairly, without dignity, and at risk for receiving substandard or no medical care.

Individual medical conditions may affect a person's family and economic stability. The health-care professional has a responsibility to consider these related problems in order to provide adequate care. IVRJ stands in support of individual religious freedoms and civil rights. However, the proposed regulation denies rather than promotes religious freedom and civil rights because it will make it possible for religion to be used as a weapon against individuals who do not share similar beliefs, violating the individual civil right to political and social freedom and equality.

Health-care professionals are called to do positive good, not just keep patients from harm. They are called to promote their knowledge and skills to the benefit of the patient and community. Along with medical experts and many people of faith, IVRJ opposes the proposed regulation. Promoting discrimination is wrong, and it is unnecessary. Furthermore, it can harm millions of people who need access to basic care and undermine our public health.

Thank you for your attention to our comments and concerns. If you have any questions, please do not hesitate to reach out to IVRJ at interfaith4rj@gmail.com.

Sincerely,

Charity L. Woods
Managing Partner

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Exhibit 89

A BOLD AND INDEPENDENT VOICE FOR THE RIGHTS OF WOMEN AND GIRLS

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

Health care is a human right, and a health care provider's personal beliefs should never determine the care a patient receives. That is why the International Women's Health Coalition strongly opposes the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule"). If enacted, this rule will effectively permit discrimination in all aspects of health care.

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

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

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involved in patient care to use their personal beliefs to deny people the care they need. For these reasons, the International Women's Health Coalition calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

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

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

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

The Proposed Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion and transition-related care. Specifically, the Department and OCR are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[1] Read in conjunction with the rest of the Proposed Rule, it is clear this is intended to allow any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care.

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

Already existing refusal of care laws are used across the country to deny patients the care they need.[2] The Proposed Rule attempts to expand these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions specifically related to the service or research activity to which they object.[3] But the Proposed Rule attempts to broaden this provision to allow individuals to refuse to perform aspects of their jobs based on a mere

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[1] *See id.* at 12.

[2] *See, e.g.*, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Catherine Weiss, et al., *Religious Refusals and Reproductive* Rights, AM. CIVIL LIBERTIES UNION (2002), https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report; Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

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

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

Similarly, the Proposed Rule defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. For example, the definition of "assist in the performance" greatly expands the types of services that can be refused to include merely "making arrangements for the procedure" no matter how tangential.[5] This means individuals not "assisting in the performance" of a procedure within the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, can now assert a new right to refuse. The Proposed Rule's definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information, including location or funding, that could help an individual to get the care they need.[6]

Furthermore, the Proposed Rule's new and unwarranted expanded definitions often exceed, or are not in accordance with, existing definitions contained within the statutes the Proposed Rule seeks to enforce. Specifically, under the Coats and Weldon Amendments "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.[7] The Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term.[8] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but goes directly against congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert.[9]

When these impermissibly broad definitions are combined with the expansive interpretations of the underlying statutes, they work together to further expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, one way the Weldon Amendment is expanded under the Proposed Rule is through the definition of

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

"discrimination."[10] In particular, the Proposed Rule defines "discrimination" against a health care entity broadly to include a number of activities, including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[11] In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is nonsensical and inappropriate. Further such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

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

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

The refusal of sexual and reproductive health care, including abortion and contraception, hurts people who are denied the care that they want and need, and it particularly affects those who already face disadvantages and discrimination. A woman denied services might have no choice but to continue an unintended pregnancy. She may resort to a clandestine, unsafe abortion, with severe consequences for her health or even risk of death. She might be forced to seek out another provider, which can be costly in time and expense, or not even a possibility. All of these scenarios can cause health problems, mental anguish and economic hardship.

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[12] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[13] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[14] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[15] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[16] Another woman was sent home by a religiously affiliated hospital with

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[10] *See* Rule *supra* note 1, at 180.
[11] *Id.*
[12] *See, e.g.*, *supra* note 3.
[13] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[14] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[15] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 29 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[16] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya

two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[17]

Globally, we see the same thing: for example, a woman in Spain learned late in her pregnancy that the fetus had an anomaly incompatible with life. She was unable to find anyone in her region who would terminate the pregnancy. The public health service declared that "in order to respect the professionals' right to objection on moral grounds," she would have to travel to Madrid. By the time she arrived at the clinic, she was bleeding heavily and had to go to a hospital for an emergency caesarean section to remove the fetus, which died soon after. They removed her uterus to stop the bleeding. She nearly died and is now unable to have any more children. Research into the experiences of women who face denial of abortion shows that they are more likely to face long term harm to their physical and psychological health, socioeconomic outcomes, and life trajectories.

b. Refusals of Care are Especially Dangerous for Those Already Facing Barriers to Care

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[18] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[19] In rural areas there may be no other sources of health and life preserving medical care.[20] In developing countries where many health systems

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Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.

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

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

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

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

are weak, health care options and supplies are often unavailable.[21] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[22] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on a wide range of hospital matters, including reproductive health care and can keep providers from offering the standard of care.[23] Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women were delayed care or transferred to other facilities at great risk to their health.[24] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[25]

On an international level, refusals have the gravest consequences for women who are already the most vulnerable. In Uruguay, for example, the highest levels of refusal based on conscience claims – above 60 percent and even reaching 80 percent – are concentrated in the more remote areas of the west and the north, where access to services is already limited. In addition, in many of the countries where the Department implements global AIDS programs, many of the patients served already face numerous barriers to care, including a broad and harmful refusal provision contained within the statute governing such programs.[26]

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

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

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

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

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

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

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

LGBTQ people already face enormous barriers to getting the care they need.[27] Accessing quality, culturally competent care and overcoming outright discrimination is even a greater challenge for those living in areas with already limited access to health providers. The proposed regulation threatens to make access even harder and for some people nearly impossible.

LGBTQ patients living in less densely populated areas already face a myriad of barriers to care including less access to health insurance coverage, lower incomes, and lower rates of paid sick leave – in addition to the universal costs of transportation, taking time from work, and other incidentals. For many, the sheer distance to a healthcare facility can be a significant barrier to getting care. For example, more than half of rural women live more than 30 minutes away from a hospital that provides basic obstetric care.[28] Patients seeking more specialized care like that required for fertility treatments, endocrinology, or HIV treatment or prevention are often hours away from the closest facility offering these services. For example, a 2015 survey of nearly 28,000 transgender adults nationwide found that respondents needed to travel much further to seek care for gender dysphoria as for other kinds of care.[29]

This means if these patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In a recent study, nearly one in five LGBTQ people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBTQ people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.[30] 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.

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

By expanding refusals of care the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest

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

[28] 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.

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

[30] 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.

on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on society."[31] The Proposed Rule plainly fails on both counts. Although the Proposed Rule attempts to quantify the costs of compliance, it completely fails to address the costs and burdens to patients who may be denied care and who then may incur and experience even greater social and medical costs.[32]

Moreover, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant religious exemptions and, in fact, bars granting an exemption when it would detrimentally affect any third party.[33] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[34]

e. *The Proposed Rule would violate international human rights standards, which do not recognize a right to conscience claims in health care and require states to guarantee access to services*

International human rights standards, to date, do not require states to guarantee a right to "conscientious objection" for health care providers. On the contrary, human rights treaty monitoring bodies have called for limitations on the exercise of conscience claims, when states allow for such claims, in order to ensure that providers do not hinder access to services and thus infringe on the rights of others. They call out states' insufficient regulation of the use of "conscientious objection," and in most cases, direct states to take steps to guarantee access to services. They also affirm clearly that claims of "conscientious objection" must never be exercised by institutions.

The European human rights systems have repeatedly stated that if domestic law allows health care providers to refuse to provide legal reproductive health services on grounds of conscience, states must ensure that they do not hinder access to care and must put mechanisms in place to

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

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

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

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

guarantee access to lawful services. Two bodies of the European human rights system have each heard three cases related to the exercise of "conscientious objection" and neither has recognized it as right in the case of health care.

For example, in the 2012 case of P and S v. Poland, a 14-year-old victim of rape was denied emergency contraception, despite reporting to the police the next day and having an examination at a health clinic, as required by law. She became pregnant as a result of the rape, but encountered numerous barriers to obtaining a lawful abortion, in part due to the use of "conscientious objection." She was subjected to coercive and biased counseling by a priest and was removed from the custody of her mother, who supported her decision to have an abortion. She also discovered that confidential information about her pregnancy had been divulged to the press. Eventually, she was able to have the abortion, but clandestinely, far from her home, and without proper post-abortion care. In this and another case from Poland, the European Court of Human Rights ("the Court"), found the practice of conscientious refusal to be in violation of the European Convention on Human Rights. It determined that Poland – by obstructing access to lawful reproductive health care information and services – had violated the individuals' right to be free from inhuman and degrading treatment, and the right to privacy. Furthermore, for the first time, the Court recognized that states have an obligation under the Convention to regulate the exercise of "conscientious objection," in order to guarantee patients access to lawful reproductive health care services.

In the 2001 Pichon and Sajous v. France case of two French pharmacists who refused to sell contraceptives, the Court decided that the right to freedom of religion does not entitle someone to follow their individual beliefs in the public sphere, especially in a situation such as this, where the product cannot be purchased other than in a pharmacy.

The European Committee on Social Rights ("the Committee"), also part of the European human rights systems, has ruled similarly as the Court, but gone a step further to say international human rights obligations–specifically the right to health, which the Charter guarantees–do not give rise to an entitlement to refuse to provide health services. In a collective complaint case, FAFCE v. Sweden, the Federation of Catholic Families in Europe (FAFCE) argued that Sweden had failed to protect the right to health, asserting that the guarantee to claim "conscientious objection" is necessary to promote the health of health care workers. They also argued that Sweden was violating the rights of health care workers' to non-discrimination, because the government had not established a regulatory framework allowing them to refuse to provide abortion services on grounds of conscience. Under Swedish law, health care providers have a duty to provide abortions; although health care institutions may choose to exempt an employee from performing abortions, exemption is not an entitlement.

The Committee found that under the Charter, neither the right to health nor the right to non-discrimination entitles health professionals to refuse to perform abortion services on grounds of personal conscience. The Committee stated that the purpose of the right to health is to guarantee individuals' access to adequate health care, not to protect the interests of health care

providers. When it comes to reproductive health care, the Committee said that the primary rights holders under the Charter are women, not their doctors.

Importantly, the Committee also went on to underscore that the Charter, "does not impose on states a positive obligation to provide a right to conscientious objection for health care workers." This is the most explicit finding yet that international human rights standards do not give rise to an entitlement to refuse health services on grounds of conscience.

In another important 2014 case, IPPF EN v. Italy, the Committee determined that the government of Italy was violating the rights to health and to nondiscrimination of women. The shortage of providers due to refusals based on conscience forced women to wait long periods or travel long distances, placing an undue burden, especially on those with fewer resources. The Committee upheld this judgment in another case in 2016, finding that the government of Italy had failed to rectify this situation.

Unlike the European Court of Human Rights, the Inter-American Court of Human Rights (IACHR has not yet had the opportunity to rule on conscience claims in health care contexts. Given the lack of rulings on the issue in the Inter-American system to date, the Inter-American Commission on Human Rights uses the standards established by the decisions from the Colombian Constitutional Court, which limited the use of conscience to refuse services. In 2006, the Colombian Constitutional Court partially decriminalized abortion. In 2008, the Court clarified the law with a ruling on the case of a 13-year-old girl who was refused an abortion by a health facility and subsequently was forced to complete her pregnancy resulting from rape. The Court tightened limitations on the use of "conscientious objection," importantly stating that the law does not permit institutional objection to abortion. They also restricted conscience claims to the individual directly involved with the procedure, which would not include administrative staff, and required the provider refusing care to make a written statement. Notably, the Court fined the health facility that denied this girl an abortion, also mandating that they provide compensation to her.

In 2014, the African Commission on Human and Peoples' Rights ("the African Commission"), charged with protecting and promoting the Maputo Protocol (Africa's main legal instrument for the protection of women and girls' rights), issued general comment number 2 on article 14. The general comment brings specific attention to conscience claims, saying "state parties should particularly ensure that health services and health care providers do not deny women access to contraception/family planning and safe abortion information and services because of, for example, requirements of third parties or for reasons of conscientious objection."

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

The Proposed Rule would seemingly allow health care entities to receive grants and contracts under HHS-funded programs or other federal health programs, such as Title X, the only domestic family planning program, while refusing to provide key services required by those

programs.[35] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[36] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[37] Under the Proposed Rule, the Department would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such funds are generally conditioned.[38] The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[39] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[40]

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

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care. Hospital systems across the country use religious beliefs to prevent their employees from treating patients regardless of the professional, ethical, or moral convictions of these providers.[41] The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions, including foreign and international organizations, to bind the hands of providers and attempt to limit the types of care they can provide.

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health providers and patients and ensure patient-centered decision-making.[42] Informed consent requires providers disclose relevant and medically accurate information about treatment choices and alternatives

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[35] *See* Rule *supra* note 1, at 180-181, 183. *See also Title X Family Planning*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2018), https://www.hhs.gov/opa/title-x-family-planning/index.html; *Title X an Introduction to the Nation's Family Planning Program*, NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOC. (2017) (*hereinafter* NFPRHA), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf.
[36] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[37] *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).
[38] *See, e.g.*, Rule *supra* note 1, at 180-185.
[39] *See* NFPRHA *supra* note 34.
[40] *See id.*
[41] *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.
[42] *See* TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).

so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[43] By allowing providers, including hospital and health care institutions, to refuse to provide patients with information, the Proposed Rule makes it impossible for patients to have full information regarding treatment options. While the Department claims the Proposed Rule improves communication between patients and providers, in truth it will deter open, honest conversations that are vital to ensuring that a patient can control their medical circumstances.[44]

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[45] Individuals seeking reproductive health care, regardless of their reasons for needing these services, should be treated with dignity and respect. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them.

Specifically, medical ethics guidelines require providers to prioritize patient care over conscience claims. Current guidelines by the International Federation of Gynecology and Obstetrics (FIGO) state that a doctor objecting to abortion based on conscience "has an obligation to refer the woman to a colleague who is not in principle opposed to termination." The current World Health Organization (WHO) safe abortion guidance further stipulates that the referral must be to someone in the same or another easily accessible health care facility. If a referral is not possible, the objecting provider is obligated to provide safe abortion to save the woman's life and to prevent risks to her health. Any woman who presents with complications due to abortion must receive treatment with urgency and respect, as with any other emergency case.

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[43] *See id.*

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

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

Health care providers or institutions that claim personal or religious beliefs to justify refusal of services undermine the objectives of their profession, which is to provide health care to all those who need it. Furthermore, providers represent a monopoly, because they offer a sought-after, specialized, and finite service. Patients are the weaker party in this situation and providers prioritizing their own consciences over the needs and rights of those they are supposed to serve shifts even more power into their hands. The more marginalized the person seeking services, the more likely they will face difficulty overcoming the power imbalance to demand and access the services they need.

In the case of the refusal of health care based on conscience claims, others pay the price. The most severely affected is, of course, the person denied care. But that is not all. Health care providers or institutions that refuse to deliver a service also increase the workloads of their peers who choose to uphold their professional obligations to deliver comprehensive sexual and reproductive health care. It also causes costly disruptions and inefficiencies in the health care system. Precious resources go to making adjustments for those who refuse to provide care. In addition to the direct costs of making accommodations, allowing providers to refuse care can distort resource allocation and create costly inefficiencies in health care systems that often are already strained.

In addition, the Proposed Rule ignores the many providers with deeply held moral convictions that affirmatively motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. Moreover, the Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[46] No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion.

The Department is Abdicating its Responsibility to Patients

The Proposed Rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.[47] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce.[48] They will place a significant and

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[46] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).
[47] *OCR's Mission and Vision*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").
[48] *See* Rule *supra* note 1, at 203-214.

burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[49] If finalized, however, the Proposed Rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities. Through robust enforcement of civil rights laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities, segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[50]

Nevertheless, there is still work to be done, and the Proposed Rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.[51] And these disparities do not occur in isolation. Black women, for example, are three to four times more likely than white women to die during or after childbirth.[52] Further, the disparity in maternal mortality is growing rather than decreasing,[53] which in part may be due to the reality that women have long been the subject of

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

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

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

[52] *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.

