Nos. 19-4254(L), 20-31, 20-32, 20-41

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

STATE OF NEW YORK; CITY OF NEW YORK; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF OREGON; COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; COMMONWEALTH OF VIRGINIA; STATE OF WISCONSIN; CITY OF CHICAGO; AND COOK COUNTY, ILLINOIS,
Plaintiffs-Appellees,

(Caption continued on inside cover)

On Appeal from the United States District Court
for the Southern District of New York

JOINT APPENDIX VOLUME VIII OF X

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PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.; NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; AND PUBLIC HEALTH SOLUTIONS, INC.

Consolidated-Plaintiffs-Appellees,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR, II, in his official capacity as Secretary of the United States Department of Health and Human Service; AND UNITED STATES OF AMERICA,

Defendants-Appellants,

DR. REGINA FROST AND CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS,

Intervenors-Defendants-Appellants,

ROGER T. SEVERINO, in his official capacity as Director, Office for Civil Rights, United States Department of Health and Human Services; AND OFFICE FOR CIVIL RIGHTS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Consolidated-Defendants-Appellants.

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Exhibit 110

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

March 27, 2018

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

Submitted Electronically

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

Dear Secretary Azar,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The Proposed Rule Expands Existing Harmful Religious Exemption Laws

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

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[9] *Rule, supra* note 1, at 3885. *See also* Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law 73 Fed. Reg. 78,071(Dec. 19, 2009) (2008 Rule) (rescinded in large part by 76 Fed. Reg. 9,968 (Feb. 23, 2011)(codified at 45 C.F.R. pt. 88)).

[10] Comment Letters on Proposed Rule Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law 73 Fed. Reg. 50,274 (Aug. 26, 2008) (on file with National Women's Law Center).

[11] American Medical Assoc. et al. Comment Letter on Proposed Rule 73. Fed. Reg. 50,274 (Aug. 26, 2008)(on file with National Women's Law Center).

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

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

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

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

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

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

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

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

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[17] *Id.*
[18] *See* Weldon Amendment, *supra* note 6.
[19] *See* Letter from Jocelyn Samuels, Director of Office for Civil Rights, to Catherine W. Short, Esq. et al. (June 21, 2016), *available at* http://www.adfmedia.org/files/CDMHCInvestigationClosureLetter.pdf.
[20] Weldon Amendment, *supra* note 6; Coats Amendment, *supra* note 6.
[21] The doctrine of *expressio unius est exclusion alterius* (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[22] 141CONG. REC. S17293 (June 27, 1995) (statement of Rep. Coats).
[23] 150 CONG. REC. H10090 (Nov. 20, 2004) (statement of Rep. Weldon).
[24] National Research Services Act of 1974, Pub. L. No, 93-348, 88 Stat. 348 § 214.

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

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

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

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

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

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[25] *See, e.g.*, Todd W. Rice, *The Historical, Ethical, and Legal Background of Human-Subjects Research*, 53 RESPIRATORY CARE 2325 (2008), http://rc.rcjournal.com/content/respcare/53/10/1325.full.pdf.

[26] *Rule, supra* note 1, at 3926.

[27] *See* 42 U.S.C. § 1395w-22 (2010).

[28] *See* Food and Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 125-26 (2000).

[29] *See Rule, supra* note 1, at 3927.

[30] *See* Center for Substance Abuse Treatment, 42 U.S.C. § 290bb (2016); Youth Suicide Early Intervention and Prevention Strategies, 42 U.S.C. § 290bb-36 (2004).

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

III. The Proposed Rule Conflicts with Federal Laws.

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

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

The Department has exceeded its authority by appropriating language from civil rights statutes and regulations that were intended to improve access to health care and applying that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only unlawful, but is nonsensical and affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce. They will place a significant and burdensome requirement on health care providers, taking resources away from patient care without adding any benefit.

Moreover, the Proposed Rule defines "discrimination" for the first time[32] and does so in a way that subverts the language of landmark civil rights statutes to shield those who would discriminate rather than to protect against discrimination. In this context, this broad definition is inappropriate. Further such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements thereby fostering confusion.

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

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

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

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

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

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

c. The Proposed Rule Conflicts with Title VII

The Proposed Rule makes no mention of Title VII, the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[37] With respect to religion, Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested unless the accommodation would impose an "undue hardship" on an employer.[38] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal

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

[35] 42 U.S.C. § 18116 (2010).

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

[37] *See* 42 U.S.C. § 2000e-2 (1964); Title VII of the Civil Rights Act of 1964, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

[38] *Id.*

obligations.[39] The Proposed Rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both the Proposed Rule and Title VII. Indeed, when similar regulations were proposed in 2008, EEOC commissioners and the Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[40]

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

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

The Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists and to stabilize the condition or, if medically warranted, to transfer the person to another facility.[41]

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

e. The Proposed Rule Violates the Establishment Clause

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[39] *Id.*

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

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

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

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

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

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

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

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

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[43] Dan Diamond, *The Religious Activists on the Rise Inside Trump's Health Department*, POLITICO (Jan. 22, 2018), https://www.politico.com/story/2018/01/22/trump-religious-activists-hhs-351735.

[44] *See, e.g.*, Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding, 82 Fed. Reg. 49,300 (proposed Oct. 25, 2017); Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47, 792 (proposed Oct. 13, 2017).

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

[46] *See HHS Action Plan to Reduce Racial and Ethnic Health Disparities,* DEP'T OF HEALTH AND HUMAN SERVS., at 7, https://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

[47] Prior to the Affordable Care Act (ACA), women were charged more for health care on the basis of sex and were continually denied health insurance coverage for services that only ciswomen, transgender, and gender non-conforming patients need. *See Turning to Fairness*, NAT'L WOMEN'S L. CTR. 1, 3-4 (2012), https://nwlc.org/wp-content/uploads/2015/08/nwlc_2012_turningtofairness_report.pdf (noting that while the ACA changed the health care landscape for women in significant ways, women still face additional hurdles).

[48] *See* Shartzer, et al., *Health Reform Monitoring Survey*, URBAN INST. HEALTH POLICY CTR. (Jan. 2015), http://hrms.urban.org/briefs/Health-Care-Costs-Are-a-Barrier-to-Care-for-Many-Women.html.

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

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

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

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

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

[51] *See, e.g.,* Judith H. Lichtman et al., Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction, 10 J. OF THE AM. HEART ASS'N 1 (2015).

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

[53] *Id.*

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

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

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

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

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

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

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

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

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

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

[59] *See id.* at 29.

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

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

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

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

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

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

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

a. The Proposed Rule Undermines the Provider-Patient Relationship

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

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

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

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

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

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

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

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

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

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

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

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

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

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[67] *Rule, supra* note 1, at 3916.
[68] Lisa Harris et al., *Obstetrician-Gynecologists' Objections to and Willingness to Help Patients Obtain an Abortion*, 118 OBSTETRICS & GYNECOLOGY 905 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4185126/.
[69] *Discrimination Against Health Care Professionals Who Provide or Support Abortion* NAT'L WOMEN'S LAW CENTER (August 2017), https://nwlc.org/resources/discrimination-against-health-care-professionals-who-provide-or-support-abortion/.
[70] Stulberg et al., *Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient Care Policies*, 73 AM. J. OF OBSTETRICS AND GYNECOLOGY e1 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3383370/
[71] *Rule, supra* note 1, at 3931; *see also Refusing to Provide Health Services*, GUTTMACHER INSTITUTE (Feb. 2018), https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services.

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

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

Conclusion

The Proposed Rule is illegal and harmful. It attempts to allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The Proposed Rule is discriminatory, violates multiple federal statutes and the Constitution, ignores Congressional intent, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons, the Center unequivocally calls on the Department to withdraw the Proposed Rule.

Sincerely,

Fatima Goss Graves

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

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

Exhibit 111

California Medical Association
Physicians dedicated to the health of Californians
1201 J Street, Suite 200, Sacramento, CA 95814-2906 • 916.444.5532 • Fax 916.444.5689

March 27, 2018

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

Submitted electronically via http://www.regulations.gov

RE: Comments of the California Medical Association: Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03

Dear Secretary Azar:

On behalf of more than 43,000 physician members and medical students of the California Medical Association (CMA), we appreciate the opportunity to provide comments on the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule") on Protecting Statutory Conscience Rights in Health Care.[1] Through a comprehensive program of legislative, legal, regulatory, economic and social advocacy, CMA promotes the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession.

CMA supports the comments of the American Medical Association on the Conscience Protections Proposed Rule and offer further comments that address issues that are of particular concern to California physicians. While CMA is a strong advocate for the conscience rights of physicians, we do not believe this Proposed Rule accomplishes its purported aims. We are concerned that the implementation of this Proposed Rule may lead to discrimination that is prohibited under both federal and California law, adversely impact patient access to comprehensive care, and inappropriately insert politics into the patient-physician relationship. Moreover, current federal and California law provide extensive protections for the conscience rights of health care providers, and the supplemental administrative burdens imposed by this rule do not add any meaningful benefit.

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 would inappropriately use OCR's limited resources to encourage discrimination in health care and undermine the ability of states to enforce their own conscience and anti-discrimination

[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* Proposed Rule].

provisions. For these reasons, CMA urges the Department to withdraw the Proposed Rule in its entirety.

1. **The Proposed Rule Expands the Scope of Existing Conscience Protections to Negatively Affect Access to Care.**

CMA is concerned with the overly broad application of existing conscience protection laws and the expansion of the definitions in the Proposed Rule. The language of the Proposed Rule would 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 dictate a patient's access to care. 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 "any program or activity with an articulable connection to a procedure, health care service, health program, or research activity."[2] In fact, merely "making arrangements for the procedure," no matter how tangential, would be included in the reach of the Proposed Rule.[3] This means individuals not "assisting in the performance" of a procedure within the ordinary meaning of the term, such as the office scheduler, the technician charged with cleaning surgical instruments, and other medical office and hospital employees, can now assert a new right to refuse care based on their religious and moral convictions. Such an interpretation is potentially disruptive to the normal operations of a medical office or other health care facility and impede the provision of necessary care to patients.

Similarly, the Proposed Rule's definition of "referral" goes beyond any understanding of the term, allowing refusals to provide any information, "by any method, pertaining to a health care service, activity, or procedures[.]" This include information "related to availability, location, training, information resources, private or public funding or financing, or directions" that could help an individual to get the health care service they need.[4] Such an expansive definition could prevent patients from getting information about the availability of comprehensive health care options in their state. CMA believes that these overly broad definitions will result in denial of care and miscommunication to patients without meaningfully advancing physicians' rights of conscience.

Furthermore, the Proposed Rule's new and expanded definitions often exceed, or are not in accordance with, existing definitions contained within the existing laws OCR seeks to enforce. For example, "health care entity" is defined under the Coats and Weldon Amendments to include a limited and specific range of individuals and entities involved in the delivery of health care.

[2] Proposed Rule, 83 Fed. Reg. at 3923.
[3] *Id.*
[4] *Id.* at 3924.

However, 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 by including a wide range of individuals, e.g., not just health care professionals, but any personnel, and institutions, including not only health care facilities and insurance plans, but also plan sponsors and state and local governments. This impermissibly expands statutory definitions and will create confusion, impeding patients' access to needed health care services and information.

2. CMA Opposes Discrimination in the Provision of Health Care and Supports Patient Access to Comprehensive Health Care.

CMA is concerned that the Proposed Rule undermines anti-discrimination protections, particularly with regard to reproductive health, sexual orientation, and gender identity. Since 2012, the Office for Civil Rights has interpreted Section 1557 of the Affordable Care Act's[5] sex discrimination prohibition to extend to claims of discrimination based on gender identity or sex stereotypes and accepted such complaints for investigation. Section 1557's protections assist populations that have been most vulnerable to discrimination, including lesbian, gay, bisexual, and transgender individuals, and help provide those populations equal access to health care and health coverage. Such individuals experience discrimination in obtaining health care which lead to lack of preventative care or delayed care.[6] Section 1557 seeks to address factors that impact access to care for certain populations but does not force physicians to violate their medical judgment. Rather, covered entities, including insurers, must "apply the same neutral, nondiscriminatory criteria [used] for other conditions when the coverage determination is related to gender transition."[7]

California law explicitly prohibits discrimination based on sex, sexual orientation, or gender identity,[8] among other factors. California law provides that persons holding licenses under the provisions of the Business & Professions Code, such as physicians, are subject to disciplinary action for refusing, in whole or in part, or aiding or inciting another licensee to refuse to perform the licensed services to an "applicant" (patient) because of any characteristics under the Unruh Civil Rights Act, that is, the applicant's race, color, sex, religion, ancestry, disability, marital

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[5] 45 C.F.R. §§92.2, 92.206, 92.207.
[6] LAMBDA LEGAL, WHEN HEALTH CARE ISN'T CARING: LAMBDA LEGAL'S SURVEY ON DISCRIMINATION AGAINST LGBT PEOPLE AND PEOPLE LIVING WITH HIV (2010). *Forum: How Discrimination Damages Health Care in LGBTQ Communities*, NPR (March, 21, 2018), https://www.npr.org/sections/health-shots/2018/03/21/594030154/forum-how-discrimination-damages-health-in-lgbtq-communities
[7] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31435 (proposed May 18, 2016) (to be codified at 45 C.F.R. pt. 92).
[8] *See generally*, CAL. CIV. CODE §51 (The Unruh Civil Rights Act) ("All persons within the jurisdiction of this state are free and equal, and no matter what their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever."_

status, national origin, medical condition, sexual orientation, or genetic information.[9] The California Supreme Court has held that physicians' religious freedom and free speech rights do not exempt physicians from complying with the Unruh Act's prohibition against discrimination based on a person's sexual orientation.[10]

California law also prohibits discrimination by any person under any program that receives any financial assistance from the state.[11] Additionally, the California Insurance Gender Nondiscrimination Act (IGNA) prohibits a health plan and insurer from "refusing to enter into, cancel or decline to renew or reinstate a contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age."[12] Sex includes both gender identity and gender expression.[13] The Proposed Rule lays the groundwork to preempt California laws that have been put into place to ensure that patients in the state have access to comprehensive health care. In addition, the Proposed Rule may also conflict with policies of agencies that accredit health care institutions. For example, the Joint Commission, which accredits and certifies nearly 21,000 facilities in the U.S., has required since 2011 that the nondiscrimination policy of every accredited facility protect transgender patients.[14] The Proposed Rule would conflict with existing state laws and accreditation requirements, creating legal confusion for California physicians.

3. CMA Supports Conscience Protections that Promote the Rights of Providers without Negatively Impacting Patient Care.

CMA policy has always sought to balance the rights of patients to access needed health care with the rights of physicians to exercise their conscience. Conscientious refusals occur most commonly in the field of reproductive medicine, and in many areas of the country patients face challenges in accessing reproductive healthcare.[15] Though CMA advocates for access to abortion

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[9] CAL. BUS. & PROF. CODE §125.6

[10] *North Coast Women's Care Medical Group, Inc. v. San Diego County Superior Court* (Benitez) 189 P.3d 959 (Cal. 2008).

[11] CAL. GOV. CODE §11135.

[12] CAL. HEALTH & SAFETY CODE §1365.5; CAL. INS. CODE §10140. *See also,* Dep't. of Managed Health Care, Gender Nondiscrimination Requirements, Letter No. 12-K (April 9, 2013), *available at* http://www.dmhc.ca.gov/Portals/0/LawsAndRegulations/DirectorsLettersAndOpinions/dl12k.pdf; CAL. CODE REGS. tit 10, § 2561.2.

[13] CAL. HEALTH & SAFETY CODE §1365.59(e).

[14] Joint Commission Standards RI.01.01.01, EP29.

[15] *See, e.g.* (2017), NAT'L WOMEN'S LAW CTR., REFUSALS TO PROVIDE HEALTH CARE THREATEN THE HEALTH AND LIVES OF PATIENTS NATIONWIDE (2017), *available at* https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/08/Refusal-to-Provide-Care.pdf; CATHERINE WEISS ET AL., AM. CIVIL LIBERTIES UNION, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS (2002), *available at* https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report; JULIA KAYE ET AL., AM. CIVIL LIBERTIES UNION HEALTH CARE DENIED (2016), *available at* https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; KIRA SHEPHERD ET AL., PUB. RIGHTS PRIVATE CONSCIENCE PROJECT, BEARING FAITH THE LIMITS OF CATHOLIC HEALTH CARE FOR WOMEN OF COLOR, 1 (2018), *available at* https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

under accepted ethical medical standards, CMA policy provides that no physician should be required to act against their moral principles. Similarly, while CMA supports the training of all OB/GYN residents and appropriate other residents in primary care specialties in the basic skills of performing abortions, CMA also supports the concept of choice for residents in training, allowing each resident to choose whether or not to participate in elective abortions. CMA has prioritized the physician-patient relationship, and seeks to ensure that health care systems do not interfere with physician-patient communications on reproductive health care, and that access to reproductive health care services is preserved. These principles properly preserve the conscience rights of physicians and their role in providing patient care.

American Medical Association (AMA) policy also recognizes that "at times the expectation that physicians will put patients [sic] needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life."[16] However, it recognizes that this freedom is not unlimited: "[p]hysicians are expected to provide care in emergencies, honor patients informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient."[17] Physicians must consider the harm to patients from refusing to provide treatment and whether the patient will be able to access needed treatment from another physician. The AMA also recognizes that physicians must clearly communicate to the patient which services a physician will or will not provide before entering into a physician-patient relationship, as well as inform patients about all relevant options for treatment, even those to which the physician has conscientious objections.[18]

The Committee on Ethics of American College of Obstetricians and Gynecologists (AGOG) has adopted a number of recommendations that "maximize respect for health care professionals' conscience without compromising the health and well-being of the women they serve."[19] Similar to the AMA opinion, the ACOG opinion recommends that physicians give patients accurate and unbiased information, as well as clearly communicate any moral objections they may have. The ACOG opinion further recognizes that physicians have a duty to refer their patients to other providers for services they cannot provide due to reasons of conscience, and to provide such services in an emergency situation where a referral is impossible. ACOG concludes: "Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based and safe access to all women seeking

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[16] American Medical Association, Policy E-1.1.7, "Physician Exercise of Conscience." *Code of Medical Ethics.* Adopted 2016.
[17] *Id.*
[18] *Id.*
[19] American College of Obstetricians and Gynecologists (ACOG*), The Limits of Conscientious Refusal in Reproductive Medicine*, ACOG Committee on Ethics Opinion Number 385, 5. Adopted November 2007. Reaffirmed 2016).

reproductive services."[20] The Proposed Rule falls short of this aim and the principles of CMA and AMA policies by expansively interpreting existing protections without properly balancing the needs of patients and physicians.

4. Current Federal and State Law Protect the Rights of Physicians and Patients

Existing federal and state laws protect the rights of physicians by allowing states to take nuanced positions on the protecting the conscience rights of health care workers, particularly with regard to abortion, sterilization, and aid-in-dying. Section 88.3 of the rule incorporates the extensive existing law protecting the conscience rights of health care providers and institutions, including, among others, the Church Amendments,[21] the Coats-Snowe Amendment[22] and the Weldon Amendment.[23] In addition, the Affordable Care Act includes health care provider conscience protections within the health insurance exchange system. The law provides that "no qualified health plan offered through an exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions."[24] Regulations implementing the Act further provide that existing laws protecting religious freedom and belief, including provider conscience laws, the Religious Freedom Restoration Act, the ACA's provisions regarding abortion services, and the ACA's preventive health services regulations, continue to apply.[25]

The Proposed Rule's provisions are not only redundant but will have a chilling effect on the enforcement of and passage of state laws that protect access to health care. The preamble of the Proposed Rule discusses at length state laws that the Department finds objectionable, including California's Department of Managed Health Care's requirement that health insurers must cover abortion services.[26] As mentioned in the Proposed Rule, California law requires most health

[20] *Id.*
[21] The Church Amendments, 42 U.S.C. § 300a-7 (2018).
[22] Public Health Service Act, 42 U.S.C. § 238n (2018).
[23] The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009).
[24] 42 U.S.C. §18023 (2018).
[25] 45 C.F.R. §92.2(b)(2).
[26] *See* Proposed Rule, *supra* note 1, at 3888-89. The health insurers filed a complaint, and OCR found there was no violation of the Weldon Amendment. Letter from OCR Director to Complainants (June 21, 2016), *available at* http://www.adfmedia.org/files/ CDMHCInvestigationClosureLetter.pdf.

plans to cover abortion services,[27] as well as all FDA-approved methods of contraception without cost-sharing.[28]

California law already properly balances the rights of physicians and their patients. California has extensive protections for health care providers that do not want to participate in abortion for moral, ethical, or religious reasons, while protecting women who need emergency care.[29] While religiously affiliated hospitals can also exercise their rights under this provision, they must post a notice of their refusal policy so that patients are properly informed about the care they will receive.[30] California law protects the rights of physicians to "decline to comply with an individual health care instruction of health care decision for reasons of conscience"[31] Additionally, California law allows a religious employer to request an exemption from generally applicable requirements for contraceptive coverage in health plans.[32] Increasing the number of federal rules in this area is both unnecessary and will create confusion for providers and their patients.

CMA has sought to ensure that physicians' rights are protected even in an evolving health care landscape. For example, the End of Life Option Act, passed in 2015, permits individuals suffering from a terminal disease to request life-ending medication under certain circumstances.[33] This bill contains extensive provisions ensuring that health care providers with conscientious objections are not subject to any professional sanctions or legal liability for refusing to participate in actions related to the Act's activities.[34] Adding a confusing and unnecessary layer of federal regulations may prevent states from successfully passing and implementing their own conscience protections. The Proposed Rule would impede the ability of states to craft nuanced solutions, such as those found in the End of Life Option Act, that protect the rights of providers in accordance with states' own values.

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[27] See, e.g., Letter from Michelle Rouillard, Director, Dep't of Managed Health Care, to Mark Morgan, Cal. President, Anthem Blue Cross (Aug. 22, 2014), *available at* https://www.dmhc.ca.gov/portals/0/082214letters/abc082214.pdf. *See also* Cal. Dep't of Health Care Servs., Letter to all Medi-Cal Managed Care Health Plans, All Plan Letter No. 15-020: Abortion Services (Sept. 30, 2015), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15- 020.pdf; Cal. Dep't of Health Care Srvs., Medi-Cal Medical Services Provider Manual Ch. Abortions at p. 1.
[28] CAL. WELF. AND INST. CODE §14132; CAL. INS. CODE §10123.196; CAL HEALTH AND SAFETY CODE § 1367.25.
[29] CAL. HEALTH & SAFETY CODE §123420.
[30] *Id.*
[31] CAL. PROBATE CODE §4734.
[32] CAL. HEALTH & SAFETY CODE §1367.25
[33] Cal. S.B. 128, Stats. 2016, ch. 1.
[34] CAL. HEALTH AND SAFETY CODE §§ 443.14-443.15.

5. CMA Opposes Unnecessary Administrative Burdens on Physicians

Finally, sections 88.4 through 88.6 of the Proposed Rule impose significant new requirements on physicians, who already face an increasing number of administrative burdens due to federal law and various existing federal program requirements. Under the Proposed Rule, physicians must submit certifications and assurance, post lengthy required notices on their website and in conspicuous physical locations, maintain detailed records, and generally ensure compliance with the new rule.[35] The Department conducts an analysis of the estimated burdens for the Proposed Rule[36] in which it looks at the implementation costs for providers. The estimate includes time for providers to familiarize themselves with the Rule and the cost to hire an attorney to review it; at least four hours of staff time to review the assurance and certification language and underlying laws; four hours of staff time to review policies and procedures and the cost of hiring an attorney to assist in the review; and the costs of printing the notice in any paper documents. These costs are burdensome enough in themselves; this analysis fails to fully consider, moreover, the significant time and resources it takes to continuously implement and enforce such a Proposed Rule, and the numerous other administrative and regulatory burdens physicians already face and the degree to which each additional burden detracts from a physician's clinical practice.[37] Excessive administrative tasks imposed on physicians divert time and focus from providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care. CMA opposes adding additional burdens to physicians that do nothing to improve the quality of patient care and create yet more regulatory hurdles for the practice of medicine.

As discussed above and in the Proposed Rule, federal and state laws already protect health care provider conscience rights.[38] These long-standing provisions of federal law provide sufficient protection to physicians seeking to exercise their conscience rights. Instead of guaranteeing additional protection, this Proposed Rule would negatively impact patient access to care, sanction discrimination in health care settings, and impose increased administrative burdens on physicians, including paperwork requirements and significant staff time with no demonstrable benefit to the provision of health care.

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[35] Proposed Rule, *supra* note 1, at 3928-30.
[36] *Id.* at 3912-15.
[37] *See, e.g* Jessica Davis, *JAMA: EHRs fail to reduce administrative billing costs,* HEALTHCARE IT NEWS (Feb. 21, 2018), http://www.healthcareitnews.com/news/jama-ehrs-fail-reduce-administrative-billing-costs; Alexi A. Wright and Ingrid T. Katz. *Beyond Burnout – Redesigning Care to Restore Meaning and Sanity for Physicians*, 378 NEW ENG. J. OF MEDICINE 308 (Jan. 2018), http://www.nejm.org/doi/full/10.1056/NEJMp1716845
[38] The Church Amendments, 42 U.S.C. §§300a-7 *et seq.* (2018); Public Health Service Act, 42 U.S.C. §236(n)); and the Weldon Amendment (Consolidated Appropriations Act, 2012, Pub.L. No. 112-74, 125 Stat. 786).

Conclusion

Thank you for your consideration. If you have questions, please contact me at jrubenstein@cmanet.org or (916) 551-2554.

Sincerely,

Jessica Rubenstein
Associate Director
Center for Health Policy
California Medical Association

Exhibit 112

GLMA
Health Professionals
Advancing LGBT Equality

March 27, 2018

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

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

To Whom it May Concern:

On behalf of GLMA: Health Professionals Advancing LGBT Equality, we write you in response to the request for public comment to strongly oppose the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.

GLMA—previously known as the Gay & Lesbian Medical Association—is a national membership association of lesbian, gay, bisexual, and transgender healthcare professionals and their allies whose mission is to ensure equality in healthcare for LGBT individuals and for LGBT healthcare professionals. Since its founding in 1981, GLMA has employed the expertise of our medical and health professionals in education, policy and advocacy, patient education and referrals, and the promotion of research to improve the health and well-being of LGBT people and their families.

GLMA believes in the critical importance of eliminating health disparities and ensuring that all people, including lesbian, gay, bisexual, and transgender (LGBT) individuals and their families, do not face discriminatory barriers when seeking quality, affordable healthcare and coverage. Numerous surveys, studies, and reports have documented the widespread extent of the discrimination experienced by LGBT individuals and their families in the health system. *When Health Care Isn't Caring*, a nationwide survey assessing the healthcare experiences of LGBT people and people living with HIV, found that the majority of the almost 5,000 respondents reported experiencing at least one of the following types of discrimination when accessing healthcare:[1]

- Health care providers refusing to touch them or using excessive precautions

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

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- 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

The US Transgender Survey, the largest survey detailing the experiences of transgender people in the United States, further documents the pervasive discrimination faced by transgender and gender nonconforming individuals in healthcare settings. According to the study, "[o]ne-third (33%) of those who saw a health care provider had at least one negative experience related to being transgender, such as being verbally harassed or refused treatment because of their gender identity."[2]

These encounters with discrimination have serious negative consequences for the health and wellbeing of LGBT individuals. They also exacerbate the significant health disparities that affect the LGBT population at large. Sources such as the National Academy of Medicine[3] (formerly the Institute of Medicine), the Centers for Disease Control and Prevention, and Healthy People 2020 report that discrimination threatens the health of the LGBT population in ways that include:[4]

- Increasing risk factors for poor physical and mental health such as smoking and other substance use;[5]
- Driving high rates of HIV among transgender women and gay and bisexual men;[6]
- Barring access to appropriate health insurance coverage, especially for transgender people;[7]
- Obstructing access to preventive screenings;[8] and
- Putting LGBT people at risk of poor treatment from health care providers who are unprepared to meet the needs of LGBT patients.[9]

As an organization of health professionals who often serve and care for patients from the LGBT community, we know that discrimination against LGBT individuals in healthcare access and coverage remains a pervasive problem and that too often this discrimination is based in religious

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[2] Sandy E. James et al., *The Report of the 2015 US Transgender Survey* (2016), *available at* http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf.