[53] *See id.*

discrimination in health care and the resulting health disparities. For example, women's pain is routinely undertreated and often dismissed.[54] And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[55] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[56] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[57]

OCR must work to address these disparities, yet the Proposed Rule seeks to prioritize the expansion of existing religious refusal laws beyond their statutory requirements and create new religious exemptions where none had previously existed rather than using already limited resources to protect patient access to health care. The Proposed Rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.[58]

The Proposed Rule Conflicts with Other Existing Federal Law

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

For example, the Proposed Rule makes no mention of Title VII,[59] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[60] With respect to religion, Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[61] For decades, Title VII has established the legal framework for religious accommodations in the

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[54] *See, e.g.*, Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001).
[55] *See, e.g.*, Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. of the Am. Heart Ass'n 1 (2015).
[56] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf. A survey examining discrimination against LGBTQ people in health care more than half of respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health care status; or health care professionals being physically rough or abusive.
[57] *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.
[58] *See supra* note 46.
[59] 42 U.S.C. § 2000e-2 (1964).
[60] *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.
[61] *See id.*

workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The Proposed Rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both. Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[62]

Furthermore, the language in the Proposed Rule would seem to put health care entities in the position of being forced to hire people who intend to refuse to perform essential elements of a position even though Title VII would not require such an "accommodation." For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling even though the employer would not be required to do so under Title VII.[63] It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

In addition, the Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[64] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[65] Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

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

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[62] Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.
[63] *See* Rule *supra* note 1, at 180-181.
[64] 42 U.S.C. § 1295dd(a)-(c) (2003).
[65] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); In In re Baby K, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, 93 Fair Empl. Prac. Cas. (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).

The Proposed Rule will have a chilling effect on the enforcement of and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. The preamble of the Proposed Rule discusses at length state laws that the Department finds objectionable, such as state laws that require anti-abortion counseling centers to provide information about where reproductive health care services can be obtained or whether facilities have licensed medical staff, as well as state laws that require health insurance plans to cover abortion.[66] 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.[67]

Conclusion

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

Sincerely,

Nina Besser Doorley

Senior Program Officer

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

Exhibit 90

March 27, 2018

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

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

To Whom it May Concern:

I am writing on behalf of the Jackson County Democrats (JCD) LGBTQ Caucus in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. The JCD LGBTQ Caucus serves and represents an estimated 11,000-12,000 LGBTQ-identified residents living in Jackson County Oregon - the largest geographic portion of which is rural. Every day too many LGBTQ people face discrimination and other barriers to accessing lifesaving care. These barriers are especially pronounced for transgender patients. The proposed regulation ignores the prevalence of discrimination and damage it causes and will undoubtedly lead to increased discrimination and flat-out denials of care for some of the most vulnerable members of our community. We all deeply value freedom of religion, but sweeping exemptions that obstruct access to care are a fundamental distortion of that principle. Americans deserve better.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

Thank you for the attention to our comments. If you have questions, please reach out to:

Liz James, Chair
Jackson County Democrats (JCD) LGBTQ Caucus
110 E 6th St, Medford
Medford, OR 97501
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Exhibit 91

Jacobs Institute
of Women's Health
THE GEORGE WASHINGTON UNIVERSITY

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

The Jacobs Institute of Women's Health appreciates the opportunity to comment on the proposed rule "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." The Jacobs Institute of Women's Health's mission is to identify and study aspects of healthcare and public health, including legal and policy issues, that affect women's health at different life stages; to foster awareness of and facilitate dialogue around issues that affect women's health; and to promote interdisciplinary research, coordination, and information dissemination, including publishing the peer-reviewed journal *Women's Health Issues*.

We urge you to withdraw this rule due to the harm it will cause the patient-provider relationship and the quality of patient care. Its impact on women and LGBTQ individuals will be particularly detrimental, and it will exacerbate the disparities already affecting those who face discrimination and limited access to care. The rule's broad definitions invite a wide range of individuals and organizations to deny appropriate care to patients.

Threats to Informed Consent and Standards of Care

Informed consent is a core tenet of healthcare, and requires that patients be fully informed of all options and their risks and benefits. A provider who fails to describe a medically appropriate option based on a personal objection to it prevents a patient from being fully informed – yet that is exactly what this rule would invite. Failure to assure informed consent has characterized shameful episodes in this country's history, including the forced or coerced sterilization of thousands of low-income women of color.[1]

[1] Shepherd K, Platt ER, Franke K, Boylan E. (2018). Bearing Faith: The Limits of Catholic Health Care for Women of Color. Public Rights, Private Conscience Project. Available: https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf

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The proposed rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the proposed rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health.

Research into services provided or withheld at Catholic hospitals demonstrates the kinds of impacts patients can suffer when their providers fail to uphold the standard of care. The Ethical and Religious Directives (ERDs) that Catholic-affiliated hospitals must follow effectively prohibit the provision of some forms of contraception and some treatments for miscarriages and ectopic pregnancies. Interviews with obstetrician-gynecologists working in Catholic-owned hospitals revealed that they could not provide the standard of care for managing miscarriages (uterine evacuation) when fetal heart tones were present; as a result, women's medically indicated care was delayed and their health placed at risk.[2] A study conducted by Ibis Reproductive Health in emergency rooms of Catholic hospitals in 2002 found more than half would not dispense emergency contraception under any circumstances, even if a woman had been sexually assaulted.[3]

In addition, the proposed rule ignores the many providers with deeply held moral convictions that affirmatively motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care.[4]

Exacerbating Existing Disparities

Allowing healthcare providers and their staff to refuse to provide certain types of healthcare will exacerbate existing health disparities. Women of color, LGBTQ individuals, and rural residents are already at greater risk of several poor health outcomes, and will see their options for comprehensive medical care further constrained if this rule is finalized.

In many states, women of color disproportionately receive their care at Catholic hospitals. A recent analysis from authors at Columbia Law School found that in 19 states, women of color are more likely than white women to give birth at Catholic hospitals.[1] They are then less likely to have access to postpartum tubal ligations or insertion of long-acting contraception (LARC). Policies that impede women's access to postpartum LARC or sterilization contribute to unwanted rapid repeat pregnancies,

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[2] Freedman LR, Landy U, Steinauer J. (2008). When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals. *American Journal of Public Health*, 98(10): 1774-1778.
[3] Harrison T. Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff. (2002). *Annals of Emergency Medicine*, 46(2): 105-110.
[4] Fernandez Lynch H & Stahl RY. (2018). Protecting Conscientious Providers of Health Care. *The New York Times*. Available: https://www.nytimes.com/2018/01/26/opinion/protecting-conscientious-providers-of-health-care.html

[5,6] which place women and their children at higher risk of poor outcomes. Given that the maternal mortality rate for black women is more than three times the rate for white women,[7] improving the quality of maternal healthcare that black women receive – including provision of any FDA-approved form of contraception they select – should be a priority. Broadening providers' ability to refuse to provide certain forms of care will further reduce access to interventions that women desire and that can improve their health outcomes.

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. 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]

Rural residents may find it especially difficult to locate an alternative provider if their nearest provider refuses to provide the care they seek. For instance, more than half of rural women live more than 30 minutes from hospital providing basic obstetrics care;[10] finding a second provider will require even more travel and care delay.

Expansive Definitions Allow Extensive Discrimination

Broad definitions of several key terms in the proposed rule raise the possibility of widespread refusals by many individuals, leading to chaotic environments in which all patients' care suffers. For example, the definition of "assist in the performance" greatly expands the types of services that can be refused to

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[5] Potter JE, Hubert C, Stevenson AJ, Hopkins K, Aiken ARA, White K, Grossman D. (2016). Barriers to Postpartum Contraception in Texas and Pregnancy within 2 Years of Delivery. *Obstetrics & Gynecology*, 127(2): 289-296.

[6] Folit-Weinberg S, Harney C, Dude A, Haider S. (2014). Have we failed them? Rapid repeat pregnancy rates and contraceptive methods in a highly motivated population. *Contraception*, 90(3): 327.

[7] Louis JM, Menard KM, Gee RE. (2015). Racial and Ethnic Disparities in Maternal Morbidity and Mortality. *Obstetrics & Gynecology*, 125(3): 690-694.

[8] Mirza SA & Rooney C. (2016). Discrimination Prevents LGBTQ People from Accessing Health Care. Center for American Progress. Available: https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care

[9] Gruberg S & Bewkes F. The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial. Center for American Progress. Available: https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/

[10] American College of Obstetricians & Gynecologists, Committee on Health Care for Underserved Women. (2014). Health Disparities for Rural Women, Committee Opinion Number 586. Available: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women#17

include merely "making arrangements for the procedure" no matter how tangential. This means individuals not "assisting in the performance" of a procedure within the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, can now assert a new right to refuse. The Proposed Rule's definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information, including location or funding, that could help an individual to get the care they need.

Harmful Impact on Title X Program

The proposed rule would seemingly allow health care entities to receive grants and contracts under HHS-funded programs or other federal health programs, such as Title X, the only domestic family planning program, while refusing to provide key services required by those programs. For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[11] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[12] Under the Proposed Rule, the Department would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such funds are generally conditioned. The proposed rule creates uncertainty about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[13] When it comes to Title X, the proposed rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals rely on Title X clinics to access services they otherwise might not be able to afford.[13]

Lack of Safeguards

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. It includes no limitations to its sweeping exemptions that would protect patients' rights under the law and ensures that they receive medically warranted treatment. Any extension of religious accommodation should always be accompanied by equally extensive protections for patients to ensure that their medical needs remain paramount, and that they are able to receive both accurate information and quality health services.

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[11] Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[12] What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).
[13] National Family Planning and Reproductive Health Association. (2017). Title X: An Introduction to the Nation's Family Planning Program. Available: https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf

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

The expanded religious exemptions in the proposed regulations also conflict with many patient protections in federal laws like the Affordable Care Act and the Emergency Medical Treatment and Active Labor Act. While protections under these laws are subject to religious exemptions provided under federal statute, they are not subject to exemptions whose scope goes beyond federal law—including many of the exemptions expanded in this rule. Additionally, the proposed regulation's approach to religious exemptions—which appears to allow for no limitations even when those exemptions unjustifiably harm patients or employers—conflict with the well-established standard under other federal laws, like Title VII of the Civil Rights Act. Title VII ensures that employers can consider the effect that providing a religious accommodation would have on coworkers, customers, and patients, as well as factors like public safety, public health, and other legal obligations. A standard that appears to allow for none of these considerations, and instead appears to require broad, automatic exemptions, would create confusion and undermine the federal government's ability to properly enforce federal laws.

Withdrawal is Warranted

The Jacobs Institute of Women's Health urges withdrawal of this proposed rule because it would result in fewer options, worse health outcomes, and wider health disparities, with particularly harmful impacts on women's access to contraception and abortion and on multiple forms of healthcare for LGBTQ individuals and rural residents.

Thank you for this opportunity to comment in response to the proposed rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." If you have any questions or concerns about our recommendations, please contact Jacobs Institute managing director Liz Borkowski at 202-994-0034 or borkowsk@gwu.edu.

Exhibit 92

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

Attention: Conscience NPRM, RIN 0945-ZA03, Docket HHS-OCR-2018-0002

To Whom It May Concern:

For the reasons detailed below, we urge the Department to set aside the proposed rule 'Protecting Statutory Conscience Rights in Health Care' published January 26.

As a Jewish organization that has been in operation for 28 years and is dedicated to improving health care for all, The Jewish Healthcare Foundation and it's operating organization the Women's Health Activist Movement (WHAMglobal) believe that every person, regardless of their gender, race, or creed, deserve to be treated with dignity and respect when accessing health care. Women, refugees and immigrants, LGBTQ people and other vulnerable communities in our country already face enormous barriers to getting the care they need. Accessing quality, culturally competent care and overcoming outright discrimination is an even greater challenge for those living in areas with already limited access to health providers. The proposed regulation threatens to make access even harder and for some people nearly impossible.

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

The Jewish Healthcare Foundation and WHAMglobal strongly believe all people should have access to compassionate, comprehensive health care, regardless of the religious or moral beliefs their health care provider hold.

Thank you for the opportunity to provide comments on the 'Protecting Statutory Conscience Rights in Health Care' proposed rule. We trust that these comments, along with the many others we expect the Departments will receive, will demonstrate to how this rule will put the health and lives of patients at risk.

Sincerely,

Karen Feinstein

Karen Feinstein, PhD
President and Chief Executive Officer
Jewish Healthcare Foundation and WHAMglobal

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Exhibit 93

jwi

To: Secretary Alex Szar, US Department of Health and Human Services

From: Lori Weinstein, CEO

Date: March 27, 2018

Re: Docket HHS-OCR-2018-002

On behalf of Jewish Women International (JWI), the leading Jewish organization working to empower women and girls, I am writing to offer comments in opposition to the proposed 45 CFR Part 88, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," as outlined at 83FR 3880 ("Proposed Rule").

As a faith-based organization, JWI recognizes the importance of protecting religious liberty, and believes that the constitutional principle of the separation of church and state created by the Establishment Clause and the Free Exercise Clause, is critical to protecting our fundamental rights. This Proposed Rule which gives non-medical personnel and health care service providers the right to deny care, services and information based on their own religious or moral beliefs about the procedure or identity of the person seeking care, is a religious accommodation that unduly burdens the person in need.

Under current law, religious exemptions are permitted in certain limited circumstances with a caveat that the safety of the patient is protected. This Proposed Rule expands the reason for the refusal, the pool of employees who can deny care, and the services that can be refused to an absurd degree. Moral conviction, a term that is undefinable and dangerously broad can now be the basis of a refusal; non-medical personnel, such as a receptionist can deny services or information; and an individual can be denied health care based on their gender identity, even if emergency care is needed.

As the Rambam, the great Jewish physician and sage known as Maimonides, wrote in his Prayer for the Physician in the 12th century: "Thou hast endowed man with the wisdom to relieve the suffering of his brother, to recognize his disorders…. In Thine Eternal Providence Thou hast chosen me to watch over the life and health of Thy creatures. I am now about to apply myself to the duties of my profession. Support me, Almighty God, in these great labors that they may benefit mankind."

The Proposed Rule threatens the lives and well-being of countless Americans, a denial of the fundamental principle of 'do no harm' and raises serious constitutional and policy issues. In light of our deep concerns we strongly urge you to recall the Proposed Rule.

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Exhibit 94

JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

March 27, 2018

Submitted electronically via regulations.gov

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

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority Notice of Proposed Rule Making (RIN 0945-ZA03; Docket No. HHS-OCR-2018-0002)

Justice in Aging appreciates the opportunity to respond to the Department of Health and Human Services (HHS) Notice of Proposed Rule Making entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." For the reasons below, we strongly urge HHS not to finalize the proposed rule. This submission supplements the comments of the Leadership Conference on Civil and Human Rights, which we also support.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Ensuring that all consumers are protected from discrimination in health care is integral to the mission of the HHS Office for Civil Rights (OCR). This mission cannot be carried out without also ensuring that providers, whatever their religious beliefs or moral convictions, adhere to nondiscrimination laws and the medical and health-related standard of care. The proposed rule would greatly expand current "conscience" protections and religious refusals, and we are deeply concerned that it would allow employees in health care settings to discriminate against and deny care to older adults and people with disabilities. Existing law already provides ample protection for health care providers to refuse to participate in a health care service to which they have religious or moral objections. As proposed, the rule will harm consumers by increasing barriers to care, allowing health care professionals to ignore established medical guidelines, and undermining open communication between providers and patients.

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I. The proposed rule's expansion of conscience protections and religious refusals could seriously compromise the health, autonomy, and well-being of older adults and people with disabilities.

The extremely broad language proposed in the rule would allow any individual or entity with an "articulable connection" to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a moral or religious objection. The rule's definitions could both undermine nondiscrimination laws that are meant to protect consumers and even foster health care settings and interactions between patients and providers that are informed by bias instead of medically accurate, evidence-based, person-centered care. This would seriously jeopardize the health, autonomy, and well-being of older adults and people with disabilities.

We are concerned that the rule's proposed definitions and applicability, which HHS repeatedly states are meant to be "broadly defined" and "illustrative, not exhaustive," could allow any member of the health care workforce to refuse to serve a patient in any way. Under the proposed rule's definitions, any individual who is a member of an entity's workforce could refuse to assist in the performance of any services or activities that have any "articulable connection"[1] to a procedure they object to. This includes "volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity."[2] Also, the definition of "referral"[3] would allow an entity to refuse to provide any information distributed by any method, including online or print, regarding any service, procedure, or activity if that information would lead to a service, activity, or procedure that the entity objects to.

The proposed rule does not articulate a definition of moral beliefs. This opens the door to a provider's own prejudices serving as the basis of denying services or care based on an individual's characteristics. For example, could a nurse assistant refuse to serve lunch to a transgender patient? Could office staff refuse to schedule an appointment for a person whom they believe to be from another country or who does not speak English well?