[3] Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), *available at* http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx.

[4] U.S. Department of Health and Human Services, *Healthy People 2020: LGBT Health Topic Area* (2015), *available at* http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

[5] Center for Disease Control and Prevention, *Lesbian, Gay, Bisexual, and Transgender Health* (2014), *available at* http://www.cdc.gov/lgbthealth/about.htm.

[6] Office of National AIDS Policy, *National HIV/AIDS Strategy* (2015).

[7] Laura E. Durso, Kellan E. Baker, and Andrew Cray, *LGBT Communities and the Affordable Care Act: Findings from a National Survey* (2013), *available at* http://www.americanprogress.org/wp-content/uploads/2013/10/LGBT-ACAsurvey-brief1.pdf.

[8] Fenway Institute, *Promoting Cervical Cancer Screening Among Lesbians and Bisexual Women* (2013), *available at* http://www.lgbthealtheducation.org/wp-content/uploads/Cahill_PolicyFocus_cervicalcancer_web.pdf.

[9] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV.*

objections. GLMA members have reported numerous instances of discrimination in care based on religious grounds. Since the Department issued the proposed regulation, GLMA members have shared with us the ways they have seen religious objections used to the detriment of the healthcare of LGBT patients, including members who have said:

- "I see patients nearly every day who have been treated poorly by providers with moral and religious objections… Patients with HIV who have been told they somehow deserved this for not adhering to God's law. Patients who are transgender who have been told that 'we don't treat your kind here'. The psychological and physical damage is pervasive."
- "[Some providers in my clinic] do not wish to have contact with transgender patients, mumbling religious incompatibilities when asked why. These people have made our transgender patients feel very uncomfortable and unwelcome at times, making them more potentially more hesitant to use the health services they may need."
- "The impact on my patients who were directly denied care was both psychological and physical. With regard to their mental wellbeing they clearly felt marginalized and disrespected. With regard to their physical wellbeing, they experienced delay in care, and in some cases disruption of their routine medication dosing or diagnostic assessment."

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 LGBT individuals already face.

LGBT people, women, and other vulnerable groups around the country already face enormous barriers to getting the care they need.[10] Accessing quality, culturally competent care and overcoming outright discrimination is even a greater challenge for those living in areas with already limited access to health providers. The proposed regulation threatens to make access even harder and for some people nearly impossible.

Patients living in less densely populated areas already face a myriad of barriers to care including less access to health insurance coverage, lower incomes, and lower rates of paid sick leave. This is in addition to the universal costs of transportation, taking time from work, and other incidentals that go along with obtaining care in the first place. For many, the sheer distance to a healthcare facility can be a significant barrier to getting care. For example, more than half of

[10] Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*; Sandy E. James et al., *The Report of the 2015 US Transgender Survey* 93–126; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV*; 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.

rural women live more than 30 minutes away from a hospital that provides basic obstetric care.[11] 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.[12]

This means if these patients are turned away or refused treatment, it is much harder—and sometimes not possible—for them to find a viable alternative. In a recent study, nearly one in five LGBT people, including 31% of transgender people, said that it would be very difficult or impossible to get the healthcare they need at another hospital if they were turned away. That rate was substantially higher for LGBT people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.[13] 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 healthcare providers or healthcare entities may not be required to participate in abortion and sterilization procedures. The regulation, however, creates ambiguity about these limited circumstances and encourages an overly broad misinterpretation that goes far beyond what the statutes permit.

For example, section (d) of the Church Amendments refers to circumstances when a person may refuse to participate in any part of a health service program or research activity that "would be contrary to his religious beliefs or moral convictions." Even though longstanding legal interpretation applies this section singularly to participation in abortion and sterilization procedures, the proposed rule does not make this limitation clear. This ambiguity can encourage an overly broad interpretation of the statute that empowers a provider to refuse to provide *any* healthcare service or information for a religious or moral reason—potentially including not just sterilization and abortion procedures, but also infertility care, treatments related to gender dysphoria, even HIV prevention or 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.[14]

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[11] 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.

[12] Sandy E. James et al.,*The Report of the 2015 US Transgender Survey* 99.

[13] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care.*

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

Healthcare providers may be misled into believing they may refuse on religious grounds to administer an HIV test or an HIV prevention regimen to a gay or bisexual man, or refuse screening for a urinary tract infection for a transgender man.[15] 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 healthcare workers to obstruct or delay access to a healthcare 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 LGBT patients' access to care services if interpreted—as the proposed rule improperly appears to do—to permit providers to choose patients based upon sexual orientation, gender identity, or family structure.

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

[15] Sharita Gruberg & Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial.*

4. The proposed rule stands in direct contradiction to the ethical and professional standards that exist across health professions to ensure nondiscrimination for LGBT patients.

The proposed rule also presents a direct conflict with nondiscrimination standards adopted by the Joint Commission and all the major health professional associations who have already recognized the need to ensure LGBT patients are treated with respect and without bias or discrimination in hospitals, clinics and other healthcare settings. Many of these efforts were prompted at least in part by GLMA's efforts through the years. For example, GLMA representatives, in coordination with other LGBT health experts, participated in the development and implementation of hospital accreditation nondiscrimination standards and guidelines developed by the Joint Commission designed to protect and ensure quality care for LGBT patients.

Similarly, GLMA has worked with the American Medical Association, among other health professional associations, over the last 15 years to ensure AMA policies prevent discrimination against LGBT patients and recognize the specific health needs of the LGBT community. All the leading health professional associations—including the AMA, American Osteopathic Association, American Academy of Physician Assistants, American Nurses Association, American Academy of Nursing, American College of Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Academy of Pediatricians, American Academy of Family Physicians, American Public Health Association, American Psychological Association, National Association of Social Workers, and many more—have adopted policies that state healthcare providers should not discriminate in providing care for patients and clients because of their sexual orientation or gender identity. By allowing discrimination against patients on the grounds of moral and religious freedom, the proposed rule obviates the ethical standards that healthcare professionals are charged to uphold.

5. 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 ensure 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 standards 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.

We are particularly concerned about the Department's attempt to radically redefine what it means to provide a referral for a patient. There is no legal basis to support the proposed transformation of the term from its plain meaning as it is used in healthcare—that is, transferring the care of a patient to a particular healthcare provider[16]—to "the provision of *any* information…pertaining to a health care service" so long as the healthcare entity believes that the healthcare service is a "possible outcome" of providing that information.[17]

This breathtakingly broad definition can exempt providers not only from refusing to transfer care to another healthcare provider, but from providing information that has an exceedingly remote connection to a procedure if the provider simply believes that it is not impossible that doing so may lead the patient to receive the treatment—even if they do not believe that it is likely or plausible. For example, it may permit a healthcare provider to refuse to inform a woman about a pregnancy complication she is experiencing, even if it can be treated, based on their belief that it is *possible* though unlikely she will opt to terminate the pregnancy. While the Department claims that statutory language—such as references to "referring for" an abortion or "making arrangements to provide referrals"—suggests that Congress intended for this term to be interpreted broadly,[18] the definition that it proposes extends so far beyond the plain meaning of the term that it amounts to a radical revision of the statutory language that undermines rather than effectuates Congress' intent for its scope.

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

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

The timing of the proposed rule also illustrates a lack of sufficient consideration. The proposed rule was published 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

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[16] American Academy of Family Physicians, *Consultations, Referrals, and Transfers of Care* (2017), https://www.aafp.org/about/policies/all/consultations-transfers.html ("A referral is a request from one physician to another to assume responsibility for the management of one or more of a patient's specific problems.... This represents a temporary or partial transfer of care to another physician for a particular condition.")

[17] Proposed Rule, 83 Fed. Reg. at 3924.

[18] *Id.* at 3895.

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 healthcare institutions or their employees on the basis of personal beliefs. This short period of time calls into question the comprehensiveness of the review of the Request for Information and whether the proposed rule was developed in an arbitrary and capricious manner.

Conclusion

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

Sincerely,

Gal Mayer, MD, MS
GLMA President

Hector Vargas, JD
GLMA Executive Director

Exhibit 113

March 27, 2018

VIA ELECTRONIC TRANSMISSION

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

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

Dear Secretary Azar and Director Severino:

Planned Parenthood Federation of America (Planned Parenthood) and Planned Parenthood Action Fund (the Action Fund) submit these comments in response to the Protecting Statutory Conscience Rights in Health Care; Delegation of Authority, released by the Department of Health and Human Services (the Department) Office for Civil Rights (OCR) and Office of the Secretary on January 19, 2018 and published in the federal register on January 26, 2018. As a trusted women's health care provider and advocate, Planned Parenthood takes every opportunity to weigh in on policy proposals that impact the communities we serve across the country.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States. Each year, Planned Parenthood's more than 600 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted diseases (STDs), and other essential care to 2.4 million patients. We also provide abortion services and ensure that women have accurate information about all of their reproductive health care options. One in five women in the U.S. has visited a Planned Parenthood health center. The majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level (FPL).

As a health care provider, Planned Parenthood knows how important it is that people have access to quality health care and information they can trust. Already, too many people in this country are denied, often without realizing it, access to medically-appropriate information and care because of a health care provider's or employer's personal beliefs. Instead of protecting

patients' access to quality care, this rule -- if finalized -- would make it easier for health care workers to refuse care, disproportionately impacting women, LGBTQ people, people with low incomes, people from rural areas, and other people already experiencing barriers to care. Importantly, the proposed rule goes beyond the reach of the statutes the Department claims to be implementing, undermining the intent of the statutes and exceeding the authority given by Congress. Further, as outlined below, the proposed rule potentially conflicts with existing civil rights statutes and state laws, and it fails to adequately account for costs.

Indeed, this proposed rule is unprecedented in its reach and harm, seeking to allow almost any worker in a health care setting to refuse services and information to a patient because of personal beliefs, which notably would include "religious, moral, ethical, or other reasons."[1] This means that under this proposed rule, a pharmacist could refuse to fill a prescription for birth control or antidepressants, a woman could be denied life-saving treatment for cancer, or a transgender patient could be denied hormone therapy. And while the proposed rule purports to be protecting the conscience rights and "personal freedom" of health care workers "with a variety of moral, religious, and philosophical backgrounds," it selectively ignores the many workers who are prevented from following their conscience by *restrictions* on care imposed by their employers.

The Department has an obligation to follow parameters established by Congress and aim for equality in health care access across the country, including for women, LGBTQ people, and people living with HIV. To this end, the Department must withdraw this proposed rule.

I. The proposed rule would endanger patients and obstruct their access to health care.

The proposed rule reflects bad public health policy. Women -- particularly women of color and women living in rural areas -- LGBTQ people, and people living with HIV already experience barriers to care, and this proposed rule would further limit health care access and result in poor health care outcomes. The proposed rule will also interfere with the ability of patients and providers to make informed medical decisions. Notably, the proposed rule does not provide any exceptions for necessary care in the case of an emergency.

A. The proposed rule would exacerbate existing barriers to health care.

The rule would erect more barriers to reproductive health care, transition-related services, and other services, and place women, LGBTQ people, and people living with HIV at greater risk of not getting the services they need. Access to comprehensive reproductive health care, including abortion, is already limited. According to a recent report, nearly half of the women of reproductive age have to travel between 10 to 79 miles, and some women have to travel 180 miles or more, to access an abortion.[2] Importantly, the proposed rule improperly expands upon

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[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3923 (Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88).

[2] J. Mearak, et. al., Disparities and change over time in distance women would need to travel to have an abortion in the USA; spatial analysis, The Lancet (Nov. 2017), http://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30158-5.pdf.

existing refusal laws and policies that already harm an untold number of people, who are often denied information and care.

It is already the case that women with pregnancy complications who seek care at religiously-affiliated hospitals have been denied information or abortion care, even when that information is critical to their health. An often-cited case is that of Tamesha Means, who was rushed to Mercy Health Partners in Muskegon, Michigan after her water broke at 18 weeks of pregnancy. She was sent home twice in excruciating pain despite the fact that there was no chance that her pregnancy would survive and that continuing the pregnancy posed significant risks to her health. Due to the hospital's religious affiliation, Ms. Means was not informed that terminating her pregnancy was the safest course for her condition, and therefore her health was put at risk.[3] Another woman, Mikki Kendall, went to an emergency room after experiencing a placental abruption. Even though her pregnancy would not survive and Ms. Kendall could have died due to the amount of blood loss, the doctor on call refused to perform an abortion and refused to contact another physician to perform the procedure. Fortunately, Ms. Kendall was able to receive the care she needed after several risky and agonizing hours.[4] Unfortunately, many people are not even aware that they may be denied medically-appropriate care and information, even in emergency situations. For instance, nearly 40 percent of the people who regularly visit Catholic hospitals do not know of the religious affiliation, and even patients that are aware of the affiliation frequently do not know the hospital refuses to provide certain services.[5]

Certain communities are particularly affected by denials of care. Health care refusals disproportionately impact Black women, and the expansions outlined in this proposed rule would likewise disproportionately impact Black women. For example, according to a recent report, hospitals in neighborhoods that are predominately Black are more likely to be governed by ethical and religious directives for Catholic health care services.[6] Additionally, people living in rural areas are significantly impacted if their provider refuses to provide necessary or preventive care. Women living in in rural areas already experience provider shortages and have to travel long distances for health care, resulting in significant gaps in care and low health outcomes.[7] By making it easier for providers to refuse care, the proposed rule would further restrict these options or cut off access to care altogether, which would compromise patient health still further.

The proposed rule also threatens access to transition-related services and HIV prevention and care -- including pre-exposure prophylaxis -- disproportionately impacting LGBTQ people and

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[3] ACLU, Tamesha Means v. United States of Catholic Bishops (June 30, 2015), https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops.

[4] Mikki Kendall, Abortion Saved my Life, Salon (May 26, 2011), https://www.salon.com/2011/05/26/abortion_saved_my_life/. .

[5] *Id.*

[6] K. Shepherd, et. al., Bearing Faith: The Limits of Catholic Health Care for Women of Color, Columbia Law School (January 2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf?mc_cid=51db21f500&mc_eid=780170d2f0.

[7] The American College of Obstetricians and Gynecologists, Health Disparities in Rural Women (2014, reaffirmed 2016), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20160402T0931414521.

people living with HIV. Discrimination in health care settings already prevents LGBTQ people from accessing the care they need. For instance, nearly one-third of transgender people surveyed said a doctor or health care provider refused to treat them due to their gender identity.[8] Related, people living with HIV frequently experience stigma in the health care system.[9] The proposed rule would increase this stigma and make it more likely that these communities are denied necessary health care.

B. The proposed rule will hinder the delivery of care.

While the Department claims that the proposed rule will "facilitat[e] open communication between providers and their patients," in fact, it would do the opposite. Specifically, the proposed rule encourages medical professionals to conceal information if they believe that information might enable a patient to seek care (even elsewhere) of which they disapprove. It also inhibits communication by increasing the risk that *patients* will conceal medically relevant information, such as sexual orientation, out of fear that their provider would refuse them care.

The proposed rule itself notes that mainstream medical groups have recognized the negative effects refusing care can have on patients and that these organizations have called for patient protections when refusals may compromise health. For example, the American Congress of Obstetricians and Gynecologists (ACOG) ethics opinion states that "in an emergency in which referral is not possible or might negatively affect 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."[10] The American Medical Association's (AMA) constitution and bylaws similarly note that physicians are required to be "moral agents" and "being a conscientious medical professional may well mean at times acting in ways contrary to one's personal ideals in order to adhere to a general professional obligation to serve patients' interests first." The constitution and bylaws further state that "having discretion to follow conscience with respect to specific interventions or services does not relieve the physician of the obligation to not abandon a patient."[11] The proposed rule would exacerbate these concerns by making it harder for medical organizations and providers to preserve existing access to reproductive health care.[12]

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[8] S. Mirza & C. Rooney, Discrimination Prevents LGBTQ people from Accessing Health Care, Ctr. for Amercian Progress (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[9] CDC, HIV Among Gay and Bisexual Men, https://www.cdc.gov/hiv/group/msm/index.htm; CDC, HIV Among African-Americans, https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-aa-508.pdf.

[10] 83 Fed. Reg. at 3888; ACOG, The Limits of Conscientious Refusal in Reproductive Medicine (Nov. 2007, reaffirmed 2016), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine.

[11] American Medical Association, Physician Exercise of Conscience: Report of the Council on Ethical and Judicial Affairs, https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/i14-ceja-physician-exercise-conscience.pdf.

[12] By ignoring these harms, the Department has failed in its obligation to acknowledge and consider the impact of a proposed rule on family well-being. *See* 83 Fed. Reg. at 3919.

C. The proposed rule does not include exceptions for medical emergencies and potentially conflicts with existing federal law.

The proposed rule could endanger women's lives because it fails to make sure that the protections of the Emergency Medical Treatment and Active Labor Act (EMTALA) apply and take precedence when a patient is facing a medical emergency. EMTALA requires virtually every hospital to provide an examination or treatment to individuals that come into the emergency room, including care for persons in active labor, and the hospital must provide an appropriate transfer if the hospital cannot stabilize the patient.[13] The proposed rule does not address EMTALA and the potential legal conflict between that Act and the proposed rule. In particular, it is unclear if the Department or a state or local government would be considered to have engaged in prohibited "discrimination" if it penalized a hospital for failing to comply with EMTALA when a pregnant woman needs an abortion in an emergency situation.[14] There is no dispute that some pregnant women develop serious medical complications for which the standard treatment is pregnancy termination.[15] The proposed rule's silence on medical emergencies could create confusion among health care institutions or even allow them to refuse to comply with existing federal requirements to treat patients with medical emergencies and thereby endanger women's lives.[16]

II. The proposed rule exceeds the authority granted under the underlying statutes.

While purporting to interpret long-standing statutes, the Department is expanding the requirements of the statutes beyond what Congress intended. The Department claims that it is seeking to clarify the scope and application of existing laws, but this rule would in fact drastically alter, not clarify, existing requirements. The Department both creates expansive definitions that did not exist before and reinterprets the provisions of the underlying laws in harmful ways.

A. The proposed rule expands the definition of various terms beyond their well-settled meanings and beyond congressional intent.

The proposed rule expands the definitions of well-settled terms used in the relevant refusal laws far beyond their commonly understood meanings, defining terms so broadly as to encompass a

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[13] 42 U.S.C. § 1395dd.

[14] The government can clearly take such action under Title VII. *See* Shelton v. Univ. of Med. & Dentistry of N.J. 223 F.3d 220, 228 (3d Cir. 2000).

[15] See *e.g.*, *Planned Parenthood v. Casey*, 505 U.S. 833, 880 (1992) ("[It is undisputed that under some circumstances each of these conditions [preeclampsia, inevitable abortion, and premature rupture of membrane] could lead to an illness with substantial and irreversible consequences.").

[16] Federal abortion policy generally has recognized the need to protect women's lives. *See e.g.*, 18 U.S.C. § 1531(a) (prohibiting abortion procedure except where "necessary to save the life of a mother"); 10 U.S.C. § 1093 (banning almost all abortion services at U.S. military medical facilities, and prohibiting Department of Defense funds, which includes health insurance payments under Civilian Health and Medical Program for the Uniformed Services, from being used to perform abortions, "except where the life of the mother would be endangered if the fetus were carried to term"); Consolidated Appropriations Act, 2017, Pub. L. No. 115-131, Title V §§ 507 131 Stat. 135 (2017) (prohibiting that funds appropriated under the Act be used to pay for an abortion except where, among other narrow exceptions, "where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed").

ridiculously wide array of activities that go well beyond congressional intent. As an initial matter, although the Department purports to be bringing the refusal laws in line with other civil rights laws, the rule proposes to define "discrimination" contrary to how it is has been long understood in those laws. Under the Department's proposed rule, "discrimination" is more broadly defined to include a large number of activities, including denying a grant, employment, benefit or other privilege, as well an unspecified catch-all phrase "any activity reasonably regarded as discrimination." It also includes any laws or policies that would have the effect of defeating or substantially impairing accomplishment of a "health program or activity." The term, "health program or activity" is then defined to include, among other things, "health studies, or any other services related to health or wellness whether directly, through payments, grants contracts, or other instruments, through insurance, or otherwise."[17] The inclusion of any impairment of a "health program or activity," as defined, only adds to an unreasonably expansive definition of "discrimination" that could be applied to anything with a tangential connection to health or wellness. As set forth below, the rule's all-encompassing definition of "discrimination" fails to account for established anti-discrimination law that reflect a balancing of interests -- protecting against religious discrimination but recognizing it is not discriminatory to require an employee to perform functions that are essential to the position for which she applied and was hired.

The proposed rule also improperly stretches the definition of "refer" to include providing "any information … by any method … that could provide any assistance in a person obtaining, assisting, training in, funding, financing, or performing a particular health care service, activity or procedure."[18] This means that any health care entity, including both individuals and institutions, could refuse to provide any information that could help an individual to get the care they need, including even to provide patients with a standard pamphlet. The objecting entity would be able to refuse to provide that information even if they believe that a particular health care service is only the "possible outcome of the referral."[19] This definition would allow health care providers to deny patients full, accurate, and comprehensive information on health care options that allow people to make their own health care decisions.

The proposed rule also defines "assist in the performance of" far more broadly than its common meaning, to include participating in any program or activity with "an articulable connection" to a procedure, health service, health program, or research activity. The proposed rule specifically notes that this includes *but is not limited to* counseling, referral, training, and other arrangements.[20] Even though the Department claims to acknowledge "the rights in the statutes are not unlimited," this definition could in effect create an unlimited right to refuse services. For example, it is unclear if an employee whose task it is to mop the floors at a hospital that provides abortion would be considered to "assist in the performance" of the abortion under this proposed rule. A definition this limitless provides no functional guidance to health care providers as to what they can ask of their employees, and the refusals permitted by health care providers and non-medical staff.

The proposed rule also broadens the health care workers that can claim "discrimination," potentially allowing a range of health care workers not directly involved in delivering care to

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[17] 83 Fed. Reg. at 3924.
[18] Referral is defined far more narrowly elsewhere in federal law. *See, e.g.*, 42 U.S.C. § 1395nn(h)(5); 42 C.F.R. § 411.351.
[19] 83 Fed. Reg. at 3924.
[20] 83 Fed. Reg. at 3923.

refuse to perform their duties at a health care facility. Specifically, the proposed rule seeks to expand the definition of "health care entity," "individual," and "workforce" to include a broad range of workers and organizations, including volunteers, trainees, and contractors.[21] The proposed rule notes that the workers included in the definitions are illustrative and not exhaustive, potentially creating the opportunity for non-medical personnel, such as receptionists or facilities staff, to refuse to perform job tasks. In particular, the notion that an individual who agrees to volunteer to perform a service for an entity has the right to then refuse to perform that service, but presumably without losing his or her status as "volunteer," is absurd. This nonsensical interpretation of the statutes exceed the Department's regulatory authority. In short, if this provision is finalized, a wide range of workers may be able to deny access to care - even if the worker's job is only tangentially related to that care.

The proposed rule also seeks to expand the health care providers and institutions that are subject to the rule's burdensome requirements. The proposed rule's broad definition of "entity" to include individuals as well as corporations, would greatly expand the individuals and institutions subject to the underlying laws' requirements.[22]

In general, the proposed rule's unreasonably expansive definitions could inhibit health care providers and institutions from offering a broad range of health care services to patients, and would ultimately limit patients' access to care. This is particularly so because in addition to expanding the terms used in the refusal laws beyond any possible meaning Congress intended, the Department has also expanded the substance of the refusal laws beyond their statutory text, as is discussed below. Thus, rather than clarify statutes that are as much as forty-years old, the proposed rule has stretched the meaning of key terms. This will lead to illogical, unworkable, and unlawful results.

B. The Department broadly interprets the Church Amendments in violation of the statute.

The Department is exceeding its statutory authority by interpreting the Church Amendments far beyond what Congress intended. Each provision of the Church Amendments was enacted at a different point in time to address specific concerns. The first two provisions of the Church Amendments were enacted in 1973 during the public debate following the *Roe v. Wade* decision, and they clarify that receipt of certain federal funds does not require a health care entity to perform abortions or sterilizations or make its facilities available for abortions or sterlizations.[23] These provisions of the Church Amendments, codified at 42 U.S.C. § 300a-7(b) and (c)(1), permit individuals to refuse to perform or assist in the performance of a sterilization or abortion in certain federally funded programs if it is contrary to their religious or moral beliefs. Sections (d) and (e) of the Amendments were passed as a part of the National Research Act, which aimed at funding biomedical and behavioral research, and ensuring that research projects involving human subjects were performed in an ethical manner. [24] The Department's purported

[21] 83 Fed. Reg. at 3923–3924.
[22] 83 Fed. Reg. at 3924.
[23] The implicated funds are the Public Health Service Act [42 U.S.C. § 201 *et seq.*], the Community Mental Health Centers Act [42 U.S.C. § 2689 *et seq.*], and the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C. § 6000 *et seq.*].
[24] See 119 Cong. Rec. 2917 (1973).

interpretation of these provisions goes far beyond both the statutory text and Congressional intent in at least two ways.

First, section (b) of the Church Amendments states that courts, public officials, and public authorities are not authorized to require the performance of abortions or sterilizations, *based on the receipt of* any grant, contract, loan, or loan guarantee under the Public Health Service Act (PHSA), the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act. The proposed rule goes beyond the text of the statute and interprets it to prohibit public authorities from *requiring any individual or institution* to perform these services if they receive a grant, contract, loan or loan guarantee under the PHSA. Therefore, while the Church Amendments only make it clear that public authorities are not allowed to require the performance or assistance in the performance of abortion or sterilization based on the receipt of certain federal funding, the proposed rule imposes a blanket prohibition on any requirements related to individuals or institutions performing or assisting in the performance of abortion and sterilization if the institution or individual receives the specified funding. Combined with the expanded definition of "assist in the performance" that impacts sections (b)(1) and (b)(2)(B), the proposed rule allows for denials of services related to abortion and sterilization by both individual providers and those ancillary to the provision of health care. It could also prevent states and the federal government from requiring a hospital to provide an abortion, even if a patient's health or life is threatened.

Second, the proposed rule interprets section (d) of the Church Amendments in a way that goes well beyond the statute and that has the potential to allow any individual employed at a vast number of health care institutions to refuse to provide care that is central to the institution. Importantly, this provision was intended to apply only to individuals who work for entities that receive grants or contracts for biomedical or behavioral research. The proposed rule incorrectly claims that paragraph (d) of the Church Amendments is not based on receiving specified funding through a specific appropriation, instrument, or authorizing statute, but applies to "[a]ny entity that carries out any part of a health service program or research activity funded in whole or in part under a program administered by" the Department.[25]

The expansive definitions of "entity," "health service program" and "assist in the performance" only serve to exacerbate this unlawful expansion. As noted, "entity" is defined broadly in the proposed rule to include a "'person', as defined in 1 U.S.C. 1 or a State, political subdivision of any State, instrumentality of any State or political subdivision thereof, or any public agency, public institution, public organization, or other public entity in any State or political subdivision of any state." "Health service program" is discussed by the Department in the proposed rule as not only including programs where the Department provides care or health services directly, but programs administered by the Secretary that provide health services through grants, cooperative agreements or otherwise; programs where the Department reimburses another entity to provide care; and "health insurance programs where Federal funds are used to provide access to health coverage (e.g. CHIP, Medicaid, Medicare Advantage)." It also may include components of State or local governments.[26]

Thus, under the proposed rule, virtually any individual could refuse to provide any type of health care or any job task that has a minimal connection to the provision of health care. This provision

[25] 83 Fed. Reg. at 3925.
[26] 83 Fed. Reg. at 3894.

would not only allow individuals to refuse to provide any type of care that they object to, but could also prevent states from protecting patients by requiring the provision of health care or fulfillment of other job duties by individuals in a medical facility. This could include, for instance, enforcing a state law that requires individual pharmacists to fill all the prescriptions they receive.