II. The expansion of religious refusals under the proposed rule is contrary to the mission of HHS and OCR and would disproportionately harm communities that already lack access to care

HHS OCR has worked for decades to ensure that the health programs and activities it regulated comply with vital nondiscrimination laws, including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act (ACA). HHS has enforced these laws by ending overtly discriminatory practices such as race segregation and segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for gender transition related services, and insurance benefit designs that

[1] 83 Fed. Reg. 3880, 3892 (Jan 26, 2018).
[2] *Id.* at 3894 (Jan 26, 2018).
[3] *Id.*

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

Nevertheless, further work is needed to address discrimination and reduce these disparities. Older adults are no exception to the stark health disparities that persist across race, national origin, gender, sexual orientation, and poverty lines. For example, a larger share of Black and Hispanic Medicare beneficiaries report fair or poor health status than white beneficiaries.[4] Similarly, Black and Hispanic adults age 65 and older are almost twice as likely as white older adults to develop diabetes.[5] Older adults who are limited English proficient (LEP), including over four million Medicare beneficiaries,[6] face difficulties finding providers, especially for in-home supports and services, who speak their preferred language and often are forced to rely on family members to interpret for them. Lesbian, gay and bisexual older adults face higher rates of disability and mental health challenges; older bisexual and gay men face higher rates of physical health challenges; bisexual and lesbian older women have higher obesity rates and higher rates of cardiovascular disease; and transgender older adults face greater risk of suicidal ideation, disability, and depression compared to their peers.[7] HIV disproportionately impacts the LGBTQ community, and it is affecting an increasing number of older adults.[8]

However, the expansion of religious refusals under the proposed rule would only make these disparities worse by disproportionately harming communities that already face barriers to care: women, people of color, people living with disabilities, people with limited English proficiency, and Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) individuals, as well as people living in rural communities. The harmful effects would be compounded for individuals who hold multiple disadvantaged identities. For example, an older adult who is gay might also have limited English proficiency, or a physical or mental disability, and may not have a choice of providers and therefore nowhere to go if they are refused care in the rural community where they live.

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[4] Kaiser Family Foundation, *Profile of Medicare Beneficiaries by Race and Ethnicity*, (March 9, 2016), *available at* http://kff.org/medicare/report/profile-of-medicare-beneficiaries-by-race-and-ethnicity-a-chartpack/.

[5] Centers for Disease Control and Prevention, *The State of Aging and Health in America*, (2013) at Figure 2, *available at* www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf

[6] CMS Office of Minority Health, Understanding Communications and Language Needs of Medicare Beneficiaries, at 8 (April 2017), *available at* www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf

[7] Fredriksen-Goldsen et al., *The Aging And Health Report: Disparities And Resilience Among Lesbian, Gay, Bisexual, And Transgender Older Adults* (Nov. 2011), *available at* www.lgbtagingcenter.org/resources/resource.cfm?r=419

[8] *See* Ctrs. for Disease Control & Prevention, HIV in the United States: At a Glance (June 2017), available at www.cdc.gov/hiv/statistics/overview/ataglance.html; Ctrs. for Disease Control & Prevention, HIV and Transgender Communities (2016), www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf.

A. *The proposed rule would harm LGBTQ older adults who continue to face widespread discrimination and health disparities.*

We are particularly concerned that the proposed rule would exacerbate the barriers to care that LGBTQ older adults face and the effects of ongoing and pervasive discrimination by potentially allowing providers to refuse to provide services and information vital to LGBTQ health. In addition to experiencing the health disparities described above, LGBT elders are more likely to be single, childless, estranged from their biological family, and reliant on families of choice, such as friends and other loved ones. Because they do not have traditional support systems in place, many LGBT elders rely on nursing homes or other long-term care facilities to receive needed services.[9] Results of a recent survey by AARP show that at least a third of LGBT adults are worried about having to hide their LGBT identity in order to have access to housing options that are suitable for older adults.[10] Over half of LGBT adults fear discrimination in health care as they age and are especially concerned about neglect, abuse, and verbal or physical harassment in long-term care facilities.[11] These concerns are even greater among Black and Latino LGBT adults and individuals who identify as non-binary.[12]

Unfortunately, these fears are a reality for many LGBT older adults. In a survey of LGBT seniors reported in our publication, *Stories from the Field*, we found numerous cases where LGBT older adults experienced discrimination in long-term care facilities ranging from verbal and physical harassment, to visiting restrictions and isolation, to being denied basic care such as a shower or being discharged or refused admission.[13] In addition to being denied care or provided inadequate care, LGBT older adults and their loved ones may be afraid to seek care because they are not treated with dignity and respect. Several LGBT older adults reported being "prayed over" without their consent or being told they would go to hell—violating their right to practice their own beliefs.[14] These discriminatory actions by facility staff could be protected under this ill-advised rule.

As proposed, the rule could allow individuals and facilities to not only refuse to provide treatment for LGBTQ individuals, but to also deny doctors and other professionals the ability to provide that treatment in their facilities. Such refusals implicate standards of care that are vital to LGBTQ health. Medical professionals are expected to provide LGBTQ individuals with the same quality of care as they would anyone else. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and

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[9] SAGE (Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders) and Movement Advancement Project, *Improving the Lives of LGBT Older Adults*, (March 2010), *available at* www.sageusa.org, www.lgbtmap.org.
[10] Houghton, Angela, AARP, *Maintaining Dignity: Understanding and Responding to the Challenges Facing Older LGBT Americans.* (Mar. 2018), *available at* https://doi.org/10.26419/res.00217.001.
[11] *Id.*
[12] *Id.*
[13] Justice in Aging et al., *LGBT Older Adults In Long-Term Care Facilities: Stories from the Field* (updated June 2015), *available at* www.justiceinaging.org.customers.tigertech.net/wp-content/uploads/2015/06/Stories-from-the-Field.pdf
[14] *Id.* at 11.

competency with LGBTQ issues as they pertain to any health services provided.[15] The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.[16] The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.[17] The proposed rule would interfere with the ability of providers to meet these standards since they would not be able to rely on the consistent support of the facilities and care teams where they practice.

B. *The proposed rule will harm older adults and people living with disabilities who rely on long-term services and supports.*

Many older adults and people with disabilities receive long-term services and supports, including home and community-based services (HCBS), from religiously-affiliated providers. However, some people who rely on these services have faced discrimination, exclusion, and a loss of autonomy due to provider objections to providing specified care. For example, individuals with HIV–a recognized disability under the ADA–have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. One man with HIV was refused care by six nursing facilities before his family was finally forced to relocate him to a facility 80 miles away.[18]

Older adults and people with disabilities often live or spend much of their day in provider-controlled settings where they receive supports and services. They may rely on a case manager to coordinate necessary services, a transportation provider to get them to community appointments, or a personal care attendant to help them take medications and manage their daily activities. Under this broad new proposed language, any of these providers could believe they are entitled to object to providing a service covered under the regulation and not even tell the individual where they could obtain that service, how to find an alternative provider, or even that the service is available to them. In these cases, a denial based on a provider's personal moral objection can potentially impact every facet of life for an older adult or person with disabilities – including visitation rights, autonomy, and access to the community. For example,

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[15] Gay Lesbian Bisexual & Transgender Health Access Project, *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients, available at* www.glbthealth.org/documents/SOP.pdf; A.M.A., *Creating an LGBTQ-friendly Practice, available at* www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice .

[16] World Prof. Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (2011), *available at* https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf.

[17] Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 512: Health Care for Transgender Individuals*, (Dec. 2011), *available at* www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals.

[18] Nat'l Women's Law Ctr., *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS*, (May 2014), *available at* https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf.

could a case manager ignore an individual's request to see an HIV specialist? Could a group home refuse to allow a same-sex couple who are residents to live together in the group home?

Finally, due to limited provider networks, older adults and people with disabilities living in rural areas may have particular difficulty finding an alternate provider. For example, home care agencies and home-based hospice agencies in rural areas are facing significant financial difficulties staying open. Seven percent of all zip codes in the United States do not have any hospice services available to them.[19] Finding providers competent to treat people with certain disabilities increases the challenge, and adding in the possibility of a case manager or personal care attendant who objects to serving the individual under this proposed rule could make the barrier to accessing these services insurmountable. Moreover, older adults and people with disabilities who identify as LGBTQ or who belong to a historically disadvantaged racial or ethnic group may be both more likely to encounter service refusals and also face greater challenges to receive (or even know about) accommodations.

III. The proposed rule undermines longstanding ethical and legal principles of informed consent and would undermine effective provider-patient communication

The proposed rule undermines informed consent, a necessary principle of person-centered decision making and a critical component of quality of care. Informed consent relies on providers disclosing medically accurate information so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[20]

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

Additionally, while virtually every state already provides for a conscience objection and a provider's right to refuse to comply with a patient's directive, state laws also impose an obligation on providers to inform patients of their objection and to make some level of effort to transfer the patient to another provider or facility that will comply with the patient's wishes. This proposed rule appears to require neither and may even preempt these state laws which protect patients' rights. If this rule is finalized, which we oppose, HHS should clarify that state conscience rule procedural requirements are not preempted.

In particular, the principles of informed consent, respect for autonomy, and self-determination are important when individuals are seeking end-of-life care or have diminishing capacity. These

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

[20] Tom Beauchamp & James Childress, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); Charles Lidz et al., INFORMED CONSENT: A STUDY OF DECISION MAKING IN PSYCHIATRY (1984).

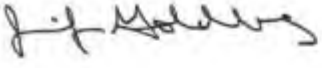
patients should be the center of health care decision-making and they or their representatives should be fully informed about their treatment options. Under the proposed rule, however, providers who object to various procedures could withhold vital information about treatment options— including options such as palliative sedation or declining artificial nutrition and hydration—and refuse to provide a referral to a provider who would honor the patient's wishes. For patients who cannot currently make health care decisions, their advance directives should be honored, regardless of the physician's personal objections, either through immediate assistance or through transfer to another facility. The blanket refusals permissible under this proposed rule would violate informed consent principles by ignoring patients' needs, desires, and autonomy and self-determination at critical times in their lives.

IV. Conclusion

Justice in Aging is deeply concerned that the proposed rule's expansion of conscience protections and religious refusals would be detrimental to older adults' health and well-being and greatly harm communities who already lack access to care and endure discrimination. HHS must ensure that all consumers are protected from discrimination and that all providers treat every patient whom they serve with dignity and respect. The proposed rule would give carte blanche to any provider to withhold care on the basis of prejudice cloaked as "moral conviction." Therefore, we strongly urge HHS not to finalize the proposed rule.

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,



Jennifer Goldberg
Directing Attorney

Exhibit 95

Lambda Legal
making the case for equality

March 27, 2018

VIA ELECTRONIC SUBMISSION

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

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

To Whom It May Concern:

Lambda Legal Defense and Education Fund, Inc. ("Lambda Legal") appreciates the opportunity provided by the Department of Health and Human Services ("HHS" or the "Department") to offer comments in response to the Proposed Rule, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03 ("Proposed Rule" or "Rule"), published in the Federal Register on January 26, 2018.[1] As described herein, the Proposed Rule both exceeds its statutory authority and contravenes this Department's mission, the legal rights of patients, the ethical obligations of health professionals, and the legal rights and responsibilities of institutional health care providers. It should be withdrawn.

Lambda Legal is the oldest and largest national legal organization dedicated to achieving full recognition of the civil rights of lesbian, gay, bisexual, and transgender ("LGBT") people and everyone living with HIV through impact litigation, policy advocacy, and public education. For decades, Lambda Legal has been a leader in the fight to ensure access to quality health care for our vulnerable communities. In recent years, Lambda Legal has submitted a series of comments to HHS regarding the importance of reducing discrimination against LGBT people in health care services, the fact that current law already protects health worker conscience rights appropriately, and the ways that conscience-based exemptions to health standards endanger LGBT people and others.[2] Recently, Lambda Legal also has opposed an HHS proposal to expand

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[1] 83 Fed. Reg. 3880 *et seq.* (proposed Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88).

[2] *Lambda Legal Comments on Proposed Rule 1557 Re: Nondiscrimination in Health Programs and Activities, 1557 NPRM (RIN 0945-AA02)* (submitted Nov. 9, 2015) ("Lambda Legal 1557 Comments"), https://www.lambdalegal.org/in-court/legal-docs/hhs_dc_20151117_letter-re-1557; *Lambda Legal Comments on Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities (RIN 0945-AA02 & 0945-ZA01)* (submitted Sept. 30, 2013) ("Lambda Legal Nondiscrimination Comments"), https://www.lambdalegal.org/in-court/legal-docs/ltr_hhs_20130930_discrimination-in-health-services. *See also* Brief of Amici Curiae Lambda Legal et al., *Zubik v. Burwell*, 136 S. Ct. 1557

the ability of religiously-affiliated health care institutions and individuals to impose their religious beliefs on workers and on patients, cautioning in detail about the likely harmful consequences of any such expansions for LGBT people and people living with HIV.[3]

As to the Proposed Rule now under consideration, Lambda Legal emphatically recommends its withdrawal because:

(1) It improperly expands statutory religious exemptions in multiple ways, including by:

(a) permitting workers to refuse job duties that cannot reasonably be understood as "assisting" with an objected-to procedure, [4] and instead have merely an "articulable" connection to the procedure[5];

(b) expanding who may assert religious objections from employees performing or assisting in specified procedures to any member of the workforce[6];

(c) using an improperly expanded definition of "referral"[7] that includes providing any information or directions that could assist a patient in pursuing care; and

(d) defining "discrimination" to focus on protecting the interests of health care providers in continuing to receive favorable financial, licensing or other treatment, rather than on patients' interest in receiving medically appropriate care[8]; and

(e) defining health care entity to include health insurance plans, plan sponsors, and third-party administrators.[9]

(2016) (Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, 15-191), http://www.lambdalegal.org/in-court/legal-docs/zubik_us_20160217_amicus.

[3] *See, e.g., Lambda Legal Comments on Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (RIN 0938-AT46)* (submitted Dec. 5, 2017), https://www.lambdalegal.org/in-court/legal-docs/dc_20171205_aca-moral-exemptions-and-accommodations; *Lambda Legal Comments on Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (RIN 0938-AT20)* (submitted Dec. 5, 2017), https://www.lambdalegal.org/in-court/legal-docs/dc_20171205_aca-religious-exemptions-and-accommodations.

[4] 42 U.S.C.A. § 300a-7(b) and (d).

[5] Section 88.2, 83 Fed. Reg. at 3923.

[6] Section 88.2, 83 Fed. Reg. at 3924.

[7] *Id.*

[8] *Id.*

[9] *Id.*

(2) It encourages workers and institutions to refuse care and does not acknowledge the rights of patients, such as the right against sex discrimination provided by Section 1557 of the Affordable Care Act.[10]

(3) It encourages workers and institutions to refuse care and does not acknowledge the legal rights and duties of health care providers, such as those under Title VII of the Civil Rights Act of 1964,[11] or health professionals' ethical obligations to patients.

(4) Using broad, vague language, it addresses a purported "problem" of health workers being pressed to violate their conscience, suggesting that workers should have broad religious rights to decline care and refuse other work of any sort in any context, going far beyond the narrow contexts specified in the authorizing statutes.

(5) Its proposed enforcement mechanisms are draconian, threatening the loss of federal funding and even the potential of funding "claw backs," with limited if any due process protections, all of which would skew health systems improperly in favor of religious refusals and against patient care.

(6) The heavy-handed enforcement mechanisms inevitably would invite discrimination and aggravate existing health disparities and barriers to health care faced by LGBT people and others, contrary to the mission of HHS and, in particular, its Office for Civil Rights.

(7) It is the result of a rushed, truncated process inconsistent with procedural requirements including the Administrative Procedure Act.[12]

In sum, the role of the HHS Office for Civil Rights ("OCR") described in the Proposed Rule is not to promote access to health care and to safeguard patients against discrimination, but instead to impose vague, overbroad *restraints* on health care provision, as a practical matter elevating "conscience" objections of workers over the needs of patients. In so doing, the Proposed Rule turns the mission of HHS/OCR on its head. Freedom of religion is a core American value, which is why it is already protected by the First Amendment of the Constitution. But, that freedom does not and must not allow anyone to impose their beliefs on others or to discriminate. This basic principle is nowhere more important than in medical contexts where religion-based refusals can cost patients their health and even worse.

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[10] 42 U.S.C.A. § 18116.

[11] Civil Rights Act of 1964 § 7, 42 U.S.C.A. § 2000e *et seq.* (1964).

[12] 5 U.S.C.A. § 500 *et seq.*

I. The Proposed Rule Improperly Expands Statutory Religious Exemptions.

The Proposed Rule improperly expands statutory religious exemptions beyond their narrow, specific parameters in numerous ways. It includes definitions that would broaden the exemptions in the Church Amendments, which currently allow health workers to decline to assist in an abortion or sterilization procedure if doing so "would be contrary to [their] religious beliefs or moral convictions."[13] The Proposed Rule reinterprets what it means to "assist in the performance" of a procedure from participating in "any activity with a *reasonable* connection" to a procedure [14] to "any … activity with an *articulable* connection" to an objected-to procedure.[15] In other words, any connection that can be described, no matter how tenuous, potentially could suffice. Confirming the potentially indefinite expansion of *what* can be deemed "assistance" is a broad definition of *who* may object. From the prior common language understanding of who might be involved in a medical procedure, the new definition appears to authorize any member of the workforce to object to performing their job duties.[16]

The Proposed Rule also includes an aggressive expansion of the concept of "referral" from the common understanding of actively connecting a patient with an alternate source of a particular service to the provision of any information or directions that could possibly assist a patient who might be pursuing a form of care to which the employee objects.[17] This goes far beyond a reasonable understanding of what the underlying statute justifies.

Similarly, where the statute authorizes "health care entities" to assert religious objections, the Proposed Rule grossly expands the entities covered by that term to include health insurance plans, plan sponsors, and third-party administrators.[18] It also adds a definition of "discrimination" that focuses not on patients' interest in receiving equal, medically appropriate services, but rather on protecting health care providers' interests in continuing to receive favorable financial, licensing or other treatment while refusing on religious or moral objections to provide care despite medical standards, nondiscrimination rules, or other requirements.[19]

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[13] 42 U.S.C.A. § 300a-7.