Nothing in the legislative history of section (d) of the Church Amendments suggests that this provision was meant to restrict the actions of this broad range of health care related individuals and organizations, nor that it was meant to apply to these individuals and institutions in the context of such a broad range of health-related programs.[27] The Department has clearly exceeded its statutory authority by attempting to create a catch-all provision that would allow almost any health care provider in the country to refuse to provide services based on a 40-year old law that was targeted to the receipt of specific, and limited, federal funds.

C. The Department's interpretation of the Weldon Amendment is not consistent with the plain language of the statute.

The Department has proposed a similarly broad -- and impermissible -- expansion of the Weldon Amendment. That amendment was added to the appropriations bill for the Departments of Labor, Health and Human Services, and Education in 2004 and each subsequent appropriations bill. It prohibits funds appropriated by those three agencies to be provided to a federal agency or program, or to a state or local government, if such agency, program, or government requires any institutional or individual health care entity to provide, pay for, provide coverage of, or refer for abortions.[28] While the text of the statute is limited to state and local governments and federal agencies or programs, the rule would apply the Weldon Amendment to "any entity that receives funds through a program administered by the Secretary or under an appropriations act [HHS]."[29] This interpretation of the Weldon Amendment would impermissibly turn private entities into "federal agencies or programs" by virtue of their receipt of HHS funding.

In addition to conflicting with the plain meaning of the statute, the Department's broad interpretation is also contrary to the legislative history of the Weldon Amendment. During final floor debates on the appropriations bill that included the first Weldon Amendment, one of its supporters explained: "The addition of conscience protection to the Hyde amendment remedies current gaps in Federal law and promotes the right of conscientious objection by forbidding federally funded government bodies to coerce the consciences of health care providers."[30] In other words, the Weldon Amendment's reference to "federal agency or program" was intended as a restriction on government bodies only, not on private entities that receive federal funds.

Indeed, the Department of Justice (DOJ) has taken the formal position that the receipt of federal funds does not mean that an organization is a federal agency or program. In litigation, the DOJ stated: the term "federal agency or program" does not automatically include private, individual family planning clinics that receive federal funds; the Weldon Amendment does not clearly

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[27] Indeed, section (d) of the Church Amendments does not by its terms impose any restrictions on health care providers. Rather, it is framed as an exemption to individuals from certain federal requirements that are contrary to their religious or moral beliefs. 42 U.S.C. § 300a-7(d).

[28] Weldon Amendment, Consolidated Appropriations Act 2017, Pub. L. 115-31, Div. H, Tit. V, Sec. 507(d).

[29] 83 Fed. Reg. at 3925.

[30] 150 Cong. Rec. H10095 (daily ed. Nov. 20, 2004) (statement of Rep. Smith) (emphasis added).

provide that an individual Title X clinic would constitute a "federal agency or program" covered by the statute, and "no agency responsible for the implementation or enforcement of the statute has adopted a reading to that effect."[31] If Congress intended for the Weldon Amendment to apply to virtually every private hospital, pharmacy, and outpatient care center in the country, and hundreds of thousands of private doctors and other health care practitioners, it surely would have said so more directly, either at the time the Weldon Amendment was enacted or in the 14 years that the amendment has been interpreted otherwise.

The unreasonably broad definitions of "discrimination" and "health care entity" also act to greatly expand the reach of the Weldon Amendment. By defining discrimination to include any adverse actions without any balancing of the interests of employers or patients, this provision could be used to attempt to strike down neutral state laws that protect access to health care. The term, "health care entity" is already defined in the Weldon Amendment, so a proposal to add certain entities via regulation clearly exceeds the authority of the Department. For example, the inclusion of "a plan sponsor, issuer, or third party administrator" expands the reach of the provision by allowing employers that provide health insurance (even if they have no connections to health care) to become "health care entities" for purposes of this protection from "discrimination."

Finally, the legislative history cited above makes it clear that the Weldon Amendment was intended to be limited to objections based on conscience, but under the proposed rule, the Department would allow refusal for *any* reason, including, for example, a financial one. All of these expansions are contrary to law and, more importantly, work to deny women access to information about and access to lawful medical services.

D. The Department similarly expands the applicability of the Coats Amendment.

The proposed rule's broad definitions of "health care entity," "refer," and "discrimination" would also expand the applicability of the Coats Amendment beyond its statutory language and intent. The Coats Amendment was adopted in 1996 in response to a new standard adopted by the Accrediting Council for Graduate Medical Education, requiring all obstetrics and gynecology residency programs to provide induced abortion training.[32] Senator Coats offered the amendment to "prevent any government, Federal or State, from discriminating against hospitals or residents that do not perform, train, or make arrangements for abortions."[33]

The amendment prohibits the federal government, or any state or local government that receives federal financial assistance, from discriminating against medical residency programs or individuals enrolled in those programs based on a refusal to undergo, require, or provide abortion training.[34] Under the Coats Amendment, the term "health care entity" is limited to "an individual physician, a postgraduate physician training program, and a participant in a program

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[31] Brief of Respondent, *NFPRHA v. Gonzales*, 391 F.Supp.2d 200 (D.D.C. 2004) (No. 04-2148).

[32] *See* 142 Cong. Rec. 5159 (March 19, 1996) (Senator Frist stating that "this amendment arose out of a controversy over accrediting standards for obstetrical and gynecological programs").

[33] 142 Cong. Rec. 4926 (March 14, 1996). *See also* 142 Cong. Rec. 5158 (March 19, 1996) (Senator Coats stating he offered the language in the bill because "it is [not] right that the Federal Government could discriminate against hospitals or ob/gyn residents simply because they choose, on a voluntary basis, not to perform abortions or receive abortion training, for whatever reason.").

[34] *See* 42 U.S.C. § 238n.

of training in the health professions."[35] However, the proposed rule's definition of health care entity would prohibit "discrimination" not just against those specified in the Coats Amendment, but also against other health care professionals, health care personnel, an applicant for training or study in the health professions, a hospital, a laboratory, an entity engaging in biomedical or behavioral research, a health insurance plan, a provider-sponsored organization, a health maintenance organization, a plan sponsor, issuer, third-party administrator, or any other kind of health care organization, facility or plan. Similar to the proposed rule's changes to the Weldon Amendment, the Department has taken a narrow statute that was enacted to address a specific concern and used the proposed rule to promote broader discrimination in health care.

III. The proposed rule would undermine health care access in programs that Congress intended to expand care for women with low incomes and their families.

The proposed rule would impact health care programs, both domestically and internationally, that are intended to expand access and quality of care for women, people with low incomes, people living with HIV, and others. The expanded scope of the rule would reach both the Title X Family Planning Program (Title X) and the President's Emergency Plan for AIDS Relief (PEPFAR).

A. The Department's proposal would reduce access to vital services through Title X and other programs by allowing objectors to ignore their general requirements contrary to the intent of these programs.

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. We find this 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 people with low-incomes. 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 objective of expanding access to reproductive health care to underserved communities.

Several of the Department's proposed provisions and definitions appear to exempt recipients of federal funds from following the rules that govern federal programs if they have an objection to doing so. As discussed above, the proposed rule's expansion of the Weldon Amendment turns private entities into "federal agencies or programs" and then bars them (as well as the Department) from "discriminating" against a "health care entity" based on its refusal to provide "referrals" for abortion.[36] "Discrimination" includes, among other things, denying federal awards or sub-awards to objectors.[37] Similarly, the proposed rule provides that the Department cannot require recipients of grants provided under the Public Health Service Act to "assist in the performance of an abortion."[38] Such "assistance" includes an unreasonably broad range of conduct, including "counseling, referral, training, and other arrangements." Also, the proposed rule provides that entities receiving Public Health Service Act grants cannot be required to

[35] 42 USC § 238n(c)(2).
[36] 83 Fed. Reg. at 3925.
[37] 83 Fed. Reg. at 3923–3924.
[38] 83 Fed. Reg. at 3925.

provide personnel for "the performance or assistance in the performance of any . . . abortion;" the overbroad definition of "assistance" again applies here.[39]

Federal agencies routinely provide financial assistance to eligible entities in the form of grants, contracts, or other agreements in exchange for the performance of a prescribed set of services or activities. The Department's approach would seem to give objectors a virtually unlimited right to ignore these generally applicable requirements and may even force the Department to fund entities that refuse to advance the fundamental goals of the programs in which they seek to participate. Nowhere in the proposed rule does the Department acknowledge that its exemptions in these areas would allow conduct that conflicts with pre-existing legal requirements. Nor does it consider how overriding these rules could undermine important health care objectives that are central to the effective administration of federally supported health programs.

The proposed rule's defects come into clear focus in the context of Title X, the nation's program for birth control and reproductive health. Title X of the Public Health Service Act empowers the Department to make grants to public and not-for-profit entities for the purpose of providing confidential family planning and related preventive services.[40] Title X gives priority to services for people with low incomes and, depending on their income and insurance status, patients may be eligible for free or discounted Title X services.[41] In 2016, Title X-funded providers served over 4 million people.[42] This total includes a disproportionate share of individuals from groups that face longstanding racial and ethnic inequities; for example, 32 percent of Title X patients identified as Hispanic or Latino, and 21 percent identified as Black in 2016.[43] Title X-funded projects offer a range of reproductive health care and information, including counseling and services related to a broad range of contraceptive methods, HIV/STI services, cancer screenings, and other care.

The Department's proposal appears to sanction conduct that would interfere with Title X's legal requirements. For example, although Title X funds are barred from going toward abortion, the program's regulations expressly require providers to offer non-directive options counseling to patients, including abortion counseling and referrals upon request.[44] Even before its codification in regulation, longstanding Departmental interpretations held that non-directive options counseling was a basic and necessary Title X service.[45] The centrality of non-directive options counseling in Title X is reinforced every year through legislative mandates in annual appropriations measures.[46] These prescriptions reflect well-settled principles of medical ethics: patients are entitled to prompt, accurate, and complete information to enable them to make informed decisions about their health. And, especially when an entity does not offer a desired

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[39] 83 Fed. Reg. at 3925.
[40] 42 U.S.C. §§ 300 - 300a-8.
[41] 42 U.S.C. § 300a–4(c).
[42] Christina Fowler, et al., RTI International, *Family Planning Annual Report: 2016 national summary* (2017), available at https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.
[43] *Id.*
[44] 42 U.S.C. § 300a-6 (prohibiting funding for abortion); 42 C.F.R. § 59.5(a)(5) (requiring non-directive options counseling and referral).
[45] *See* Comptroller General of the United States, "Restrictions on Abortion and Lobbying Activities In Family Planning Programs Need Clarification" (Sept. 1982), available at http://www.gao.gov/assets/140/138760.pdf.
[46] *See, e.g.*, Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, 131 Stat 135 (2017).

service such as abortion, health professionals have a responsibility to provide the information and referrals needed to ensure that such services are provided to patients in a timely and competent manner. Yet, under the proposal, entities that object to "assist[ing] in the performance of abortion" could claim a right to refuse to offer non-directive options counseling and referrals to Title X patients.

On top of interfering with counseling and referrals under Title X, the proposed rule could also override other program requirements. For instance, Title X requires projects to provide medical services, including "a broad range of acceptable and effective medically approved family planning methods."[47] This unquestionably includes long-acting reversible contraceptive methods such as intrauterine devices (IUDs). The central place of IUDs, which are exceptionally effective, in the family planning repertoire is cemented by the Centers for Disease Control and Prevention's (CDC) Quality Family Planning recommendations. These recommendations provide, for example, that "[c]ontraceptive services should include consideration of a full range of FDA-approved contraceptive methods," and a "broad range of methods, including long-acting reversible contraception (i.e., intrauterine devices [IUDs] and implants), should be discussed with all women and adolescents."[48] Despite these national clinical standards of care, some individuals are opposed to contraception or certain forms of contraception, and under the proposed impermissible expansion of Church (d) discussed above, any individual working for an entity participating in Title X could claim a right to refuse to provide information or services related to contraception for Title X patients.

If allowed by the Department, such exemptions not only would overtake pre-existing legal rules, but could also thwart the critical health care objectives that federal programs are meant to advance. For example, Congress's purpose in passing Title X was, in part, "to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services," and "to enable public and nonprofit private entities to plan and develop comprehensive programs of family planning services."[49] Permitting health care entities to withhold vital counseling, referrals, and services is hardly conducive to the "comprehensive" approach that was contemplated by Congress. In practical terms, such policies could cut off access to basic, preventive health care and information for the low-income and uninsured people who turn to Title X-funded providers.

Since the inception of these important public health programs, entities that do not want to provide the required services are free to decline to participate. All recipients of federal funds, however, should be bound by the same, general requirements and serve the same priorities in order to serve program beneficiaries and faithfully adhere to Congress's aims.

B. The proposed rule would severely undermine the purpose and effectiveness of U.S. funded health programs around the world.

The Department's global health programs include those focused on combating HIV/AIDS and malaria, improving maternal and child health, and enhancing global health security. In addition

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[47] 42 C.F.R. § 59.5(a)(1).
[48] Centers for Disease Control and Prevention, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, 7, 8, (2014), available at https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.
[49] Act of Dec. 24, 1970, Pub. L. No. 91-572, § 2, 84 Stat. 1504 (1970).

to funds directly appropriated to the Department for global health, considerable funding is transferred to the Department by the State Department and USAID to administer global AIDS programs under PEPFAR.

We strongly oppose the statutory prohibition on the use of foreign aid funding for abortion as a method of family planning, known as the Helms Amendment, both as it is written and the broader manner in which it is applied, and the broad and harmful refusal provision contained within the statute governing PEPFAR, which are both cited in the proposed regulation.[50] The Helms Amendment effectively coerces women into continuing unwanted pregnancies because the health care they are able to access is provided with U.S. funding. The outcome of this harmful policy is increased unwanted pregnancies and maternal morbidity and mortality.

PEPFAR's statutory refusal provision, which applies only to organizations, already puts beneficiaries at risk and undermines the overall program. For example, this restriction allows PEPFAR-participating organizations to refuse to provide condoms (or any other service to which they object) or even information about condoms to people served by the program -- despite the fact that the purpose of the program is to combat HIV/AIDS and condom provision is proven to be an essential component of effective HIV prevention programs. Organizations may even refuse to coordinate their activities or have any other relationship with programs that provide the services or information to which they object, creating a serious barrier to ensuring that the full range of HIV prevention, care, and treatment activities are available in any one community or to any individual client.

The proposed rule would go even further than the statutory refusal provision and under the guise of paragraph (d) of the Church Amendments allow any individual working under global health funds from the Department (whether the funds are from direct appropriations or transferred from another agency and then administered by the Department) to refuse to perform or assist in any part of a health service program. As explained above, this expansion of Church (d) is contrary to Congress' intent in enacting this provision. The result is to magnify the harm of PEPFAR's refusal provision by appearing to allow individuals to refuse to treat any patient if doing so would violate his or religious beliefs or moral convictions, without concern for the needs of the patient and regardless of what type of health service the patient needs -- whether it be contraception, a blood transfusion, a vaccination, condoms to prevent HIV transmission, sexually transmitted infection screenings and treatment, or even information about health care options. The proposed rule would impact a limitless array of health services.

Moreover, individuals could potentially use this broad interpretation of section (d) of the Church Amendments to pick and choose which patients to assist, making LGBTQ individuals, adolescent girls and young women, and other marginalized populations particularly vulnerable to discrimination in the provision of services. This is particularly egregious in the context of HIV/AIDS programs where these communities face elevated risk in many parts of the world. In developing countries where health systems are especially weak, there is a shortage of available health care options and supplies, and individuals often travel long distances to obtain the services that they need; it is particularly critical that individual health care providers do not deny patients the information and services that they need. Such action undermines the purpose of the programs and the rights of those they intend to serve.

[50] 83 Fed. Reg. at 3926–3927.

Furthermore, the proposed rule does not refer or defer to any but a small set of federal provisions governing U.S. foreign policy and foreign assistance, or to the agencies entrusted to set this policy. This could create confusion or even conflict with existing laws and policies, which may differ, for example, across PEPFAR implementing agencies and departments.

Finally, we are deeply concerned that the proposed rule defines recipient and subrecipient as including foreign and international organizations, including agencies of the United Nations. There are likely unique and severe compliance and certification burdens on international recipients and subrecipients, including, but not limited to with regard to translation and conflict with local law and policy. The proposed rule may directly conflict with the laws and policies of other countries where global health programs operate, putting those implementing the global health programs in an untenable position. For example, some countries may require health care providers to provide necessary care in emergency situations or information or referral for all legal health services - requirements that would be in direct conflict with this proposed regulation. The application of these requirements to UN agencies, such as the World Health Organization (WHO) with whom the Department works on issues like measles and polio, may be wholly unworkable given their missions and structures and could completely jeopardize the ability of these agencies to partner with the Department.

V. The proposed rule would cause chaos and confusion as it is inconsistent with federal and state laws designed to prohibit discrimination and increase people's access to care.

The Department claims that it is creating a regulatory scheme that is "comparable to the regulatory schemes implementing other civil rights laws." First, the proposal does not warrant the broad enforcement authority delegated to the newly created division within OCR. The proposed rule and underlying statutes are not civil rights laws, and the proposed rule seeks to grant OCR the authority to take enforcement actions. Further, the proposed rule is not consistent with civil rights laws as it fails to provide covered entities due process protections afforded under Title VI of the Civil Rights Act (Title VI). Finally, the proposed rule would create confusion as to the interaction with existing federal and state laws. In particular, the proposed rule does not explain how it interacts with Title VII of the Civil Rights Act (Title VII) and it undermines states' ability to require care.

A. The proposed rule provides expanded enforcement authority to OCR, while at the same time lacking necessary due process protections, such as those provided by Title VI.

While the proposed rule purports to model itself after "the general principles . . . enshrined in Title VI of the Civil Rights Act (Title VI)," it includes draconian enforcement provisions that are wildly out of sync with those in Title VI. Title VI requires a four step process before a federal agency may deny or terminate a recipient's federal funds: 1) the recipient must be notified that it has been found not in compliance with the statutes and that it can voluntarily comply; 2) the recipient must be afforded an opportunity for a hearing on the record and the agency must make an express finding of failure to comply; 3) the Secretary or head of the agency must approve the decision to suspend or terminate funds; and 4) the Secretary of the agency must file a report with the House and Senate legislative committees with jurisdiction over the applicable programs that explains the grounds for the agency's decision, and the agency may not terminate funds

until 30 days after the report is filed.[51] The proposed rule affords no such procedural due process for those accused, investigated, or those found in violation of the underlying requirements. In particular, if the proposed rule were to become law as is, then a recipient could have its financial assistance withheld in whole or in part, have its case referred to DOJ, or face a range of other unspecified actions – all without the opportunity to explain or defend its actions.

Additionally, Title VI clearly requires that an agency must engage in a concerted effort to obtain voluntary compliance *before* it may begin enforcement proceedings against an entity found to be in violation.[52] Specifically, federal law states that "effective enforcement of Title VI requires that agencies take prompt action to achieve voluntary compliance in all instances in which noncompliance is found."[53] The proposed rule loosely states that "OCR will inform relevant parties and the matter will be resolved informally wherever possible," and notes that while attempting to obtain this informal compliance, OCR can simultaneous engage in a range of enforcement actions.[54] This is not consistent with Title VI as it does not require the Department to attempt to achieve voluntary compliance from an entity *before* enforcement actions are taken.

Further, no guidance is given about the actions that would trigger each enforcement mechanism. For instance, would failure to meet the rule's requirement to post a notice result in millions of dollars of funds being withheld? Can failure to certify intention to comply with the rule result in a referral to DOJ? This proposed rule seems to allow OCR unlimited discretion to choose its enforcement mechanism -- including withdrawal of all federal funding and/or a referral to DOJ within any assurance that the Department's actions are proportionate to the violation. The Supreme Court has found government overreach when Congress authorized the Department to utilize federal financial assistance to control recipients' actions. Specifically, in *National Federation of Independent Business v. Sebelius*, the Supreme Court held that Congress exceeded its authority when it authorized the Department to withhold federal financial assistance from a state's Medicaid program if the state failed to expand the program's eligibility.[55] The Court explained if the Department withheld all federal funding from a state for failing to comply with conditions attached to the funding, then States would not have a "genuine choice whether to accept the offer" for funding.[56] Such financial inducement was found to be akin to a "gun to the head."[57] Therefore, the Department does not have unbridled authority to withhold federal financial assistance, and the Department's actions must be proportionate to the violation.

The enforcement actions contemplated under the proposed rule resulting from a formal or informal complaint are all the more problematic given that the entity may ultimately not be found in violation of the proposed rule's requirements. Covered entities subject to a "compliance review or investigation" must inform any Department funding component of such review, investigation, or complaint, and for five years, the entity must disclose on applications for new or renewed federal financial assistance or Department funding that it has been the subject of a

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[51] 42 U.S.C. § 2000d-1.

[52] 42 U.S.C. § 2000d-1.

[53] 28 C.F.R. § 42.411(a).

[54] 83 Fed. Reg. at 3930.

[55] National Federation of Independent Business v. Sebelius, 567 U.S. 519, 588 (2012).

[56] *Id.* at 584.

[57] *Id.* at 582.

review, investigation, or complaint.[58] This disclosure must be done even if the compliance reviews or investigations are found frivolous or do not lead to a finding of violation. The Department can conduct compliance reviews "whether or not a formal complaint has been filed." The Department is also "explicitly authorized to investigate 'whistleblower' complaints, or complaints made on behalf of others, whether or not the particular complainant is a person or entity protected by" the refusal laws.

The Department's sweeping enforcement authority, coupled with the lack of specific guidance to covered entities about what the proposed rule would require, places an unwarranted burden upon covered entities. The proposed rule is not consistent with Title VI - in particular, the rule does not offer due process and affords the Department complete discretion to impose penalties disproportionate to actions or alleged actions.

B. The proposed rule upsets the balance for religious objection long enshrined in law by Title VII.

For more than 50 years, Title VII has provided protections against religious discrimination.[59] In defining "discrimination" in a way that can be understood as both different from and far broader than it has long been understood, the Department has both exceeded its authority and caused confusion. In particular, the proposed rule does not clearly state that "discrimination" has the same limits as it does in the context of religious discrimination under Title VII and in particular that the "reasonable accommodation/undue hardship" framework for assessing if there has been "discrimination" also applies under the proposed rule. On its face, it is unclear if the proposed rule adopts Title VII's reasonable accommodation/undue hardship standard, or rather, creates a *per se* rule that allows employees' beliefs to take precedence over the needs and interests of health care providers and their patients under any circumstance.

Under Title VII and the case law interpreting it: [A]n employer, once on notice, [must] reasonably accommodate an employee whose sincerely held religious belief, practice or observance conflicts with a work requirement, *unless providing the accommodation would create an undue hardship, . . . [meaning] that the proposed accommodation in a particular case poses a "more than de minimis" cost or burden.*[60] Court cases that have addressed the issue of religious refusal have found that there are limits to what employers must do to accommodate refusals, and specifically that it is legal and appropriate for employers to prioritize maintaining patient access to care.[61] Additionally, years of case law interpreting religious accommodation

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[58] 83 Fed. Reg. at 3929–3930.

[59] 42 U.S.C. § 2000e(j).

[60] U.S. Equal Employment Opportunities Comm'n, Section 12: Religious Discrimination, Compliance Manual 46 (2008), *available at* http://eeoc.gov/policy/docs/religion.html [hereinafter EEOC Compliance Manual] (emphasis added).

[61] *See, e.g.*, *Walden v. Centers for Disease Control & Prevention*, 669 F.3d 1277 (11th Cir. 2012) (The plaintiff was employed as a counselor through CDC's employment assistance program, but refused to counsel people in same-sex relationships. After she was laid off, the court held that CDC "reasonably accommodated Ms. Walden when it encouraged her to obtain new employment with the company and offered her assistance in obtaining a new position"); *Bruff v. N. Miss. Health Servs.*, 244 F.3d 495, 501 (5th Cir. 2001) (the accommodation requested by plaintiff—a counselor who refused to counsel individuals on certain topics that conflicted with her religious beliefs—constituted an undue hardship

provisions of Title VII has made clear that an accommodation should not place an unfair load on co-workers.[62] Finally, case law has made it clear that "Title VII does not require an employer to reasonably accommodate an employee's religious beliefs if such accommodation would violate a federal statute."[63] The proposed rule fails to give any consideration to this binding precedent or suggest why "discrimination" should be given any different meaning in the context of the refusal laws.

By requiring a balancing of interests between the employee, the employer, and the employer's clients, Title VII ensures that accommodating the religious beliefs of an employee in the health care field does not harm patients by denying them health care and/or health care information. Title VII also avoids placing employers in the untenable position of having employees on staff who will not fulfill core job functions. The Department has ignored that balancing, undermining its stated goal to "ensure knowledge, compliance, and enforcement of the Federal health care conscience and associated antidiscrimination laws."[64] In so doing, the Department should bear in mind that a decision not to incorporate the Title VII reasonable accommodation/undue hardship balancing would lead to absurd and disastrous results. For example, a health care provider could be forced to hire employees who refuse to be involved in medical services that form the core of the medical care it offers. The Department should also bear in mind Executive Order 13563's injunction, which as the Department notes requires it to "avoid creating redundant, inconsistent, or overlapping requirements applicable to already highly-regulated industries and sectors."

The ability of health care employers to continue providing medically appropriate services and information would be significantly compromised if they are forced to operate under a rule which could be understood to compel them to hire, retain, and/or not transfer employees who refuse to provide medically necessary health services and information to patients -- or face a possible penalty of loss of all federal funding.

C. The proposed rule limits states' authority to increase health care access for their citizens.

This rule would undermine states' ability to protect and expand health care access. States have an important role to play when addressing the harm from denials of health care. State laws that require institutions to provide information, referrals, prescriptions, or care in the event of a life or health risk are vital safeguards for individuals who might be impacted by religious refusals. The expansion of the Weldon and Church Amendments through new definitions and a

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because it would have required her co-workers to assume her counseling duties whenever she refused to do so, resulting in a disproportionate workload on co-workers); *see also Haliye v. Celestica Corp.*, 717 F. Supp. 2d 873, 880 (D. Minn. 2010) ("when an employee has a religious objection to performing one or more of her job duties, the employer may have to offer very little in the way of an accommodation—perhaps nothing more than a limited opportunity to apply for another position within the organization") (citing Bruff).

[62] *See, e.g., Tagore v. United States*, 735 F.3d 324, 330 (5th Cir. 2013) ("more than de minimis adjustments could require coworkers unfairly to perform extra work to accommodate the plaintiff"); *Harrell v. Donahue*, 638 F.3d 975, 980 (8th Cir. 2011) ("an accommodation creates an undue hardship if it causes more than a de minimis impact on co-workers").

[63] *Yeager v. First Energy Generation Corp.*, 777 F.3d 362, 363 (6th Cir. 2015).

[64] 83 Fed. Reg. at 3887.

reinterpretation of existing law could render useless any existing or future state laws that protect patients and consumers.

The Department makes it clear that there are certain types of state laws that they seek to eliminate by reinterpreting the federal refusal laws. For example, the Department clearly wants to undermine state laws that require coverage of abortion. To do so, the Department not only reverses their position on the application of the Weldon amendment, but actually changes the existing (and statutory) definition of "health care entity" so as to include plan sponsors and third party administrators. This will mean more individuals are covered under the statute. The Department has previously rejected this interpretation noting "by its plain terms, the Weldon Amendment's protections extend only to health care entities and not individuals who are patients of, or institutions, or individuals that are insured by such entities."[65]

The Department also highlights state laws that require crisis pregnancy centers to provide information or referrals, as well as state laws and previous lawsuits that seek to require the provision of health care by an institution when a patient's health or life is at risk. The Department clearly wishes to contort the federal refusal laws to address state laws that it finds objectionable. If Congress had wanted to prohibit federal, state, and local governments from ever requiring health care entities to provide, pay for, cover, or refer for abortions, it could easily have done so. The Department now reinterprets these laws to attempt to limit the reach of state laws that protect patients from harmful denials of health care, including laws that simply require referrals to another provider.