[14] 45 C.F.R. § 88.2 (2008) (emphasis added).

[15] Proposed Rule, 83 Fed. Reg. at 3923 (emphasis added).

[16] Section 88.2, 83 Fed. Reg. at 3924.

[17] Section 88.2, 83 Fed. Reg. at 3924.

[18] Section 88.2, 83 Fed. Reg. at 3924.

[19] Section 88.2, 83 Fed. Reg. at 3924.

In numerous places, the Proposed Rule seems to indicate that HHS is adopting interpretations that would extend the Amendments' reach beyond current understanding that the exemptions only concern abortion and sterilization and follow the common medical understanding of those terms.[20] As one example, it seems likely that the "sterilization" references within the Proposed Rule could be applied to deny health care to transgender patients because the Rule itself, at footnote 36, cites *Minton v. Dignity Health* approvingly.[21] *Minton* addresses whether a Catholic hospital was legally justified when it blocked a surgeon from performing a hysterectomy for a transgender man as part of the prescribed treatment for gender dysphoria. The hospital defended on religious freedom grounds, arguing that it was bound "to follow well-known rules laid down by the United States Conference of Catholic Bishops," including rules prohibiting "direct sterilization."[22]

But, to equate hysterectomy to treat gender dysphoria with direct sterilization is medically inaccurate. Sterilization procedures undertaken for the *purpose* of sterilization are fundamentally different from procedures undertaken for other medical purposes that incidentally affect reproductive functions. Regardless of whether the United States Conference of Catholic Bishops considers gender transition-related care to be sterilization as a religious matter, were the federal government to approve a religious rationale as grounds for stretching a federal statute and permitting denial of medically necessary care would be problematic for both statutory interpretation and Establishment Clause reasons.

The Proposed Rule's apparent embrace of the Bishops' view poses an overtly discriminatory and unacceptable threat to transgender patients. This concern is not speculative. The Proposed Rule's footnote referencing *Minton* supports the following statement: "Many religious health care personnel and faith-based medical entities have further alleged that health care personnel are being targeted for their religious beliefs."[23] For the Proposed Rule to equate a transgender patient expecting to receive medically necessary care from health care personnel with those personnel "being targeted for their religious beliefs" is a chilling indicator of the direction the Proposed Rule would take health care in this country. Not only would health providers be invited to turn away transgender patients, but those that abide by their obligation to

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[20] *Compare* cases describing statute's applicability to provision or refusal provide abortions or sterilization, *e.g., Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695 (2d Cir. 2010), *and Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974), *with Geneva Coll. v. Sebelius*, 929 F. Supp. 2d 402 (W.D. Pa. 2013), *on reconsideration in part* (May 8, 2013) (statute does not apply to provision of emergency contraception, which is not abortion or sterilization).

[21] No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017).

[22] Defendant Dignity Health's Reply Brief in Support of Demurrer to Verified Complaint, *Minton v. Dignity Health*, No. 17-558259, at 2 (Calif. Super. Ct. Apr. 19, 2017) (filed Aug. 8, 2017), https://www.aclusocal.org/sites/default/files/brf.sup_.080817_defendant_dignity_healths_reply_in_support_of_demurrer_to_verified_complaint.pdf.

[23] Proposed Rule, 83 Fed. Reg. at 3888 n. 36.

provide nondiscriminatory care and require their employees to act accordingly could be stripped of federal funding if equal treatment of those patients offended any workers' personal beliefs.

The overbroad definitions and suggestive language all contribute to the alarming overall theme of the Proposed Rule—that it addresses a purported problem of health workers ostensibly being pressed wrongfully to act against their rights of conscience. The Proposed Rule's suggested cure appears to be that workers should have broad religious rights to decline care of any sort in any context. This theme starts with the broad language stating the Proposed Rule's purpose and runs throughout the rule.[24] It creates at least a serious concern that, for example, language long understood to be bounded by its statutory context only to concern abortion and sterilization could be misconstrued as authorizing health care providers to refuse to participate in *any* part of *any* health service program or research activity "contrary to [their] religious beliefs or moral convictions."[25] While such an interpretation obviously could be challenged legally, many patients have neither the knowledge nor the means to resist such improper care refusals and would simply suffer the delay or complete denial of medically needed treatments.

II. The Proposed Rule Invites Workers And Institutions To Refuse Care And Does Not Acknowledge The Rights Of Patients.

By issuing the Proposed Rule, HHS invites health workers and institutions to refuse to provide medical care for religious reasons, without acknowledging that patients often have countervailing rights. Yet, all federal agencies, including HHS, must comply with the federal statutes that protect LGBT people and others from discrimination, such as Section 1557 of the Affordable Care Act, which bars discrimination based on sex in federally funded health services and programs.[26] Properly understood, Section 1557 protects transgender patients from discriminatory denials of care based on their gender identity or transgender status.[27] It also protects lesbian, gay, and bisexual patients.[28] Even if it were not contrary to the mission of OCR

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[24] *See, e.g.*, Section 88.1 (Purpose); Appendix A (required notice to employees) to 45 C.F.R., 83 Fed. Reg. at 3931 (declaring broad right to accommodation for any religious or moral belief); 83 Fed. Reg. at 3881, 3887-89, 3903 (addressing "problem" of workers being required to meet patient needs despite their personal beliefs).

[25] 42 U.S.C.A. § 300a-7(d). See cases cited *supra* note 20.

[26] 42 U.S.C.A. § 18116.

[27] *Rumble v. Fairview Health Services*, 2015 WL 1197415 (D. Minn. March 16, 2015) (Affordable Care Act, Section 1557). *See also Whitaker v. Kenosha Unified School District No. 1 Board of Education, 858 F.3d 1034 (7th Cir. 2017)* (analogous protection against sex discrimination in Title IX protects transgender students); *EEOC v. R.G. v. G.R. Harris Funeral Homes, Inc.*, __F.3d __, 2018 WL 1177669 (6th Cir. March 7, 2018) (analogous protection against sex discrimination in Title VII protects transgender workers).

[28] *Cf. Zarda v. Altitude Express, Inc.*, 883 F.3d 100 (2d Cir. 2018) (sexual orientation discrimination is sex discrimination under Title VII); *Hively v. Ivy Tech Comm'ty College*, 853 F.3d 339 (7th Cir. 2017) (same).

to undermine patient protections against discrimination, the agency lacks the authority to reduce the protections provided to patients by separate statutes.

The ACA also includes patient protections to ensure access to essential health services, including reproductive health services. Yet, the Proposed Rule's aggressive approach to advancing conscience rights offers nothing to explain how those refusal rights are to coexist with patients' rights under the ACA. As to these conflicts, Lambda Legal joins the comments submitted by the National Health Law Program.

Moreover, the Proposed Rule also is inconsistent with several core constitutional guarantees: (1) each of us is entitled to equal protection under law; (2) the Establishment Clause forbids our government from elevating the religious wishes of some above the needs of others to be protected from harm, including the harms of discrimination; and (3) congressional spending powers have limits. On the latter point, the Proposed Rule references the spending powers of Congress as grounds for the new enforcement powers created for HHS to condition federal funding upon health care providers' acquiescence in religious refusal demands of their workers.[29] However, as well-established by *South Dakota v. Dole*[30] and its progeny, Congress's spending powers are limited. Any exertion of power must be in pursuit of the general welfare; must not infringe upon states' abilities "to exercise their choice knowingly, cognizant of the consequences of their participation"; must be related "'to the federal interest in particular national projects or programs;'" and must be otherwise constitutionally permissible.[31]

Multiple Equal Protection and Establishment Clause concerns implicate the final prong of the *South Dakota v. Dole* test for unconstitutional conditions on federal funds. But the first prong deserves immediate focus because it obviously does not serve the general welfare to use severe de-funding threats to intimidate medical facilities into deviating from medical practice standards in favor of religious interests in secular settings, to the detriment of individual and public health.

In addition, with its explicit intention to enforce federal "conscience" rights despite contrary state and local protections for patients, the Proposed Rule further implicates federalism concerns. It states: "Congress has exercised the broad authority afforded to it under the Spending Clause to attach conditions on Federal funds for respect of conscience, and such conscience conditions supersede conflicting provisions of State law[.]"[32] It then asserts that it "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.[33] Yet, by inviting health professionals and

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[29] Proposed Rule, 83 Fed. Reg. at 3889.

[30] 483 U.S. 203 (1987).

[31] *Id.* at 207-08.

[32] Proposed Rule, 83 Fed. Reg. at 3889.

[33] *Id.* at 3918-19.

other workers to turn away patients and refuse job duties in such a sweeping way, the Proposed Rule directly conflicts with state and local nondiscrimination laws and other patient protections. Its assertions to the contrary are patently inaccurate.

III. The Proposed Rule Invites Workers To Refuse Care And Does Not Acknowledge The Legal Rights And Duties, And Ethical Obligations, Of Health Care Providers.

The Proposed Rule aims improperly to empower workers to object to job duties without addressing the impacts on employers and coworkers left somehow to try to ensure that patient needs are met by others, with whatever increased costs, workload, and other burdens it may entail. The proposed approach fails to acknowledge that the federal employment nondiscrimination law, Title VII of the Civil Rights Act of 1964, limits the extent to which employers are to be burdened by employee demands for religious accommodation.[34] Undue burdens on employers could include objections by coworkers to unfair additional job duties or to coworker proselytizing. Likewise, it certainly would impose unjustifiable burdens to require employers to hire duplicate staff simply to ensure patient needs are met by employees willing to perform basic job functions. Indeed, courts have confirmed that when denial of a requested accommodation is "reasonably necessary to the normal operation of the particular business or enterprise,"[35] employers, including health care employers,[36] need only show that they "offered a reasonable accommodation *or* that a reasonable accommodation would be an undue burden."[37]

Such limitations on employee religious rights are essential to ensure that health care employers can hire those who will perform the essential functions of their jobs, and will comply with all statutory obligations including prohibitions against discrimination. If instead, employees who claim "conscience" objections to providing the health care services to LGBT people or people living with HIV are empowered by the Proposed Rule to threaten their employees with loss of federal funding if they do not allow such discrimination, employers will face logistical

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[34] 42 U.S.C.A. § 2000e *et seq. See, e.g., See, e.g., Bruff v. North Miss. Health Servs., Inc.*, 244 F.3d 495, 497-98 (5th Cir. 2001) (Title VII duty to accommodate employees' religious concerns did not require employer to accommodate employee's requests to be excused from counseling patients about non-marital relationships, which meant "she would not perform some aspects of the position itself"); *Berry v. Dep't of Social Servs.*, 447 F.3d 642 (9th Cir. 2006) (employer entitled to prohibit employee from discussing religion with clients).

[35] 42 U.S.C.A. § 2000e-2(e).

[36] *See, e.g., Grant v. Fairview Hosp. & Healthcare Servs.*, No. Civ. 02-4232JNEJGL, 2004 WL 326694 (D. Minn. Feb. 18, 2004) (hospital wasn't required to accommodate employee's request to be able to proselytize or provide pastoral counseling to patients to try to persuade them not to have abortions); *Robinson v. Children's Hosp. Boston*, Civil Action No. 14-10263-DJC, 2016 WL 1337255 (D. Mass. Apr. 5, 2016) (granting hospital employee's request to forgo flu shot would have been an undue hardship for hospital).

[37] *See, e.g., Sánchez-Rodríguez v. AT & T Mobility P. R., Inc.*, 673 F.3d 1, 8 (1st Cir. 2012).

nightmares and the employees without such beliefs will be unfairly subjected to increased workloads.

This seems like an inevitable repercussion particularly in light of the Proposed Rule's explanation in its definition of prohibited "discrimination" that "religious individuals or institutions [must] be allowed a level playing field, and that their beliefs not be held to disqualify them from participation in a program or benefit."[38] This definition lacks any qualifying language confirming that employers may condition employment on willingness to perform essential parts of a job. The likely effects would include increased burnout among those staff who have additional work delegated to them when religious exemptions are claimed. The Proposed Rule also would drain institutional resources as employers must respond (with management time and legal fees) to complaints filed by overburdened workers and by those who file implausible "conscience" objections upon receiving negative work evaluations. The waste of essential health care resources in service of improper denials of medical care cannot be justified.

Moreover, the Proposed Rule similarly ignores that health professionals are bound by ethical standards to do no harm and to put patient needs first. Concerning the application of this point to ensuring patients' reproductive health needs are not improperly subordinated to others' religious concerns, Lambda Legal endorses the comments submitted by the National Health Law Program. Concerning patients' needs to be treated equally regardless of gender identity, sexual orientation, and other irrelevant personal characteristics, the Joint Commission's accreditation standards and the ethical rules of the American Medical Association and other leading medical associations all impose a duty of nondiscrimination. For example, AMA Ethical Rule E-9.12 prohibits discrimination against patients and Ethical Rule E-10.05 provides that health professionals' rights of conscience must not be exercised in a discriminatory manner.[39] But that is precisely what results when, for example, a medically necessarily hysterectomy is denied to a patient because it is needed as treatment for gender dysphoria, and is provided to other patients as treatment for fibroids, endometriosis, or cancer.[40]

The Tennessee Counseling Association has expressed the bottom line cogently. Like many medical associations across the country, the TCA has codified the "do no harm" mandate and issued a formal statement opposing legislation proposing to allow denials of medical care through religious exemptions in that state: "When we choose health care as a profession, we

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[38] Proposed Rule, 83 Fed. Reg. at 3892.

[39] AMA ethical rule E-9.12, "Patient-Physician Relationship: Respect for Law and Human Rights," E-10.05, "Potential Patients."

[40] See discussion of Proposed Rule reference to *Minton v. Dignity Health*, No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017), at page 5, footnote 22. *See also Conforti v. St. Joseph's Healthcare Sys.* (D. N.J. filed Jan. 5, 2017), case documents at https://www.lambdalegal.org/in-court/cases/nj-conforti-v-st-josephs; Amy Littlefield, *Catholic Hospital Denies Transgender Man a Hysterectomy on Religious Grounds*, Rewire.News, Aug. 31, 2016, https://rewire.news/article/2016/08/31/catholic-hospital-denies-transgender-man-hysterectomy-on-religious-grounds/.

choose to treat all people who need help, not just the ones who have goals and values that mirror our own."[41]

IV. The Proposed Rule's Enforcement Mechanisms Are Draconian And Would Skew Health Systems In Favor Of Religious Refusals And Against Patient Care.

The Proposed Rule's enforcement mechanisms include aggressive investigation, require medical facilities to subject themselves to an extensive scheme of regulatory surveillance by HHS, and allocate authority to OCR "to handle complaints, perform compliance reviews, investigate, and seek appropriate action."[42] The Proposed Rule even "make[s] explicit the Department's authority to investigate and handle violations and conduct compliance reviews *whether or not a formal complaint has been filed*."[43] In addition to conditioning federal funding on prospective pledges to comply with broad, vague requirements, penalties can include not just the loss of future federal funding but even the potential of funding "claw backs,"[44] all with limited if any due process protections.

For many major medical providers, the threat of loss of federal funding is a threat to the facilities' very existence. It is nearly unfathomable that the government intends to force medical facilities either to forego their ethical obligations not to harm their patients or to close their doors. But, that easily could be the effect of the Proposed Rule in many instances. More often, the likely result would be simply to skew health systems dangerously in favor of religious refusals and against patient care. Doing so would both invite discrimination and aggravate existing health disparities and barriers to health care faced by LGBT people and others, contrary to the mission of HHS and, in particular, its Office for Civil Rights.

V. The Proposed Rule Inevitably Would Invite Discrimination And Worsen Health Disparities Affecting LGBT People And Others.

Discrimination and related health disparities already are widespread problems for LGBT people and people living with HIV.[45] In 2010, Lambda Legal conducted the first-ever national

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[41] *See* Emma Green, *When Doctors Refuse to Treat LGBT Patients*, The Atlantic, April 19, 2016, https://www.theatlantic.com/health/archive/2016/04/medical-religious-exemptions-doctors-therapists-mississippi-tennessee/478797/, citing Tenn. Counseling Assoc., *TCA Opposes HB 1840* (2016), http://www.tncounselors.org/wp-content/uploads/2016/03/TCA-Opposes-HB-1840-3.9.16.pdf.

[42] Proposed Rule, 83 Fed. Reg. at 3898.

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

[44] *Id.*

[45] *See, e.g.*, Inst. of Med., *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011) ("IOM Report") (undertaken at the request of the National Institutes of Health, and providing an overview of the public health research concerning health disparities for LGBT people and the adverse health consequences of anti-LGBT attitudes),

survey to examine the refusals of care and other barriers to health care confronting LGBT people and people living with HIV, *When Health Care Isn't Caring: Survey on Discrimination Against LGBT People and People Living with HIV*.[46] Of the nearly 5,000 respondents, more than half reported that they had experienced at least one of the following types of discrimination in care:

- Health care providers refusing to touch them or using excessive precautions;
- Health care providers using harsh or abusive language;
- Health care providers being physically rough or abusive;
- Health care providers blaming them for their health status.[47]

Almost 56 percent of lesbian, gay, or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and almost 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care.[48] Almost 8 percent of LGB respondents reported having been denied needed care because of their sexual orientation,[49] and 19 percent of respondents living with HIV reported being denied care because of their HIV status.[50] The picture was even more disturbing for transgender and gender-nonconforming respondents, who reported the highest rates of being refused care (nearly 27 percent), being subjected to harsh language (nearly 21 percent), and even being abused physically (nearly 8 percent).[51]

Respondents of color and low-income respondents reported much higher rates of hostile treatment and denials of care. Nearly half of low-income respondents living with HIV reported that medical personnel refused to touch them, while the overall rate among those with HIV was

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https://www.ncbi.nlm.nih.gov/books/NBK64806; Sandy E. James et al., Nat'l Ctr. For Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 93-129 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf; Lambda Legal, Health Care; Shabab Ahmed Mirza & Caitlin Rooney, Ctr. For Am. Progress, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

[46] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010) ("Lambda Legal, Health Care"), http://www.lambdalegal.org/publications/when-health-care-isnt-caring.

[47] *Id.* at 5, 9-10.

[48] *Id.*

[49] *Id.* at 5, 10.

[50] *Id.*

[51] *Id.* at 10-11.

nearly 36 percent.[52] And while transgender respondents as a whole reported a care-refusal rate of almost 27 percent, low-income transgender respondents reported a rate of nearly 33 percent.[53] People of color living with HIV and LGB people of color were at least twice as likely as whites to report experiencing physically rough or abusive treatment by medical professionals.[54]

Also detailed in the report are particular types of discrimination in health care based on gender identity, sex discrimination against LGB people, and discrimination against people living with HIV. Such discrimination can take many forms, from verbal abuse and humiliation to refusals of care;[55] to refusal to recognize same-sex family relationships in health care settings to the point of keeping LGBT people from going to the bedsides of their dying partners;[56] to lack of understanding and respect for LGBT people.[57] The resulting harms are manifold, from transgender patients denied care postponing, delaying, or being afraid to seek medical treatment, sometimes with severe health consequences, or resorting out of desperation to harmful self-treatment;[58] to the mental and physical harms of stigma;[59] to other immediate physical harms from being denied medical care.

As described, the discriminatory treatment of LGBT people too often occurs in the name of religion. When it does, that religious reinforcement of anti-LGBT bias often increases the mental health impacts of discrimination.[60]

Since the 2010 Lambda Legal survey, other studies have similarly documented the disparities faced by LGBT people seeking health care. For example, *The Report of the 2015 U.S. Transgender Survey*, a survey of nearly 28,000 transgender adults nationwide, found that 33 percent "of respondents who had seen a health care provider in the past year reported having at least one negative experience related to being transgender, such as verbal harassment, refusal of treatment, or having to teach the health care provider about transgender people to receive

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[52] *Id.* at 11.

[53] *Id.*

[54] *Id.* at 12.

[55] *Id.* at 5-6.

[56] *Id.* at 15-16.

[57] *Id.* at 12-13.

[58] *Id.* at 6, 8, 12-13.

[59] *Id.* at 2.

[60] Ilan H. Meyer et al., *The Role of Help-Seeking in Preventing Suicide Attempts among Lesbians, Gay Men, and Bisexuals*, Suicide & Life Threatening Behavior, 8 (2014), http://www.columbia.edu/~im15/papers/meyer-2014-suicide-and-life.pdf ("[A]lthough religion and spirituality can be helpful to LGB people, negative attitudes toward homosexuality in religious settings can lead to adverse health effects") (internal citations omitted).

appropriate care" and that "23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person[.]"[61]

The Center for American Progress in 2017 conducted another nationally representative survey with similar results about LGBT health disparities, including findings that:

> Among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:
>
> > 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation.
> >
> > 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation.
> >
> > 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner.
> >
> > 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them.
> >
> > 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[62]
>
> Among transgender people who had visited a doctor or health care providers' office in the past year:
>
> > 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity.
> >
> > 12 percent said a doctor or other health care provider refused to give them health care related to gender transition.
> >
> > 23 percent said a doctor or other health care provider intentionally misgendered them or used the wrong name.

[61] James et al., *supra* n. 45, at 93.

[62] Mirza & Rooney, *supra* n. 45.

> 21 percent said a doctor or other health care provider used harsh or abusive language when treating them.
>
> 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[63]

Independently of our own and others' research studies, Lambda Legal has become distressingly aware of the nature and scope of the discrimination problem from our legal work and requests for assistance received by our Legal Help Desks. We have repeatedly submitted information about the pattern of religion-based refusals of medical care to LGBT people in response to HHS requests. For example, in our 2013 response to the Request For Information for Section 1557 of the ACA, we documented numerous cases in which health professionals had denied medical care or otherwise discriminated against LGBT people and/or people living with HIV, based on the professionals' personal religious views, including:

> • Guadalupe "Lupita" Benitez was referred for infertility care to North Coast Women's Care Medical Group, a for-profit clinic that had an exclusive contract with Benitez's insurance plan. After eleven months of preparatory treatments, including medication and unwarranted surgery, Lupita's doctors finally admitted they would not perform donor insemination for her because she is a lesbian. The doctors claimed a right not to comply with California's public accommodations law due to their fundamentalist Christian views against treating lesbian patients as they treat others. In a unanimous decision, the California Supreme Court held that religious liberty protections do not authorize doctors to violate the civil rights of lesbian patients. *North Coast Women's Care Med. Grp., Inc. v. San Diego Cnty. Superior Court (Benitez)*, 189 P.3d 959 (Cal. 2008)
>
> • Counseling student's objections to providing relationship counseling to same-sex couples. *Keeton v. Anderson-Wiley*, 664 F.3d 865 (11th Cir. 2011) (finding student unlikely to prevail on free speech and religious liberty claims challenging her expulsion from counseling program due to her religiously based refusal to counsel same-sex couples, contrary to professional standards requiring nonjudgmental, nondiscriminatory treatment of all patients).
>
> • Physician's objection to working with an LGB person. *Hyman v. City of Louisville*, 132 F. Supp. 2d 528, 539-540 (W.D. Ky. 2001) (physician's religious beliefs did not exempt him from law prohibiting employment discrimination based on sexual orientation or gender identity), *vacated on other grounds by* 53 Fed. Appx. 740 (6th Cir. 2002).

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[63] *Id.*

• Proselytizing to patients concerning religious condemnation of homosexuality. *Knight v. Connecticut Dep't of Pub. Health*, 275 F.3d 156 (2d Cir. 2001) (rejecting free exercise wrongful termination claim of visiting nurse fired for antigay proselytizing to home-bound AIDS patient).

• Refusal to process lab specimens from persons with HIV. *Stepp v. Review Bd. of Indiana Emp. Sec. Div.*, 521 N.E.2d 350, 352 (Ind. 1988) (rejecting religious discrimination claim of lab technician fired for refusing to do tests on specimens labeled with HIV warning because he believed "AIDS is God's plague on man and performing the tests would go against God's will").[64]

In addition, testimonies received in Lambda Legal's health survey describe similar encounters with health professionals who felt free to express their religiously grounded bias toward LGBT patients:

• Kara in Philadelphia, PA: "Since coming out, I have avoided seeing my primary physician because when she asked me my sexual history, I responded that I slept with women and that I was a lesbian. Her response was, 'Do you know that's against the Bible, against God?'"[65]

• Joe in Minneapolis, MN: "I was 36 years old at the time of this story, an out gay man, and was depressed after the breakup of an eight-year relationship. The doctor I went to see told me that it was not medicine I needed but to leave my 'dirty lifestyle.' He recalled having put other patients in touch with ministers who could help gay men repent and heal from sin, and he even suggested that I simply needed to 'date the right woman' to get over my depression. The doctor even went so far as to suggest that his daughter might be a good fit for me."[66]

Lambda Legal documented additional recent examples of health care denials or discriminatory treatment in its amicus brief to the Supreme Court in *Masterpiece Cakeshop v. Colorado Civil Rights Commission*,[67] including the following two Lambda Legal cases:

- Lambda Legal client Naya Taylor, a transgender woman in Mattoon, Illinois, who sought hormone replacement therapy (HRT), a treatment for gender dysphoria, from the health clinic where she had received care for more than a decade. When her primary care physician refused her this standard treatment, clinic staff told her that, because of

[64] Lambda Legal Nondiscrimination Comments (citations partially omitted).

[65] *Id.*

[66] *Id.*

[67] *See* Brief of Amici Curiae Lambda Legal et al., *Masterpiece Cakeshop Ltd. v. Colorado Civil Rights Comm'n*, No. 16-111, at 11-14, 17-18, 26, 30 (filed Oct. 30, 2017), https://www.lambdalegal.org/in-court/cases/masterpiece-cakes-v-co-civil-rights-commission.

the religious beliefs of the clinic's doctors, they do not have to treat "people like you."[68]

- Lambda Legal client Jionni Conforti, who was refused a medically necessary hysterectomy despite his treating physician's desire to perform the surgery. The hospital where the surgeon had admitting privileges was religiously affiliated and withholds permission for all gender transition-related care.[69]

These examples are just a tip of the iceberg, a few of many incidents across the country in which religion has been used to justify denial of health care or other discrimination against LGBT people and people living with HIV. Although courts consistently have rejected such reliance on religion to excuse discrimination, examples of religion-based discrimination in health care continue to occur with regularity.[70] This mistreatment contributes to persistent health disparities, including elevated rates of stress-related conditions.[71]

Given this landscape, Lambda Legal is deeply concerned that this Proposed Rule, designed to protect and even encourage religious refusals of health care, inevitably will facilitate further discrimination by health professionals in contexts involving sexual orientation, gender identity, or HIV status. As a result, the health of patients across the country, as well as others, would be at risk, and "conscience" claims could too easily become a way for providers to turn away LGBT patients. The past examples of religiously-based discrimination indicate there is significant likelihood that too-many individual and institutional care providers will demand exemptions from rules and standards designed to ensure that patients receive proper treatment regarding the following needs:

- Treatment of patients who need counseling, hormone replacement therapy, gender confirmation surgeries, or other treatments for gender dysphoria.
- For patients with a same-sex spouse or who are in a same-sex relationship, bereavement counseling after the loss of a same-sex partner or other mental health care that requires

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[68] In April 2014, Lambda Legal filed a claim of sex discrimination on Ms. Taylor's behalf under Section 1557 of the ACA; however, Ms. Taylor subsequently passed away and her case was voluntarily dismissed. *See* Complaint, *Taylor v. Lystila*, 2:14-cv-02072-CSB-DGB (C.D. Ill., Apr. 15, 2014), *available at* https://www.lambdalegal.org/in-court/legal-docs/taylor_il_20140416_complaint.

[69] *See Conforti v. St. Joseph's Healthcare Sys.* (D. N.J. filed Jan. 5, 2017) case documents at https://www.lambdalegal.org/in-court/cases/nj-conforti-v-st-josephs. *See also* Amy Littlefield, *Catholic Hospital Denies Transgender Man a Hysterectomy on Religious Grounds*, Rewire.News, Aug. 31, 2016, https://rewire.news/article/2016/08/31/catholic-hospital-denies-transgender-man-hysterectomy-on-religious-grounds/.

[70] *See* Lambda Legal 1557 Comments; Brief of Amici Curiae Lambda Legal et al., *Zubik v. Burwell*, 136 S. Ct. 1557 (2016).

[71] *See* Mark Hatzenbuehler, *Structural Stigma: Research Evidence and Implications for Psychological Science*, 71 AM. PSYCHOLOGIST, 742, 742–51 (2016), http://dx.doi.org/10.1037/amp0000068; IOM Report, *supra* n. 45.

respectful acknowledgment of a person's sexual orientation or gender identity.

- Care for patients living with HIV, including the option of pre-exposure prophylaxis (PrEP), a highly effective medication that dramatically reduces the risk of HIV infection among those who are otherwise at high risk, including people who are in a sexual relationship with a partner who is living with HIV.
- Treatment of patients who are unmarried or in a same-sex relationship and require infertility treatment or other medical services related to pregnancy, childbirth or pediatric needs.

In addition, the Proposed Rule threatens to undermine the community's trust in health care providers. Although there may be health care facilities that remain safer places for patients who face increased risk of discrimination in health care facilities, those facilities that are more welcoming of LGBT patients and patients seeking HIV care and willing to provide them with full health care access will become overburdened and increasingly unable to meet the needs of all who come through their doors.

If the number of health care facilities that LGBT people can feel comfortable going to, knowing they won't be turned away is reduced as the inevitable result of this Proposed Rule, access to health care will become harder, and nearly impossible for some, who, for example, are low income[72] or who live in remote areas and cannot travel long distances for medical care. Patients seeking more specialized care such as infertility treatments or HIV treatment or prevention are already often hours away from the closest facility. The Proposed Rule threatens to build even greater barriers between those who are most vulnerable and the health care they need.

For the Proposed Rule to transform the role of HHS from an agency focused on ensuring nondiscriminatory provision of health care to one that facilitates refusals of care is a disturbing about-face contrary to the Department's mission and authorizing statutes. Its failure to explain how the enhanced powers of health care providers to refuse patient care in the name of "conscience" should be reconciled with the protections for patients under the ACA and other statutes, and for employers under Title VII, make clear that this proposal is legally untenable as well as unjustifiably dangerous as a matter of federal health policy.

VI. The Proposed Rule Is The Result Of A Rushed, Truncated Process Contrary To The Department's Mission And Inconsistent With Procedural Requirements.

Considering the well-recognized health disparities and difficulty obtaining nondiscriminatory care that already confront the LGBT community, the Proposed Rule's apparent goal of inviting more discrimination and care denials to LGBT people and is peculiar

[72] Contrary to some misperceptions, LGBT people and people living with HIV are disproportionately economically disadvantaged. *See, e.g.*, M.V. Lee Badgett et al., *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community*, WILLIAMS INST. (June 2013), https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-poverty-update-june-2013.

and alarming. Indeed, the lack of concern for the Proposed Rule's inevitable impacts is especially shocking because this Department itself has conducted studies revealing disparities in LGBT health outcomes. As reported in the 2014 National Health Statistics Reports:

> [R]ecent studies have examined the health and health care of lesbian, gay, and bisexual (LGB) populations and have found clear disparities among sexual minority groups (i.e., gay or lesbian and bisexual) and between sexual minorities and straight populations. These disparities appear to be broad-ranging, with differences identified for various health conditions (e.g., asthma, diabetes, cardiovascular disease, or disability) … health behaviors such as smoking and heavy drinking … and health care access and service utilization …. Across most of these outcomes, sexual minorities tend to fare worse than their nonminority counterparts.[73]

Thus, in addition to the legal and ethical conflicts it would generate, the Proposed Rule also would undermine HHS's national and local efforts to reduce LGBT health disparities. For example, this Department's "Healthy People 2020 initiative" and the Institute of Medicine have called for steps to be taken to address LGBT health disparities"[74]; medical associations including the American Medical Association, the Association of American Medical Colleges, the American College of Physicians, the American Psychiatric Association, and others are committed to improving medical care for LGBT people through education and cultural competency training; and legislation is increasingly being considered and passed to improve LGBT health access and reduce health disparities.[75] The Proposed Rule endangers the important progress made on this front.

With this Department's past focus on addressing LGBT health disparities, it would be a bizarre and disturbing reversal of course for HHS now to become an active participant in the very denials of health care and discriminatory treatment that cause these disparities. Years of careful study and deliberation went into framing the protections against discrimination implemented pursuant to Section 1557 of the ACA, including the explicit protections against gender identity discrimination and other forms of sex discrimination and the accompanying

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[73] Brian W. Ward et al., *Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013*, Nat'l Health Statistics Report No. 77, 1, (July 15, 2014), https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf.

[74] Dep't of Health & Human Servs., *Healthy People 2020: LGBT Health Topic Area* (2015), http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health; IOM Report.

[75] *See* Timothy Wang et al., The Fenway Inst., *The Current Wave of Anti-LGBT Legislation: Historic Context and Implications for LGBT Health* at 6, 8-9 (June 2016), http://fenwayhealth.org/wp-content/uploads/The-Fenway-Institute-Religious-Exemption-Brief-June-2016.pdf.

value statement that "HHS supports prohibiting sexual orientation discrimination as a matter of policy[.]"[76]

In addition, the Proposed Rule has been issued without adequate time spent considering the thousands of comments submitted on related proposals. It lacks acknowledgment of countervailing interests of patients and many health provider institutions, let alone any explanation of how those interests are to be reconciled with the proposed aggressive enforcement of inconsistent religious interests. All in all, the Department's process has been arbitrary, capricious, and dangerous.[77] Consequently, along with its numerous other legal infirmities, it also violates the Administrative Procedure Act.[78]

VII. Conclusion

The Proposed Rule would have a chilling effect on the full and unbiased provision of health care, including to members of the LGBT community and everyone living with HIV, in a manner that conflicts with ethical, legal, and constitutional standards. While freedom of religion is a fundamental right protected by our Constitution and federal laws, it does not give anyone the right to use religious or moral beliefs as grounds for violating the rights of others. Instead, the Constitution commands that any religious or moral accommodation must be "measured so that it does not override other significant interests" or "impose unjustified burdens on other[s]."[79] Indeed, when the Supreme Court addressed the related question in *Burwell v. Hobby Lobby Stores, Inc.*, it explained that a religious accommodation should be provided in that case because the impact on third parties would be "precisely zero."[80]

Here, the Proposed Rule conflicts with statutory rights of health care providers to operate with reasonable efficiency and cost, and within their ethical obligations to care for patients according to professional standards. Most importantly, it also conflicts with legal and ethical protections for patients, potentially putting their health and even lives at risk. It is ill conceived and has no place in federal health policy.