The proposed rule invites those who oppose access to reproductive health to make OCR complaints by allowing any individual to file a complaint, whether or not they are the subject of any potential violation. This may have a chilling effect on states' willingness to enforce their own laws. The uncertainty regarding whether enforcement of state laws is "discrimination," especially as to health care entities that refuse to provide medical services or insurance coverage for reasons other than moral or religious reasons, would inhibit states' ability to increase access and provide for the well-being of their citizens. The negative effects of such confusion and uncertainty in our public health care system would certainly fall disproportionately on the millions of people in this country who already experiences barriers to health care access and worse health outcomes, including but not limited to women, LGBTQ people, and people living with HIV.

VI. The proposed rule fails to properly account for the enormous costs it would impose on providers, patients, and the public.

The Department purports to have conducted an economic analysis for the proposed rule, as required by Executive Order 12866 as well as the Regulatory Flexibility Act, but that analysis is deficient in at least two respects.[66] First, and critically, the Department's analysis ignores entirely the cost to patients of reduced access to health care, fewer health care options, less

[65] Letter from Jocelyn Samuels, Director, Office for Civil Rights to Catherine Short, Life Legal Defense Foundation et. al. re: OCR Transaction Numbers: 14-193604, 15-193782, & 15-195665 (June 21, 2016), http://www.adfmedia.org/files/CDMHCInvestigationClosureLetter.pdf.

[66] That Act requires an analysis of a rule's effects on small businesses, including non-profits. The proposed rule's analysis at 83 Fed. Reg. 3918 is inadequate because as explained below it radically underestimates costs. And while the proposed rule notes that some entities are exempted from some requirements based on cost concerns, it fails to explain why those exemptions (which at any rate would not mitigate the costs described below) were so limited.

comprehensive medical information, impeded ability for patients to make their own health care choices, and interference with provider-patient relationships.[67] Also contrary to Executive Order 12866, it fails to account for how these costs are distributed, e.g. whether they will fall disproportionately on women, rural residents, individuals with low incomes, people of color, LGBTQ people, and people living with HIV. It fails to account for the public health costs associated with reduced patient access to medical information, contraception, abortion, and other reproductive health care, or delays in accessing care due to refusals. Thus, it clearly fails multiple requirements under Executive Order 12866, including the requirement that the Department analyze "any adverse effects on the efficient functioning of the economy, private markets (including productivity, employment, and competitiveness), health, safety, and the natural environment), together with, to the extent feasible, a quantification of those costs."

Second, the Department's estimate of costs that the rule imposes on health care providers is far too low. Given the new burdensome notice and attestation policies, it is unrealistic to think that health care providers -- who as of 2015, employed more than 12 million employees -- would be able to adjust all of their policies, train all of their hiring managers, and ensure and document compliance with the proposed rules, for less than $1000 the first year and less than $900 in subsequent years.[68] Moreover, the Department's cost analysis ignores entirely the enormous cost imposed on health care providers if they were required to employ people unwilling to fulfill job functions necessary to deliver care.

Therefore, the Department's estimate that the proposed rule would cost over $812 million dollars within the first five years is inadequate.[69] But even if it would *only* cost the amount estimated by the Department (which it would not), that sum could be far better used to *provide* health care to individuals and correct inequities in the health care system. While the Department claims the rule is required to "vindicate" the religious or moral conscience of health care providers, significant portions of the proposed rule have nothing to do with the Department's purported motivation. Rather, certain sections give license to HMOs, health insurance plans, or any other kind of health care organization to refuse to pay for, or provide coverage of necessary abortion services for any reason—even financial.[70] These provisions do not protect anyone's conscience, they simply undercut providers' ability to deliver care and consumers' ability to obtain and pay for medical services. The limited resources of the Department and health care providers should be better spent.

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We strongly urge the Department to withdraw this rule. In 2011, the Department withdrew a

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[67] The Department claims that the rule provides non-quantifiable benefits, such as more diverse and inclusive workforce, improved provider patient relationships; and equity, fairness, and non-discrimination. This proposed rule would in fact lead to the exact opposite of these intended benefits. While the Department claims to be protecting the psychological, emotional, and financial well-being of health care workers who refuse to provide care, the proposed rule does not mention the psychological, emotional, or financial harms to patients of well-being associated with being denied access to care.

[68] Kaiser Family Foundation, State Facts: Total Health Care Employment (May 2015), https://www.kff.org/other/state-indicator/total-health-care-employment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[69] The economic analysis estimates the cost at $312 million dollars in year one alone and over $125 million annually in years two through five. And those estimates are based on "uncertain" assumptions that the costs would decrease after five years. 83 Fed. Reg. at 3902.

[70] 83 Fed. Reg. at 3925.

similar rule that was enacted in 2008 noting that the 2008 rule attempting to clarify existing laws had "instead led to greater confusion." This rule has the potential to cause even more confusion and, more egregiously, to reduce access to critical health care even more severely than the 2008 rule. It would jeopardize many people's health and lives. Planned Parenthood strongly urges the Department to follow the law and withdraw this dangerous rule.

Respectfully,

Dana Singiser
Vice President of Public Policy and Government Relations
Planned Parenthood Action Fund
Planned Parenthood Federation of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005

Exhibit 114

March 27, 2018
U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945–ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

VIA ELECTRONIC SUBMISSION

Re: Comments on Notice of Proposed Rule on Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (Docket No.: HHS–OCR–2018–0002)

We are writing to express our deep concern and full opposition to the Notice of Proposed Rulemaking ("the proposed rule" or "the NPRM") on Protecting Statutory Conscience Rights in Health Care, published by the Department of Health and Human Services ("HHS") on January 26, 2018. HHS' proposed rule clearly aims to limit access to healthcare services, including reproductive healthcare services, by grossly mischaracterizing and expanding federal healthcare refusal laws at the expense of patient care. We strongly urge HHS to withdraw this NPRM in its entirety.

Since 1992, the Center for Reproductive Rights has used the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past 26 years have expanded access to reproductive healthcare around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetrics care, contraception, safe abortion services, and comprehensive sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where every woman is free to decide whether or when to have children and whether or when to get married; where access to quality reproductive healthcare is guaranteed; and where every woman can make these decisions free from coercion or discrimination.

As articulated below, this NPRM should be withdrawn in its entirety because:

- It proposes expanding religious and moral refusal laws without protecting access to care, which historically has harmed women,
- LGBTQ individuals, and marginalized communities;
- It violates the Administrative Procedure Act on multiple grounds, including by severely and repeatedly exceeding the parameters and authority of the federal refusal laws it purports to enforce;
- It harmfully prioritizes healthcare provider objections over patient care; and
- It is unconstitutional.

I. The Misapplication and Misuse of Healthcare Refusal Laws Harms Women and Marginalized Individuals and Violates International Human Rights Law.

A. Where religious and moral refusal laws are implemented without protecting access to healthcare, including reproductive healthcare, women are harmed.

The proposed rule attempts to expand religious and moral refusal laws at the expense of ensuring access to care. In general, religious and moral refusal laws allow an individual to opt out of providing a specific healthcare service on religious or moral grounds. Because religious and moral refusals to healthcare inherently create an impediment to the provision of healthcare, refusals must be balanced with the patient's right to receive a healthcare service or benefit, and should be implemented in a way that ensures the patient's right to care is protected.[1] This principle is protected and advanced by numerous laws, including the Emergency Medical Treatment and Labor Act (EMTALA), international human rights standards,[2] and professional standards set by various medical associations, such as the American College of Obstetricians and Gynecologists and the American Medical Association.[3]

When implemented without balancing, religious and moral refusal laws can be and have been exploited to limit access or deny care, particularly in the field of reproductive healthcare. Refused services include access to safe pregnancy termination, miscarriage management, and contraception, which are all necessary to ensure women's health and wellbeing.

Where healthcare entities prioritize refusals without also ensuring access to care, they risk the health and safety of patients. For example, researchers have documented numerous instances in which the Ethical and Religious Directives ("the Directives") at Catholic hospitals have led hospital administrators to prohibit doctors from treating patients. Rape survivors have been denied access to and information about emergency contraception at hospitals that prioritize religious concerns over patient wellbeing. Likewise, pharmacists with religious objections have denied women emergency contraception,[4] making it impossible for some women to obtain emergency contraception in time to prevent pregnancy.[5]

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[1] The Supreme Court has held in the past that religious exemptions must be balanced against the impact on women's healthcare. In Zubik v. Burwell, the Court ordered the parties to resolve their cases in a way that ensured there would be *no* impact on women's access to seamless contraceptive coverage. Zubik v. Burwell, 136 S. Ct. 1557, 1560 (2016). Similarly, Burwell v. Hobby Lobby rejected the notion that for-profit corporations' religious beliefs must be accommodated regardless of the impact—specifically noting that the new accommodation would have an impact on women that "would be precisely zero." Burwell v. Hobby Lobby, 134 S. Ct. 2751 (2014).

[2] Brief for foreign and international law experts, Lawrence O. Gostin, et al. as Amici Curiae supporting respondents, Zubik v. Burwell, 136 S. Ct. 1557 (2016) (Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, and 15-191), http://www.scotusblog.com/wp-content/uploads/2016/02/02.17.16_amicus_brief_in_support_of_respondents-_crr.pdf.

[3] The American College of Obstetricians and Gynecologists and the American Medical Association both recognize a duty to refer in order to safeguard patients' rights and access to certain reproductive healthcare. *See, e.g.,* American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 385: The limits of conscientious refusal in reproductive medicine*, 2007, https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine ("Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request."); American Medical Association, *AMA Code of Medical Ethics Opinion 1.1.7: Physician Exercise of Conscience*, https://www.ama-assn.org/delivering-care/physician-exercise-conscience ("In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.").

[4] Pharmacists in at least twenty-four states have refused to sell birth control or emergency contraception to women. *See* Gretchen Borchelt, *Pharmacists Can't Be Allowed to Deny Women Emergency Contraception*, U.S. NEWS & WORLD REPORT, Oct. 15, 2012, http://www.usnews.com/opinion/articles/2012/10/15/pharmacists-cant-be-allowed-to-deny-women-emergency-contraception.

[5] *See* Catholics for Choice (formerly Catholics for a Free Choice), *Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms* (Jan. 2002), http://www.catholicsforchoice.org/wp-content/uploads/2013/12/2002secondchancedenied.pdf.

Similarly, a study of care for ectopic pregnancies concluded that some Catholic hospitals, based on the Directives, were "precluding physicians from providing women with ectopic pregnancies with information about and access to a full range of treatment options [. . .] resulting in practices that delay care and may expose women to unnecessary risks."[6] And in one case of miscarriage mismanagement, a woman named Tamesha Means was sent home twice by a Catholic hospital, even though her water had broken after only 18 weeks of pregnancy and she was in excruciating pain.[7] The hospital justified its denial of care based on a Directive prohibiting pre-viability pregnancy termination. Even when Tamesha returned for the third time, now presenting with an infection, the hospital denied her care until she began to deliver, when the hospital finally tended to her miscarriage. [8]

Mis-implementation of refusal laws may also result in severe sanctions for those who prioritize patient care over religious concerns. In a widely-reported case, a Catholic hospital provided an abortion to a woman whose risk of mortality was "close to 100 percent" if she continued the pregnancy.[9] The hospital administrator, Sister Margaret McBride, was promptly excommunicated,[10] and the diocese stripped the hospital of its Catholic affiliation.[11] The U.S. Conference of Catholic Bishops supported the sanctions and issued a memo confirming that the Directive in question does not permit the direct termination of a pregnancy—even to save a woman's life.[12]

The prioritization and exploitation of refusals over patient care, even in emergency situations, has already resulted in harm to women who are deprived of healthcare, especially reproductive healthcare. The NPRM dangerously continues in this vein by failing to address the impacts on patient care, and may exacerbate the types of harm described above. The NPRM should therefore be withdrawn in its entirety.

B. Religious and moral refusal laws disproportionately affect marginalized individuals, including economically disadvantaged women, rural women, and LGBTQ individuals.

By significantly expanding the reach of federal refusal laws without guaranteeing access to care, the proposed rule threatens harm to all patients, but may particularly increase the risk of

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[6] A.M. Foster et al., *Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study (Abstract)*, 21 WOMEN'S HEALTH ISSUES (Mar.-Apr. 2011), http://www.ncbi.nlm.nih.gov/pubmed/21353977.

[7] ACLU, *Tamesha Means v. United States Conference of Catholic Bishops*, updated June 30, 2015, https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops?redirect=reproductive-freedom-womens-rights/tamesha-means-v-united-states-conference-catholic-bishops.

[8] In another example, a patient who was 19 weeks pregnant presented with a miscarriage. Instead of providing a uterine evacuation, the Catholic hospital transferred her to a tertiary medical center and refused to provide medical care even when she became septic with a 106-degree fever—all because a fetal heartbeat could still be discerned. *See* Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774 (2008), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.

[9] Barbara Bradley Hagerty, *Nun Excommunicated for Allowing Abortion*, NPR, May 19, 2010, http://www.npr.org/templates/story/story.php?storyId=126985072.

[10] Id. Ms. McBride has since regained good standing with the Catholic Church. *McBride un-excommunicated*, AMERICA MAGAZINE, Dec. 14, 2011.

[11] Dan Harris, *Bishop Strips Hospital of Catholic Status After Abortion,* ABC NEWS, Dec. 22, 2010, http://abcnews.go.com/Health/abortion-debate-hospital-stripped-catholic-status/story?id=12455295.