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[76] Press Release, U.S. Dep't of Health & Human Servs., HHS Finalizes Rule to Improve Health Equity Under the Affordable Care Act (May 13, 2016), https://wayback.archive-it.org/3926/20170127191750/https://www.hhs.gov/about/news/2016/05/13/hhs-finalizes-rule-to-improve-health-equity-under-affordable-care-act.html.

[77] 5 U.S.C.A. § 706(2)(a).

[78] 5 U.S.C.A. § 500 *et seq.*

[79] *Cutter v. Wilkinson*, 544 U.S. 709, 722, 726 (2005).

[80] 134 S. Ct. 2751, 2760 (2014). Indeed, every member of the Court, whether in the majority or in dissent, reaffirmed that the burdens on third parties must be considered. *See id* at 2781 n. 37; *id.* at 2786–87 (Kennedy, J., concurring); *id.* at 2790, 2790 n. 8 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ., dissenting).

For the foregoing reasons, we emphatically recommend that the Department set aside this Proposed Rule.

Most respectfully,

LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.

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Exhibit 96

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LCHC
LATINO COALITION FOR A HEALTHY CALIFORNIA

March 26, 2018

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

By Electronic Submission

Re:Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, Proposed Rule (RIN 0945-ZA03 and Docket No. HHS-OCR-2018-002

To whom it may concern:

I am writing on behalf of the Latino Coalition for a Healthy California in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. The Latino Coalition for a Healthy California (LCHC)—the only statewide organization with a specific emphasis on Latino health—was founded in 1992 by health care providers, consumers and advocates to impact Latino health by focusing on policy development and community involvement. Part of our mission is to ensure Latinos are being protected from health and social injustice. We are here to ensure their problems are being voiced, heard and tackled.

The proposed rule puts Californians at great risk: The regulations as proposed introduce broad and poorly defined language to the existing law that already provides ample protections to health care workers that refuse to participate in a health care service to which they have a moral objection. This could result in medical, behavioral and oral health care that fails to comply with established medical practice guidelines, negating long-standing principles of informed consent, undermining the ability of health facilities to provide care in an orderly and efficient manner. As written, the law could allow anyone such as providers, behavioral therapists, pharmacists, hospitals, insurers or other health care entities to be misled into believing that they may refuse on religious grounds to administer an HIV test to a gay or bisexual man or to provide mental health counseling to a transgender woman who may be at risk of self-harm.

Latino Coalition for a Healthy California
a project of Tides Center
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Web Site: www.lchc.org

The proposed rule has the potential to exacerbate disparities for Californians: The proposed regulations fail to account for the significant burden that will be imposed on patients, a burden that will fall disproportionately on women, people of color, persons with disabilities, and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals. These communities already experience severe health disparities and discrimination. In California for example, Latinos and African Americans have twice the prevalence of type 2 diabetes and are twice as likely to die from the disease. These types of health disparities are often compounded for people of color who hold multiple intersectional identities (ie. women, individuals living with disabilities, LGBTQ, people living in rural communities). For example, LGBTQ and HIV-affected people of color were more likely to require medical attention as a result of hate violence when compared to other survivors. In California, African-American women are more likely to die in childbirth and less likely to access critical post-partem care. Rather than encouraging health care providers to find additional justifications for the denial of critical health care services, HHS should focus on its mission of eliminating barriers to care for those who need it the most.

The proposed rule is unwarranted and will make it impossible for OCR to do its job of ensuring patients are protected from discrimination: The proposed rule is a giant step backwards in preventing discrimination in health care settings. By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the Department seeks to use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. As stated in the NPRM itself, between 2008 and November 2016, the Office for Civil Rights received 10 complaints alleging violations of federal religious refusal laws; OCR received an additional 34 similar complaints between November 2016 and January 2018. By comparison, during a similar time period from fall 2016 to fall 2017, OCR received more than 30,000 complaints alleging either civil rights or HIPAA violations. These numbers demonstrate that rulemaking to enhance enforcement authority over religious refusal laws is not warranted.

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

[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].

LCHC
LATINO COALITION FOR A HEALTHY CALIFORNIA

For all these reason, we urge the administration to put patients first, and withdraw the proposed regulations.

Sincerely,

Jeff Reynoso, DrPH, MPH

Executive Director

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Exhibit 97

LeadingAge®

March 27, 2018

SUBMITTED ELECTRONICALLY

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 Protection NPRM, RIN 0945-ZA03, HHS-OCR-2018-0002

LeadingAge is pleased to submit comments with respect to the proposed rule, entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (the "Proposed Rule").

The mission of LeadingAge is to be the trusted voice for aging. Our 6,000+ members and partners include nonprofit organizations representing the entire field of aging services, 39 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 30 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy and applied research.

We have specific concerns with respect to some operational aspects of the Proposed Rule.

Disparate Impact Analysis Should Not Be Incorporated Into the Proposed Rule

In the discussion of the defined terms *Discriminate or Discrimination*, the Department states that "OCR will regard as presumptively discriminatory any law, regulation, policy or other such exercise of authority that has as its purpose, or explicit or otherwise clear application, the targeting of religious or conscience-motivated conduct." It then solicits comment on whether disparate impact analysis would be appropriate for incorporation into the Proposed Rule. Given the interplay of the expansive definition of *Discriminate or Discrimination* in Section 88.2 and

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the broad range of entities, organizations and individuals under Section 88.7(b) that may lodge a complaint with OCR for a "potential" violation of Federal health care conscience protection and associated anti-discrimination laws, LeadingAge urges the Department not to incorporate disparate impact analysis into the Proposed Rule as it would incentivize interest groups to manipulate data as a means of further expanding the scope of impermissible conduct under the Proposed Rule and the underlying laws when there was no clear intent to discriminate. This would, in turn, cause well-meaning providers and others to divert resources away from their work simply to defend themselves from spurious claims of discrimination.

The Requirement for Assurances and Certifications Should Be Eliminated from the Proposed Rule

Under Section 88.4 of the Proposed Rule, LeadingAge members, most of whom are Medicare and/or Medicaid-certified providers, would be required to submit an assurance and certification of compliance with the rule. The commentary indicates that this is to be done annually; however the regulatory language at Section 88.4(b)(1) states that the assurance and certification are to be made "as a condition of any reapplication for funds . . . or as a condition of an amendment or modification of the instrument that extends the term of such instrument or adds additional funding to it."

The requirement lacks clarity in the context of Medicare and Medicaid providers and is even more troubling in that such assurance and certification seemingly would apply going forward in the future, which is wholly inappropriate given that the rule largely will be complaint-driven and a provider may not anticipate when making an assurance and certification in good faith and to the best of their knowledge at the time it was made, that a particular practice could be claimed, and subsequently determined by OCR, to violate the conscience protections and associated anti-discrimination provisions covered by the rule.

Additionally, certification of compliance would necessarily involve great expense for LeadingAge members in having to obtain a legal opinion regarding compliance of their policies and procedures with the conscience protections and anti-discrimination laws covered by the proposed rule.

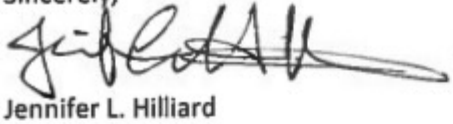
Accordingly, we ask the Department to eliminate the assurance and certifications requirement altogether as it is inappropriate in the context of a complaint-driven enforcement framework.

The Department Should Institute an Independent Hearing and Appeals Mechanism

Among the remedies in Section 88.7(j)(3) that OCR may employ in the event of a failure or *threatened* failure to comply with Federal health care conscience and associated anti-discrimination laws is the temporary withholding of cash payments (pending correction of the deficiency) and even termination of Federal funding altogether. The loss of Federal funding, even temporarily, could threaten the mission of LeadingAge provider members. We, therefore, urge the Department to include some form of appeals mechanism that is independent of OCR to ensure that providers and other covered entities are afforded the opportunity to present their evidence and arguments to a neutral body. Further, any OCR-initiated remedy should necessarily be stayed during the pendency of the appeal. The stakes are simply too high and the ramifications are too great to do otherwise.

Again, LeadingAge appreciates the opportunity to submit comments on the Proposed Rule. Please do not hesitate to contact us if you wish to discuss any of these comments further.

Sincerely,



Jennifer L. Hilliard
Director, Philanthropy and Legal Affairs

Exhibit 98

March 27, 2018

Department of Health and Human Services
Office for Civil Rights
Attn: Conscience NPRM, RIN 0945-ZA03
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Re: Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03, Proposed New 45 CFR Part 88 Regarding Refusals of Medical Care

Legal Voice submits these comments on the proposed rule published at 83 FR 3880 (January 26, 2018), RIN 0945-ZA03, with the title "Ensuring that the Department of Health and Human Services [the "Department"] Does Not Fund or Administer Programs or Activities that Violate Conscience and Associated Anti-Discrimination Laws" (the "Proposed Rule" or "Rule").

As an organization dedicated to advancing women's and LGBTQ rights, Legal Voice is committed to supporting all families and ensuring meaningful access to health care, especially as it relates to sexual and reproductive health and family planning.

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

The Proposed Rule and its impact on patients' access to care is particularly concerning in Washington state where, due to refusals of care, transgender individuals have been denied access to medically necessary treatments, terminally ill patients have faced often insurmountable barriers in accessing death with dignity services (Chapter 70.245 RCW), and women suffering miscarriages have experienced delays and denials of care - placing their health and lives at risk. While Washington State has strong state laws to protect patient access to care, the Proposed Rule attempts to increase rather than decrease the number of patients denied needed medical care and information. Further, a 2016 report found that Catholic hospital beds made up 40.9% of the hospital beds in Washington State,

making it the state with the third highest number of Catholic beds nationally. *See* Health Care Denied, 26 (May 2016), *available at* https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied. Thus in Washington state and especially in rural areas of Washington, religious health care entities are often the only providers available to patients. The Proposed Rule, by giving providers an unfettered right to refuse care, would have a significantly detrimental impact on Washington state patients, especially on those with limited health care options.

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

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

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

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

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

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

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

A. Assist in the Performance

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

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

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

B. Referral or Refer for

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

Providing a green light for the refusal to provide information that patients need to make informed decisions about their medical care not only violates basic medical ethics, but also far exceeds Congress's language and intent. A referral—as used in common parlance and the underlying statutes—has a far more limited meaning than providing *any* information that *could* provide *any assistance*

whatsoever to a person who may ultimately decide to obtain, assist, finance, or perform a given procedure sometime in the future. The meaning of "referral or refer for" in the health care context is to *direct* a patient elsewhere for care. *See* Merriam-Webster, https//www.merriam-webster.com/dictionary/referral ("referral" is "the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment").

C. Discriminate or Discrimination

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

D. Other Expansions of the Scope of the Refusal Statutes

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

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

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

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

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

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

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

[1] Although the Notice of Proposed Rulemaking highlights religious freedom and rights of conscience, a number of the referenced statutes—and the proposed expansions of those in the Rule—do not turn on the existence

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

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

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

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

These harms would fall most heavily on historically disadvantaged groups and those with limited economic resources. Women, LGBT (lesbian, gay, bisexual, and transgender) individuals, people of color, immigrants, young people, the elderly, and members of other groups who continue to struggle for equal rights are those who most often experience refusals of care.

In Washington State we have seen that members of these groups experience disproportionate denials of care. *See e.g. Enstad v. PeaceHealth,* No. 2:17-cv-01496-RSM (W.D. Wash Oct. 5, 2017)(Complaint)(a case currently being litigated in which a transgender individual was denied insurance for medically necessary treatment); *see also* In Their Own Words: Patient Stories, *available at* https://www.aclu-wa.org/pages/their-own-words-patient-stories (last viewed March 20, 2018) (stories of women in Washington state that have experienced refusals in care while miscarrying); *see also* JoNel Aleccia, *Aid-in-Dying Laws Don't Guarantee That Patients Can Choose To Die,* Kaiser Health News (Jan. 26, 2017) *available at* https://khn.org/news/aid-in-dying-laws-dont-guarantee-that-patients-can-choose-to-die/ (discussing a complaint filed by a hospice nurse regarding a terminally ill man who shot himself after he was repeatedly denied information about death with dignity at a Washington state hospice).

Likewise, poor and low-income people will also suffer acutely under the Proposed Rule. They are more likely to rely on health care that is in some manner tied to federal funding, and less likely to have other options at their disposal if they are denied access to care or information. Because it will limit access to health care, harm patients' outcomes, and undermine the central, public health mission of the Department, the Proposed Rule should be withdrawn.

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

The Proposed Rule appears to allow institutional and individual health care providers to manipulate and distort provider-patient communications and deprive patients of critical health care

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of any religious or moral justification. The Proposed Rule would empower not only those acting based on conscience, but others acting, for example, out of bare animus toward a patient's desired care or any aspect of their identity.

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

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

By erroneously expanding the meaning of "assist in the performance of," "refer for" and "make arrangements for," as described above, however, the Proposed Rule purports to allow health care providers to refuse to provide basic information to patients in ways that were never contemplated by the underlying statutes. Further indication that the Rule is an overreach not contemplated in the underlying statutes is provided in federal regulations. See e.g., 42 CFR 438.10(e)(2)(v)(C) "For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, the State *must* provide information about where and how to obtain the service" (emphasis added). As described above, the broad definitions included in the Proposed Rule may be used to immunize the denial of basic information about a patient's condition as well as their treatment options.

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

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

A. Title VII

The Proposed Rule is not only unauthorized and harmful to patients, it is also unnecessary to accommodate individual workers—federal law already amply protects individuals' religious freedom in the workplace. For more than four decades, Title VII has required employers to make reasonable accommodations for current and prospective employers' religious beliefs so long as doing so does not pose an "undue hardship" to the employer. 42 U.S.C. §§ 2000e(j), 2000e-(2)(a); *Trans World Airlines,*

Inc. v. Hardison, 432 U.S. 63, 84 (1977); EEOC Guidelines, 29 C.F.R. § 1605.2(e)(1).[2] Thus, Title VII—while protecting freedom of religion—establishes an essential balance. It recognizes that an employer cannot subject an employee to less favorable treatment because of that individual's religion and that generally an employer must accommodate an employee's religious practices. However, it does not require accommodation when the employee objects to performing core job functions, particularly when those objections harm patients, depart from the standard of care, or otherwise constitute an undue hardship. *Id.* This careful balance between the needs of employees, patients, and employers is critical to ensuring that religious beliefs are respected while at the same time health care employers are able to provide quality health care to their patients.

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

B. EMTALA

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

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

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

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

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

C. Section 1557

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

The Refusal Statutes must be read to coexist with the statutory nondiscrimination requirements of the ACA and similar state nondiscrimination laws – such as the Washington law against discrimination, Chapter 49.60 RCW. If a nondiscrimination requirement has any meaning in the health care context, it must mean that a patient cannot be refused care simply because of their race, color, national origin, sex, age, or disability. And as courts have recognized, the prohibition on sex discrimination under the federal civil rights statutes should be interpreted to prohibit discrimination against transgender people. *See Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1049-50 (7th Cir. 2017) (discrimination against transgender students violates Title IX, which is the basis for the ACA's prohibition on sex discrimination);); *see also EEOC v. R.G. & G.R. Funeral Homes, Inc.*, 2018 WL 1177669 at *5-12 (6th Cir. Mar. 7, 2018) (Title VII). Notwithstanding these protections, as well as explicit statutory protections from discrimination based on gender identity and sexual orientation in many states, including in Washington state (*see e.g.*, RCW 49.60.030 and RCW 49.60.040(26)), the Proposed Rule invites providers to discriminate against LGBT patients, particularly transgender people.

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

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

But no clarity, only more questions ensue, because the Proposed Rule does not explain how its requirements interact with state and local law (nor does it provide any statutory authority on which those requirements rest under federal law, as discussed above). The Rule's expansion of definitions, covered entities, and enforcement mechanisms appears to impermissibly invite institutions and individuals to violate state law, and to attempt somehow to inhibit states from enforcing their own laws that require institutions to provide care, coverage, or information (*see e.g.* RCW 48.43.065). The Proposed Rule also includes a troubling preemption provision, which specifies state and local laws that are "equally or more protective of religious freedom" should be saved from preemption, 83 FR 3931, and ignores the importance of maintaining the protection of other state laws, such as laws mandating non-discrimination in the provision of health care or requiring that state funding be available for certain procedures.

Washington State as a lawsuit to enforce our state's Reproductive Privacy Act, Chapter 9.02 RCW, a 1991 law enacted by voter initiative that guarantees fundamental rights for Washington state residents, is cited as part of the rationale for the Rule. *See* 83 FR 3889; *see also Coffey v. Pub. Hosp. Dist. No 1*, 15-2-00217-4 (Skagit Cnty. Super. Ct. June 20, 2016). Further, the Proposed Regulation and its treatment of state and local laws put at risk not only the Reproductive Privacy Act, but also our states' strong anti-discrimination protections including the Washington State Equal Rights Amendment, Wash. Const. Art. XXXI, the Washington Law Against Discrimination, Chapter 49.60 RCW, the Reproductive Parity Act, SSB 6219, 65th Leg. (Wa. 2018) (amending 48.43 RCW), and the Washington Death with Dignity Act, Chapter 70.245 RCW.

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

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

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

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

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

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

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

* * *

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

Sincerely,

Fajer Saeed Ebrahim
If/ When/How Reproductive Justice State Fellow

Exhibit 99

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 Proposed Rule, "Protecting Statutory Conscience Rights in HealthCare, Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03

To whom it may concern:

This comment is in response to the Proposed Rule, "Protecting Statutory Conscience Rights in HealthCare; Delegations of Authority" for the Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03.

This comment is provided on behalf of the LGBT Community Advisory Board of Washington, DC. The LGBT Community Advisory Board is comprised of members of the Washington, DC metropolitan community who wish to support research and education toward the advancement of lesbian, gay, bisexual, transgender, queer and intersex health in our region.

This comment commends certain clauses in the "ESTIMATED BENEFITS" provision of the Proposed Rule, however, not as they are currently intended to be interpreted. Specifically, we agree that "in **supporting a more diverse medical field, the proposed rule would create ancillary benefits for patients…a society free from discrimination**…" Securing a diverse health care professional workforce is critical to ensure that children and adults from all racial, ethnic, sexual and gender minority, socioeconomic, religious and geographic backgrounds see role models in their health care providers that reflect their cultures, preferences and values and to ensure that the highest quality health care is provided to all. Health care professionals currently do not reflect the racial, ethnic, sexual, gender, and religious diversity of Americans in need of health care services.

The Proposed Rule as it is written is troublesome in several ways. **Most concerning is a lack of balance between protections of health care professionals and the patients** they serve. A patient enters into a relationship with a health care professional for certain services that affect the life and health of the patient. Historically, rules of conscience protecting health care providers have been limited to performing direct and highly controversial procedures such as

abortion and sterilization. This proposed rule goes much farther in allowing health care providers to refuse appointment scheduling, ancillary services, symptom relief or other services to a woman who has recently had an abortion: this is detrimental to the health and life of the patient. The proposed rule suggests that any action, even if tangential to a health care service, could be refused on the basis of moral conviction. Refusing to provide a referral to any individual in need of health care services on the basis of religion is in direct violation of the Hippocratic Oath.

Lesbian, gay, bisexual, transgender, queer and intersex individuals already face discrimination in the health care system and denial of care. **This proposed rule exacerbates an already unequal system and widens health disparities to privilege those with the most power at the expense of those with the least.** The broad scope of the Proposed Rule could lead health care providers to discriminate against patients for any health service, simply because the health care professional claims to have a moral reason to do so. This could prevent protected classes of people, based on race, ethnicity, nationality, sexual orientation, gender identity, religion or other reasons from receiving lifesaving services and/or services critical to quality of life simply because the health care provider objects to providing care to that patient.

Specifically, we are concerned that the proposed rule could prevent health care services that patients have a right to and deserve, including:

- Access to birth control and family planning
- In vitro fertilization for lesbian and gay couples and/or transgender persons
- Treatment for individuals with HIV/AIDS
- Hormone replacement therapy and indicated gender-affirming surgical interventions for transgender individuals
- End of life care
- Basic health care for any sexual or gender minority to whom a health care provider states a moral objection to treating for any reason.

These risks are not hypothetical. In the 2017 federal case Conforti v. St. Joseph's Healthcare System, a transgender man was denied a medically indicated hysterectomy; a Catholic hospital refused his surgery on the basis of his gender. In another documented case, a pediatrician refused care of an infant based on the sexual orientation of the child's parents.[1] In another recent case, a patient with HIV was refused medication by a hospital.[2] Another hospital discharged a transgender teen admitted for suicidal ideation who ended up completing suicide.[2] Approximately, 29% of transgender people in a 2017 survey reported being refused basic health care simply because of their gender identity and a similar percentage were assaulted in medical settings.[2]

Furthermore, health insurance coverage for any sexual or gender minority, racial/ethnic minority, religious minority or any other person could be compromised or completely lost in order to cater to a stated religious or moral belief of a health

[1] Baldas, T. (2015). Pediatrician wouldn't care for baby with 2 moms. Detroit Free Press. Available at https://www.freep.com/story/news/local/michigan/macomb/2015/02/18/discrimination-birth/23640315/

insurance executive or employee, clearly creating discrimination toward those with fewer financial resources in order to protect those with greater financial resources. Health insurance providers have, in fact, already refused coverage for infertility treatment to lesbian women while covering the same services for straight women.[2]

Protecting health professionals from referring patients to services in order to protect the "conscience" of the provider will result in the loss of life and health for patients. Patients attend clinics, hospitals and Emergency Rooms with the expectation of receiving needed health care services based on their individual symptoms. Not providing these citizens with health care aligned with their health needs because of a claim to right of conscience laws is akin to a police officer not protecting an individual about to be shot, a teacher refusing to teach a child or a lawyer refusing to defend an innocent citizen due to bias developed, taught or learned over time.

Refusing health care services is not a benign action. In a 2017 survey, 41% of lesbian, gay, bisexual, transgender and queer people who reside in non-urban settings indicated that it would be "very difficult" or impossible" to find health care elsewhere if not provided by their local hospital.[3] Thus deciding not to provide a needed health care service may be the difference between care and no care, or even life and death for some patients.

Additionally, protecting parental religious beliefs is important. However, balance between parent beliefs and children's health is warranted. Vaccinations, provision of mental health services and **basic medical care should not be out of reach of children** due to parental beliefs.

Furthermore, the threat of withholding funding to organizations reliant on federal funds, such as grantees, due to potential conflicts of moral conscience impedes science, creates obstacles to limiting the spread of communicable diseases and stirs confusion among those working daily to advance the health of Americans.

Overall, the Proposed Rule invites conflicts between the rights of health care professionals and patients as well as between health care professionals and their employing organizations. Such broad-sweeping and vague language will create a litigious system where patients avoid and delay care due to perceived or actual discrimination and health care organizations err on the side of executives and employees over patient care.

The Proposed Rule clearly violates Title VII of the Civil Rights Act by inviting discrimination of individuals whom the Department of Health and Human Services has an obligation to protect. It should be substantially revised

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[2] Reuters. (2016). Lesbians sue New Jersey for discrimination over infertility law. NBC News. Available at https://www.nbcnews.com/feature/nbc-out/lesbians-sue-new-jersey-discrimination-over-infertility-law-n628216

[3] 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.

to narrow specifically what services a health care professional can legally refuse to a patient and in what context while ensuring alternative and expeditious health care services for those in need of health care and ancillary services--including those with gender dysphoria and any racial, ethnic, sexual, gender, religious or other minority in need of health care services for any reason.

Submitted by the following groups and individuals,

The LGBT Community Advisory Board, Washington, DC

Mandi Pratt-Chapman, citizen of Alexandria, VA

Rachelle Tepel, citizen of Arlington, VA

Joshua Riley, citizen of Cheverly, MD

Tony Burns, citizen of Washington, DC

Audra Campbell, citizen of the DC metropolitan area

Sean Randolph, citizen of the DC metropolitan area

Sherry Davis Molock, Ph.D., M.Div. Pastor, Beloved Community Church, Accokeek, MD

Robin Lewis, Outreach and Social Justice Ministry Director, Beloved Community Church, Accokeek, MD

Exhibit 100

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 LHI-Houston in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1] LHI-Houston serves thousands of Lesbian, Gay, Bisexual and Queer identifying women and anyone transgender and nonbinary, particularly people of color, all throughout the greater Houston area.

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.

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

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

[2] *See, 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.

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 Refusals: Undermining Quality of Care for Women," noted that "refusal clauses and institutional

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[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/

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]

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

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

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

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

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

[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.

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[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

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[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/.

states, women of color are more likely than white women to give birth in Catholic hospitals.[27] Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provide guidance on a wide range of hospital matters, including reproductive health care, and can keep providers from offering the standard of care.[28] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[29]

7. The Department is abdicating its responsibility to patients

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

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

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

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

Conclusion

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

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[27] *See* Kira Shepherd, et al., *supra* note 19, at 12.
[28] *See id.* at 10-13.
[29] *See, e.g., Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.
[30] *See* Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.
[31] *See, e.g., When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf.
[32] *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, NAT'L GAY AND LESBIAN TASK FORCE & NAT'L CTR. FOR TRANSGENDER EQUALITY, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.
[33] *See, e.g.*, Rule, *Supra* note 1, at 3888-89.

Exhibit 101

MASSACHUSETTS Health & Hospital ASSOCIATION

March 27, 2018

Roger Severino
Director, Office for Civil Rights
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 515F
Washington, DC 20201

Re: Docket No.: HHS- OCR - 2018—0002, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority; Proposed Rule issued January 26, 2018

Dear Mr. Severino:

The Massachusetts Health & Hospital Association (MHA), on behalf of its member hospitals, health systems, physician organizations, and allied healthcare providers appreciates this opportunity to offer comments related to the Department of Health and Human Services (HHS) Office for Civil Rights' (OCR) proposed rule regarding certain statutory conscience protections.

At the outset it is important to note that the Massachusetts provider community has consistently worked with our medical staff to ensure that personal views that are raised and discussed within various levels of care are respected as they relate to providing care and treatment of our patients and our communities that we serve. The adoption of the conscience protections for health care professionals within the federal affordable care act was similar to requirements that have been adopted within both Massachusetts statues as well as healthcare licensure requirements. In particular, healthcare providers have had the ability to raise religious concerns related to care and treatment, during which the facility or clinic will work with the provider to determine how to accommodate those concerns as well as ensure continued care and treatment for the patients.

However, the Massachusetts provider community also has a strong commitment to ensuring that all patients are able to access emergent, urgent, and medically necessary care. In Massachusetts, it is standard policy for all hospitals and health system to not discriminate in the delivery of emergent, urgent, and medical necessary care on the basis of the patient's race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability. As a result, we are concerned about possible conflicts that may result in the enforcement of the proposed regulations by OCR given conflicting state laws and regulations. To that end, we provide the following comments for consideration by OCR to reflect hospital and other healthcare provider's obligations under specific state requirements.

OCR Enforcement of Provider Conscience Rights:

While MHA and our members are considerate of a healthcare provider's ability to determine the medical necessity and treatment options for patients, hospitals and health system also recognize the individual clinician's religious rights (as their conscience rights) related to participating in various care and treatment.

MASSACHUSETTS Health & Hospital ASSOCIATION

In keeping with the principle that the conscience (or religious) protections should be treated akin to an individuals' civil rights, MHA urges OCR to ensure that the enforcement policies and practices applicable to the conscience protections are comparable to the long-standing policies and practices applicable when guaranteeing other civil rights protections for employees and staff. OCR should not invent new, distinct, or additional policies and practices that add unnecessary complexity and burden or prefer conscience protections over other civil rights.

Specifically, OCR should use existing civil rights frameworks as the model for the conscience protections at issue, such as evaluating facts and circumstances to determine whether a hospital has done all it reasonably can to accommodate religious conscience objections of individual medical staff. This not only would place the conscience protections on a level playing field with other civil rights, but would ensure that the conscience protections are guaranteed through an enforcement framework that already has proven effective in analogous civil rights contexts. We would urge not sanctioning a healthcare provider (the hospital or health care system) for failing to accommodate the moral or religious beliefs of an employee or medical staff where, despite being on notice of his or her right to do so, the individual did not give the hospital or health care system advance notice of his or her religious beliefs.

Again it is important to note that under existing federal and state laws/regulations, healthcare facilities already provide reasonable accommodation for employees who disclose their sincerely held religious beliefs. This type of framework has successfully protected employees, including those of hospitals and health systems, from religious discrimination. For this reason we would urge OCR to keep the framework for review based on the requirement of reasonably accommodating the sincerely held religious beliefs of employees and medical staff. The regulation should not be expanded to include moral objections without creating a framework for considering such concern that is not based on existing state laws or regulations.

Conflict with Existing Provider Licensure and Standards of Care:

We would also strongly urge OCR to consider the current requirements that healthcare providers have under existing Centers for Medicare and Medicaid Services (CMS) conditions of participation as well as other federal and state requirements. There are specific requirements related to the delivery of care and treatment for all patients by a provider who is receiving federal and state funding through Medicare, state Medicaid programs (like the Massachusetts MassHealth program), and the Social Security Act. More specifically, Massachusetts providers are required under state law and regulations to meet specific access requirements for low income patients under the Health Safety Net program. In addition state licensure requirements for a facility and individual professional licensure requirements also stipulate the care and treatment of a patient regardless of their race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability.

We strongly urge OCR to recognize the potential conflicting requirements under existing federal and state laws and regulations that would prevent the enforcement of a provider conscience regulation as outlined in the draft regulations. If strictly enforced as drafted, we are also concerned that many providers would be out of compliance with the requirements outlined above

MASSACHUSETTS Health & Hospital ASSOCIATION

impacting provider eligibility for reimbursement under the federal and state public programs. For these reasons we urge OCR to consider the government's interests in not only ensuring fundamental fairness but also avoiding inappropriate disruption of health services that are funded by federal and state resources.

Increase of Unnecessary Regulatory Burdens:
In the proposed rule, MHA would also request OCR to consider the increased regulatory burdens of both the certification of compliance as well as the proposed notice requirements.

Healthcare providers, such as hospitals and health systems, already have to sign cost reports and other documents with CMS that indicate that the facility is in compliance with all applicable federal rules and regulations. These include applicable civil rights laws, access to care standards, and operational requirements issued by a multitude of federal Health and Human Services (HHS) agencies. The provider community strongly feels that in addition to the four stated exceptions for providing compliance with the regulations, providers should also be able to utilize existing certification requirements that express the facilities adherence to federal regulatory requirements under HHS. Requiring a detailed analysis and certification for this specific rule may result in the slippery slope of requiring similar certifications for all other rules and requirements issued by HHS. This would add to the overall paperwork burden and unnecessary use of resources by providers that should be focused on patient care.

MHA is also opposed to the requirement of having a separate HHS notice requirement. Hospitals in particular are already required to provide a multitude of forms and notices to patients when they arrive for services (inpatient or outpatient) that create substantial confusion for patients and caregivers. We would strongly urge that COR instead allow providers to use those notices that are developed in various states that take into consideration the key messages of the provider conscience religious considerations, but tailored to each state specific standards. Adding in additional notice requirements that are contradictory to the state requirements is confusing to patients which lead to delays in care. In addition, duplicative notifications increase costs in signage, postage, and other materials. So we urge OCR to reconsider their approach and allow notices to be based on state specific requirements.

Thank you for considering our comments. Should you have any questions about the points raised in this letter, please do not hesitate to contact me at (781) 262-6034 or agoel@mhalink.org.

Sincerely,

Anuj K. Goel, Esq.
Vice President, Legal and Regulatory Affairs

Exhibit 102

MLRI MASSACHUSETTS LAW REFORM INSTITUTE

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March 27, 2018

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

Submitted electronically to https://www.regulations.gov/comment?D=HHS-OCR-2018-0002-0001

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

To Whom It May Concern:

I am writing on behalf of the Massachusetts Law Reform Institute (MLRI) in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. MLRI is a Massachusetts statewide nonprofit poverty law and policy center. Its mission is to advance economic, racial and social justice through legal action, policy advocacy, coalition building, and community outreach. MLRI also serves as the statewide poverty law support center for the Massachusetts civil legal services delivery system, providing expertise and support to local legal aid programs and also to social service, health care and human service providers, and other community organizations that serve low income people.

MLRI strongly opposes this proposed rule. It will make it more difficult for many patients including women, LGBTQ people, people of color, people living with HIV, people with substance use disorders, immigrants and low-income people to obtain access to medically necessary care. The regulations as proposed would introduce overly broad and poorly defined language to the existing law that already provides ample protection for the ability of health care providers to refuse to participate in a health care service to which they have moral or religious objections. Far from clarifying existing law, the proposed rule sows confusion and conflicts with existing laws such as the Emergency Medical Treatment and Labor Act, Title VII, legal principles of informed consent, and existing jurisprudence on the Establishment Clause.

The proposed rule will increase the likelihood of vulnerable patients facing discrimination and provide no protections for patients being denied care, even in emergencies. As drafted, the rule would not even require that patients be informed of all their potential treatment options and referred to alternative providers of needed care. 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

For these reasons, MLRI urges HHS to rethink this ill-considered proposed rule and withdraw it in its entirety.

Yours truly,

Victoria Pulos
Senior Health Law Attorney

Exhibit 103

MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

March 23, 2018

HENRY L. DORKIN, MD, FAAP
President

ALAIN A. CHAOUI, MD, FAAFP
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Executive Vice President

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

Re: **45 CFR Part 88; HHS–OCR–2018–0002; RIN 0945–ZA03**

Dear Secretary Azar:

I am submitting the following comments on behalf of the 25,000 physicians, residents and medical students of the Massachusetts Medical Society (MMS) in response to the notice of proposed rulemaking "Protecting Statutory Conscience Rights in Health care, Delegations of Authority." 45 CFR, Part 88, HHS-OCR-2018-0002; RIN 0945-ZA03. As the following comments detail, the MMS is strongly opposed to these proposed rules, which would undermine the basic tenets of a physician's oath to provide care to all patients.

The proposed rule would expand the ability of individuals and entities in health care settings to elect not to participate in activities that they deem contrary to their religious and/or moral beliefs. It would also make the Office of Civil Rights (OCR) responsible for the oversight and enforcement of complaints made on those grounds.

The MMS recognizes the importance and value of allowing physicians and other clinicians not to participate in interventions that they personally feel to be immoral; however, existing "conscience clauses" encoded in state law, federal statutes, institutional policies, and professional societies' policies—including the policies of the MMS—already provide such protections.[iii]

If passed, this proposed rule would therefore create a problem where none exists, and would exacerbate an existing one. In explaining the grounds for this proposed rule, the OCR has cited a recent increase in complaints from clinicians who claim to have been compelled to participate in interventions to which they were morally opposed. However, the number of such claims—36 complaints in a three-month period—is so modest as to suggest that existing mechanisms to protect physicians are operating as well as could reasonably be expected.[iii]

The proposed rule would expand the already sufficient provisions far beyond the scope needed to protect the religious freedom of clinicians, and in so doing, would further jeopardize vulnerable patients' access to health care. Discrimination towards patients is a significant issue under the current system: in 2017, the OCR received over 30,000 complaints on behalf of patients on the basis of discrimination and/or privacy violations.[iv] If the proposed rules are adopted, even more patients will face discrimination in healthcare.

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The MMS has long held anti-discriminatory policies affirming the rights of all patients to evidence-based health care. Specifically, our policy states that the MMS "strongly supports the rights of individuals to health, happiness, and liberty regardless of sexual orientation, gender identity, or nationality, and urges all governments to recognize these rights." Physicians have a fundamental duty to care for all patients.

If this rule were enacted as written, it would erode the essential right to care for already disadvantaged patient populations, including but not limited to patients on the LGBTQ spectrum—particularly transgender patients—and patients seeking abortion services. The rule could also have negative public health consequences on a population level. We are concerned that a misreading of this policy could lead to consequences such as clinicians being punished for refusing to treat patients who are not vaccinated due to religious beliefs; decreases in school immunization rates; undermining of public health efforts to protect children against vaccine preventable diseases; and interference with hospital programs which require healthcare workers to be immunized against influenza.

Furthermore, the proposed rule contravenes the intent upon which protections to religious freedom are based. The fundamental right underlying religious tolerance is the right to freedom from discrimination on the basis of religion. Encouraging discrimination against vulnerable patient populations by warping religious freedom protections for clinicians is an affront to the principles on which religious freedom is fundamentally based.

As physicians, we have an obligation to ensure patients are treated with dignity while accessing and receiving the best possible care to meet their clinical needs. We will not and cannot, in good conscience, compromise our responsibility to heal the sick based upon a patient's racial identification, national or ethnic origin, sexual orientation, gender identity, religious affiliation, disability, immigration status, or economic status. In view of this, the Massachusetts Medical Society opposes this current rulemaking. We look forward to working with you on other issues to help improve the health and welfare of our patients and physicians who serve them.

Sincerely,

Henry L. Dorkin, MD, FAAP

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[i] https://www.thehastingscenter.org/briefingbook/conscience-clauses-health-care-providers-and-parents/#

[ii] http://www.massmed.org/Governance-and-Leadership/Policies,-Procedures-and-Bylaws/MMS-Policy-Compendium-(pdf)/
See policies on "Medical Education/Performing Procedures" and "Abortion"

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

[iv] https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

Exhibit 104

MEDICARE RIGHTS CENTER
Getting Medicare right

March 27, 2018

VIA ELECTRONIC SUBMISSION

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

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

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." We are concerned that this rule would put people with Medicare at risk of lacking access to medically necessary treatment and information they need to make educated, person-centered choices. Medicare beneficiaries, their families, and caregivers need to know their medical needs and choices will be honored within the Medicare program and the health care system as a whole.

Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

The Department of Health and Human Services ("HHS" or "the Department") has introduced this NPRM in an effort to ensure that the religious and conscience rights of medical providers and practitioners are not infringed. While Medicare Rights respects the exercise of such conscience rights, we have serious concerns with the proposed rule, including how the rule fails to balance the potential conflict between providers' conscience rights and the rights of citizens to access needed heath care without discrimination or undue barriers, the potential implications for emergency care, and the need for informed choice and transparency.

Below, please find our comments on (1) **Balancing Rights**, (2) **Emergency Care**, and (3) **Informed Choice and Transparency**.

Balancing Rights

We are very concerned that the proposal fails to address two vital things: (1) How this rule will interact with existing federal and state laws that already protect sincerely held religious beliefs; and (2) How this rule will interact with the rights of patients. These omissions make uncertainty, confusion, and disorder surrounding the rights and obligations of patients, physicians, other health care providers, and health care institutions more likely, not less.

In the preamble, the Department states that the proposed rule is an attempt to "ensure that persons or entities are not subjected to certain practices or policies that violate conscience, coerce, or discriminate, in violation of such Federal laws."[1] While protecting those who provide health care from discriminatory policies that may force them to choose between their beliefs and their continued or future employment is an important goal, the right of a provider to conscientiously object is not absolute.

Rather, the rights of providers to conscientiously object must be balanced against the rights of patients to access the care and information they need, consistent with their own sincerely held conscience and religious beliefs. Here, the rule falls far short. It appears instead to prioritize the conscience rights of organizations and personnel at the expense of the needs and rights of patients to receive care and information that is appropriate, medically necessary, freely chosen, transparent, and person centered, and to which they are entitled under federal law.[2]

Patients are the reason health care exists. Ensuring that patients have the care they need, to the extent they want such care, must be the primary goal of any health care system. The proposed rule is silent on the needs of patients, including what disclosures must be made to them, how care can be ensured, or what remedies they will have if their rights are infringed. Given the rule's silence, it is hard to know if the proposal intends religious objections to take precedence over patient needs and rights.

Additionally, the proposal does not address the limitations necessarily placed on the implementation of this rule by Title VII of the Civil Rights Act of 1964, or the careful balance that Act creates between religious rights, beliefs, and practices, and the need for employers and institutions to serve people. This failure will cause confusion for providers as practitioners, and expose them to liability and uncertainty as employers.

Title VII already requires that employers accommodate employees' religious beliefs to the extent there is no undue hardship on the employer.[3] Yet, the proposed regulations make no reference to Title VII, current Equal Employment Opportunity Commission (EEOC) guidance, or the extensive, controlling case-law interpreting these provisions and carefully balancing the rights of employers and employees under which an employer many not discriminate against an employee based on that employee's race, color, religion, sex, and national origin, but an employee must be able to perform

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[1] *NPRM* at 3880, available at: https://www.gpo.gov/fdsys/pkg/FR-2018-01-26/pdf/2018-01226.pdf
[2] 42 U.S.C. § 1395w–22
[3] 42 U.S.C. § 2000e-2.; *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

the essential functions of the job.[4] The proposed rule must ensure that the long-standing balance set in Title VII between the right of individuals to enjoy reasonable accommodation of their religious beliefs and the right of employers to conduct their businesses without undue interference is maintained.

While the proposal does identify "avoidance of undue burden on the health care industry" as a policy objective, that is limited to the newly proposed section 88.4 regarding assurance and certifications of compliance.[5] Nowhere does it discuss, even in passing, the complex issues that will arise if employees or institutions cannot meet their obligations under existing employment, anti-discrimination, or provision-of-service law because of their conscientious objections.

As Title VII provides protection for individual beliefs while still ensuring employers can operate their businesses as they see fit, so too do other existing federal and state civil rights laws balance the religious and other rights of providers with the very real need to protect patients against discrimination—including the adverse consequences of health care refusals—based on a variety of characteristics, such as race, gender, sexual orientation, immigration status, disability, and HIV status.[6]

For example, the Medicare program places conditions of participation on providers and institutions, including requiring Medicare Advantage organizations to provide access to all of the benefits of the Medicare fee-for-service program[7] and holding hospitals to "Conditions of Participation" to ensure that patients' rights are respected and that they received medically appropriate care.[8] Troublingly, the proposed rule does not explore the interaction between its mandate and these kinds of existing protections.

Additionally, the proposed rule does not define "discrimination." This lack of clarity regarding what constitutes discrimination may undermine non-discrimination laws. Because of the potential harm to individuals if religious refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.[9] Instead, courts have held that the government has a compelling interest in ending discrimination and that anti-

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[4] *NPRM* at 3880.
[5] *NPRM* at 3897.
[6] See, e.g. Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,194 (Sept. 8, 2015) (codified at 45 C.F.R. pt. 2).
[7] 42 U.S.C. § 1395w–22
[8] 42 CFR 482.13 (b) (2) (The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. . . .
(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives)
[9] See e.g., *Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government's interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that "the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family"); *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race," and are narrowly tailored to meet that "critical goal."[10] The uncertainty regarding how the proposed rule will interact with non-discrimination laws is extremely concerning.

Illustrating how organizations or personnel will be able to abide by each of these laws and regulations as well as this proposal is an absolutely vital step in rulemaking—but this proposed rule fails to make these interactions clear. As a result, its expansive definitions and seemingly broad application leaves open the question of whether health care personnel or institutions could potentially refuse to provide some or all services to entire categories of patients.

Emergency Care

In addition to the need for more specificity regarding the general balance between individual conscience rights and patient needs, there is the issue of emergency care, which is expressly addressed in the Social Security Act.[11] Federal and state laws reflect the long-standing obligation of health care institutions to provide assessment and care in an emergency. The Emergency Medical Treatment and Labor Act (EMTALA), for example, requires hospitals to stabilize patients who come to the emergency room in medical emergencies.[12] Any final rule should clarify the interplay of conscience rights with physicians' and hospitals' legal obligations under EMTALA.

It is concerning, then, that the proposed rule does not just avoid discussion of these legal obligations; it appears to suggest there should be no obligation to provide care in an emergency situation. In the preamble, the Department gives several reasons for this proposed rule, the first being that "allegations and evidence of discrimination and coercion have existed since 2008 and increased over time."[13]

To support this claim, the Department states that the previous rule was promulgated to address "an environment of discrimination toward, and attempted coercion of, those who object to certain health care procedures based on religious or moral convictions" and that rescinding the guidance has allowed this discriminatory environment to prosper.[14] As evidence of this growing trend, the Department cites regulatory comments, lawsuits, news reports, and polling data.

In this discussion, the Department also points to the American Congress of Obstetricians and Gynecologists (ACOG) 2016 reaffirmation of an ethics document as confirmation of the aforementioned "environment of discrimination" toward health care providers.[15] The referenced

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[10] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, slip op. at 46 (2014).
[11] Centers for Medicare & Medicaid Services, *Emergency Medical Treatment & Labor Act,* available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/
[12] 42 U.S. Code § 1395dd
[13] *NPRM* at 3887.
[14] *Ibid.*
[15] *Ibid.*

ACOG guidance—"The Limits of Conscientious Refusal in Reproductive Medicine"[16]—was originally issued in 2007 and, according to the Department "at least, in part, prompted the 2008 rule."[17]

While reproductive medicine is fertile ground for those seeking conscience exceptions and therefore may have a reasonable place in this policy making discussion, the Department does not to cite a reproductive health-related section of ACOG's ethics document as an example of provider coercion. Rather, HHS focuses on the following provision, in which ACOG addresses a provider's obligation to treat a patient in an emergency situation:

"[i]n an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."[18]

By citing this ACOG recommendation as a reason for the proposed rule, the Department is suggesting that it disagrees with this specific provision, and that providing medically indicated and requested care in an emergency runs counter to the purpose of the rule. We are extremely concerned about the impact such an approach to care provision would have on patients in emergent situations. For example, could the proposed rule allow institutional health care providers, such as hospital emergency rooms, to refuse to provide emergency care? If so, this puts patients who need emergency medical care at grave risk and would run afoul of EMTALA's requirements to, at a minimum, stabilize patients who come to the emergency room in medical emergencies.[19]

The lack of clarity in the proposed rule will cause confusion and put the health and lives of patients at risk. A provider's right to refuse access to health care must not come at the expense of a patient's right to needed care.

Informed Choice and Transparency

We are also concerned that the under the rule, covered entities would be free not only to refuse to perform any given health care service, but also to deny patients access to information about or referrals for such services, by defining "referral" in a staggeringly broad way.[20] Specifically, under the proposed rule, an objecting provider could refuse to provide a patient with any information distributed by any method, regarding any service, procedure, or activity when the provider "sincerely understands the particular health care service, activity, or procedure [to which he or she objects] to be a purpose or possible outcome of the referral."[21] This would seemingly allow providers to refuse to give patients any information that they could then use to access care. In addition, the Department states that the underlying statute of the proposed rule permits entities to deny help to anyone who is likely to make a referral for an abortion or "for other kinds of

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[16] ACOG Committee Opinion, *The Limits of Conscientious Refusal in Reproductive Medicine*, available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine
[17] *NPRM* at 3388, Footnote 37.
[18] *NPRM* at 3388.
[19] 42 U.S. Code § 1395dd
[20] *NPRM* at 3894.
[21] *NPRM* at 3895.

services."[22] The breadth and vagueness of this definition could lead providers to refrain from providing information vital to patients out of anxiety and confusion of what the proposed rule permits, or requires, them to do.

The proposed regulation would allow a provider to refuse to counsel patients for services or provide medical information and options for any medical treatment without a mechanism to ensure patients get the information they need to make informed health care decisions. Cutting patients off from critical information without a disclosure that the information, services, or referral may be incomplete may not be the intent of the rule, but there is no requirement in the text that objectors be transparent about their refusals.

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

The NPRM establishes that transparency and openness are valuable, and we agree that "poor communication negatively affects continuity of care and undermines the patient's health goals."[23] In addition to such practical concerns, ethical and legal standards also require that professionals ensure patients have the information they need to provide informed consent to care. However, the rule does not appear to require any disclosure on the part of objecting providers or institutions. Indeed, one case highlighted in the NPRM revolved around a hospital's lack of transparency about provider unwillingness to assist a patient through California's Aid-in-Dying rule.[24] As it stands, the proposed regulation threatens to fundamentally undermine the relationship between providers and patients, who will have no way of knowing which services, information, or referrals they may have been denied.

By contrast, Medicare rules require that Medicare Advantage organizations that object to paying for particular referrals or counseling must notify both the Centers for Medicare & Medicaid Services and any current or prospective enrollees of their refusal, with advance notice for current enrollees.[25] Such notice allows patients and their families to determine for themselves if the provider or institution offer sufficient services to meet the patient's wants and needs. Any finalized rule should use such notice requirements as a model and must be explicit in requiring that such notice be given, in writing, and in advance whenever possible, to ensure patients and families have the information they need to make informed, person-centered choices.

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[22] *Ibid.*
[23] *NPRM* at 3917.
[24] *NPRM* at 3889.
[25] The Centers for Medicare & Medicaid Services, *Managed Care Manual,* Chapter 6, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c06.pdf.

Conclusion

The center of all health care decision making must be the person receiving care. The patient, in the medical context, is supposed to be the focus, in close partnership with their families if they choose and always with practitioners in order to "ensure that decisions respect patients' wants, needs and preferences and solicit patients' input on the education and support they need to make decisions and participate in their own care."[26]

No system that ignores or overrides the person's wants, needs, or preferences, or that fails to provide necessary information, can ever be person centered. While person centeredness is an aspirational goal for the health care system, it must be at the forefront in our thinking, not shunted aside when there are other considerations on the table.

The proposed rule does not appear to take the person at the heart of health care—the patient—into account at all when discussing the rights of providers and other entities. No regulatory action in health care can succeed unless it accounts for the fundamental purpose of health care—patient well-being.

Coupled with this rule's silence about its interaction with various statutes, this omission would create chaos and confusion if this rule were finalized as-is. We urge that HHS abandon this approach and instead explore ways to bring this rule into harmony with existing law, to find a balance in the rights of patients and practitioners, to protect the health, well-being, and access to care of all patients, and to promote person-centered practices that must be at the heart of our health care system.

Thank you for the opportunity to provide comment.

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[26] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.