[12] U.S. Conference of Catholic Bishops, *The Distinction between Direct Abortion and Legitimate Medical Procedures* (June 23, 2010), http://www.usccb.org/about/doctrine/publications/upload/direct-abortion-statement2010-06-23.pdf.

exploitation and abuse of refusals at the expense of marginalized individuals. While an objecting provider presents an obstacle to any patient, it may impose a particularly challenging burden on marginalized individuals. Economically disadvantaged women, rural women, and LGBTQ individuals already face barriers to care, including limited financial means, language and cultural differences, medical providers' unconscious biases, historic discrimination, and geography.[13] And now a healthcare provider's religiously motivated refusal to provide care may force a patient to choose between foregoing care or taking on the burden of locating and traveling to a non-refusing provider.

An individual who needs to plan a new visit to a non-objecting provider will often need a flexible work schedule and faces added transportation and child care costs. This creates an additional hardship, especially for economically disadvantaged women.[14] In rural areas, the closest non-objecting provider may be located far away. For example, after being denied emergency contraception by her local pharmacist, a woman in Ohio was forced to drive 45 miles to another pharmacy in order to obtain it.[15] Many women in similar situations do not have the means to make these additional trips.[16] The impact of refusals therefore falls heavily on rural women, who are four times more likely to reside in medically underserved areas.[17] Reproductive health services are especially difficult for them to access, since obstetrics/gynecologic services and other medical specialties are even less common in rural settings.[18] The inappropriate expansion of refusals under the NPRM will undoubtedly exacerbate this harm.

LGBTQ individuals also face particularly acute barriers to receiving the healthcare they need, which are compounded by religious and moral refusal laws. Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other healthcare provider had refused to see them because of their actual or perceived sexual orientation in the year before the survey.[19] 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 healthcare they need at another hospital if they were turned away.[20] 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.[21] When they are able to access care, many individuals report "that health care professionals have used harsh language towards them, refused to touch them or used excessive precaution, or blamed the individuals for their health

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[13] American College of Obstetricians and Gynecologists, *Committee Opinion No. 516: Health Care Systems for Underserved Women* (Jan. 2012), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-Systems-for-Underserved-Women.

[14] *See, e.g.*, Kaiser Family Foundation, *Women and Health Care: A National Profile* 24 (July 2005), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/women-and-health-care-a-national-profile-key-findings-from-the-kaiser-women-s-health-survey.pdf.

[15] Gretchen Borchelt, *Pharmacists Can't Be Allowed to Deny Women Emergency Contraception*, U.S. NEWS & WORLD REPORT, Oct. 15, 2012, http://www.usnews.com/opinion/articles/2012/10/15/pharmacists-cant-be-allowed-to-deny-women-emergency-contraception.

[16] Id.

[17] *See* National Women's Law Center, *Fact Sheet: If You Care about Religious Freedom You Should Care about Reproductive Justice!* (2014), https://nwlc.org/resources/if-you-care-about-religious-freedom-you-should-care-about-reproductive-justice/, (citing U.S. Department of Health & Human Services, *Facts about . . . Rural Physicians*, http://www.shepscenter.unc.edu/rural/pubs/finding_brief/phy.html).

[18] Id.

[19] *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, NATIONAL GAY AND LESBIAN TASK FORCE & NATIONAL CTR. FOR TRANSGENDER EQUALITY (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

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

[21] Id.

status."[22] Nearly one-quarter of transgender individuals report delaying or avoiding medical care when sick or injured, at least partially due to medical providers' discrimination and disrespect.[23]

The proposed expansion of federal refusal laws' reach will fall hardest on these populations, which already face hurdles in accessing care. As a result, the proposed rule may result in even more marginalized individuals being harmed as a result of not being able to obtain needed healthcare. Therefore, the NPRM should be withdrawn in its entirety.

C. The NPRM's proposed interpretation of religious and moral refusal laws violates international human rights laws and standards.

International human rights law requires that conscientious objections are permitted only to the extent that they do not infringe on others' access to healthcare. This requires the government to ensure that healthcare personnel's refusals to provide reproductive healthcare, including abortion care, on grounds of conscience do not jeopardize women's access to reproductive healthcare. Indeed, international human rights bodies have consistently noted the need for governments to strike a balance between protecting the right to demonstrate one's freedom of conscience and the right of women to obtain safe and legal reproductive health services. By expanding religious and moral refusals while completely failing to address how patient care will still be protected, the proposed rule violates international law.

While international human rights standards recognize the right of medical personnel to conscientiously object to the provision of sexual and reproductive health services, the exercise of this right cannot constitute a barrier to the effective enjoyment of sexual and reproductive rights. United Nations (UN) human rights treaty monitoring bodies have explicitly specified that, at a minimum, regulatory frameworks must ensure an obligation on healthcare providers to refer women to alternative health providers in a timely manner,[24] must not allow institutional refusals of care,[25] and must guarantee that an adequate number of healthcare providers willing and able to provide abortion services are available at all times in health facilities and within reasonable

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[22] National Women's Law Center, *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS,* May 2014, http://www.nwlc.org/sites/default/files/pdfs/lgbt_refusals_factsheet_05-09-14.pdf (citing 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/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf).

[23] National Center for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey: Executive Summary* 3 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf; National Women's Law Center, *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS,* May 2014, http://www.nwlc.org/sites/default/files/pdfs/lgbt_refusals_factsheet_05-09-14.pdf (citing Jaime M. Grant, et. al., *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, NATIONAL GAY AND LESBIAN TASK FORCE & NATIONAL CTR. FOR TRANSGENDER EQUALITY (2011), http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf (internal quotations omitted)).

[24] *See, e.g.*, Report of the Committee on the Elimination of Discrimination Against Women, General Recommendation No. 24, 20th-21st Sess., Jan. 19-Feb. 5, June 7-25, 1999, ch. I, ¶ 11, U.N. Doc. A/54/38/Rev.1, GAOR, 44th Sess., Supp. No. 38 (1999) [hereinafter CEDAW, General Recommendation No. 24]; Committee on Economic, Social, and Cultural Rights, General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), ¶¶ 14, 43, U.N. Doc. E/C.12/GC/22 (May 2, 2016) [hereinafter CESCR, General Comment No. 22]; Committee on the Elimination of Discrimination Against Women, Concluding Observations on the Combined Fourth and Fifth Periodic Reports of Croatia, ¶ 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (July 28, 2015); Committee on the Elimination of Discrimination Against Women, Concluding Observations on the Combined Seventh and Eighth Periodic Reports of Hungary, 54th Sess., Feb. 11-Mar. 1, 2013, ¶¶ 30-31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (Mar. 1, 2013); Committee on Economic Social, and Cultural Rights, Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant (Poland), 43d Sess., Nov. 2-20, 2009, ¶ 28, U.N. Doc. E/C.12/POL/CO/5 (Dec. 2, 2009). *See also* Committee on the Elimination of Discrimination Against Women, Concluding Observations on the Seventh Periodic Report of Italy, ¶¶ 41-42, U.N. Doc. CEDAW/C/ITA/CO/7 (July 24, 2017).

[25] *See* Committee on the Rights of the Child, Concluding Observations on the Combined Third to Fifth Periodic Reports of Slovakia, ¶ 41(f), U.N. Doc. CRC/C/SVK/CO/3-5 (July 20, 2016).

geographical reach.[26] In addition, any regulations must ensure that allowing conscientious objections does not inhibit the performance of services in urgent or emergency situations.[27]

For example the UN Human Rights Committee, which is charged with interpreting and monitoring countries' implementation of the International Covenant on Civil and Political Rights ("ICCPR"), has affirmed that governments must ensure that medical professionals' refusals to provide abortion care on grounds of conscience do not impede women's access to legal abortion services.[28] The United States has ratified the ICCPR, meaning that the United States is obligated to comply with and implement the provisions of the treaty subject to any reservations. The UN Human Rights Committee and the UN Committee on Economic, Social and Cultural Rights ("CESCR Committee") have found that states must introduce regulations and implement appropriate referral mechanisms in cases of provider conscientious objection.[29] The Committee on the Elimination of All Forms of Discrimination Against Women[30] has echoed the need for adequate referral mechanisms and has noted that "[i]t is discriminatory for a state party to refuse to provide legally for the performance of certain reproductive health services for women."[31] Similar findings have also been reached by other UN human rights experts.[32] Likewise, the European Court of Human Rights has found that states are obligated to organize health services in such a way as to ensure that conscience-based refusals do not prevent women from obtaining reproductive health services, including abortion services, to which they are legally entitled.[33]

UN human rights experts have noted the United States' particular obligations in this regard. While conducting a fact-finding visit to the country in 2015, the UN Working Group on Discrimination Against Women examined U.S. federal and state policies and found that they do not adequately protect women's access to reproductive health services. The Working Group's report on the visit provided recommendations for improving efforts to eliminate discrimination and reiterated that:

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[26] Committee on Economic, Social, and Cultural Rights, General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), ¶¶ 14, 43, U.N. Doc. E/C.12/GC/22 (May 2, 2016).
[27] Id., at ¶ 43.
[28] Human Rights Committee, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant (Poland), 100th Sess., Oct. 11-29, 2010, ¶ 12, U.N. Doc. CCPR/C/POL/CO/6, (Nov. 15, 2010); Human Rights Committee, Concluding Observations on the Seventh Periodic Report of Poland, ¶¶ 23-24, U.N. Doc. CCPR/C/POL/CO/7 (Nov. 23, 2016).
[29] *See* Human Rights Committee, Concluding Observations on the Sixth Periodic Report of Italy, ¶¶ 16-17, U.N. Doc. CCPR/C/ITA/CO/6 (May 1, 2017); Human Rights Committee, Concluding Observations on the Seventh Periodic Report of Colombia, ¶¶ 20-21, U.N. Doc. CCPR/C/COL/CO/7 (Nov. 17, 2016); Committee on Economic, Social and Cultural Rights, Concluding Observations on the Sixth Periodic Report of Poland, ¶¶ 46-47, U.N. Doc. E/C.12/POL/CO/6 (Oct. 26, 2016). *See also* Human Rights Committee, Concluding Observations on the Seventh Periodic Report of Poland, ¶¶ 23-24, U.N. Doc. CCPR/C/POL/CO/7 (Nov. 23, 2016).
[30] Although the United States has not yet ratified the Convention on the Elimination of All Forms of Discrimination Against Women or the International Covenant on Economic, Social, and Cultural Rights, as a signatory, it nevertheless has international obligations with respect to each. Michael H. Posner, Assistant Sec'y of State, Bureau of Democracy, Human Rights, and Labor, *Address to the American Society of International Law: The Four Freedoms Turn 70* (Mar. 24, 2011) (transcript available at https://2009-2017.state.gov/j/drl/rls/rm/2011/159195.htm) ("While the United States is not a party to the [ICESCR], as a signatory, we are committed to not defeating the object and purpose of the treaty."). Specifically, a country that has signed a treaty has an obligation "to refrain from acts which would defeat the object and purpose of a treaty" until it expresses its intention not to become a party. Vienna Convention on the Law of Treaties art. 18, Jan. 27, 1980, 1155 U.N.T.S. 331. While the United States is not a party to the Vienna Convention, it recognizes that many of the Convention's provisions have become customary international law and has signaled its intention to abide by the principles contained in treaties it has signed. *See Vienna Convention on the Law of Treaties*, U.S. DEP'T OF STATE, http://www.state.gov/s/l/treaty/faqs/70139.htm.
[31] Report of the Committee on the Elimination of Discrimination Against Women, General Recommendation No. 24, 20th-21st Sess., Jan. 19-Feb. 5, June 7-25, 1999, ch. I, ¶ 11, U.N. Doc. A/54/38/Rev.1, GAOR, 44th Sess., Supp. No. 38 (1999).
[32] *See* Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, ¶¶ 24, 65(m), U.N. Doc. A/66/254 (Aug. 3, 2011).
[33] *See* R.R. v. Poland, No. 27617/04 Eur. Ct. H.R (2011); P. and S. v. Poland, No. 57375/0 Eur. Ct. H.R. (2012).

> [l]aws on religious or conscience based refusals to provide reproductive health care in the United States should be reconciled with international human rights standards. Refusal to provide sexual and reproductive health services on the grounds of religious freedom should not be permitted where such refusal would effectively deny women immediate access to the highest attainable standard of reproductive health care and affect the implementation of rights to which they are entitled under both international human rights standards and domestic law.[34]

The NPRM moves in the opposite direction of the recommendations, and instead prioritizes religious and moral refusals at the cost of patients' well-being by allowing a healthcare entity's moral or religious beliefs to supersede a patient's access to healthcare. Furthermore, the proposed rule appears to allow healthcare entities to refuse to provide information about available healthcare options, without disclosing the fact that they are choosing to withhold some information to patients, thus lacking safeguards to ensure continuity of quality patient care when a provider objects on religious or moral grounds.

In addition to attempting to allow providers to refuse to provide care or information without any consideration of patient needs, the NPRM, as further explained below, expands the scope of who can lodge a complaint alleging a violation of religious and moral beliefs to the HHS Office for Civil Rights ("OCR"), what practices or policies they can complain about, and the consequences of such complaints against providers and healthcare institutions. This dangerous expansion will create a chilling effect on providers of certain types of healthcare, leading to further reductions in healthcare access. The NPRM should therefore be withdrawn in its entirety.

II. The Proposed Rule Violates the Administrative Procedure Act

The proposed rule violates the Administrative Procedure Act ("APA") on multiple grounds. Not only does the NPRM suffer from several procedural defects, HHS fails to justify the proposed rule based on underlying facts and data, and it fails to engage in an appropriate cost-benefit analysis. Moreover, the proposed rule is arbitrary and capricious, an abuse of discretion, and not in accordance with law, because it mischaracterizes and inappropriately expands the scope of underlying federal refusal laws. For all of these reasons, HHS must withdraw the proposed rule in its entirety.

A. The proposed rule exhibits procedural flaws under the APA and the Paperwork Reduction Act (PRA).

Under the APA, "agency action, findings, and conclusions found to be . . . without observance of procedure required by law" shall be "held unlawful and set aside."[35] The NPRM suffers from multiple procedural defects. First, HHS failed to include any mention of an intent to regulate on this issue within the Unified Regulatory Agenda, as required by Executive Order 12866.[36]

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[34] Human Rights Council, 33d Sess., Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice on Its Mission to the United States of America, ¶¶ 71, 95(i), U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).
[35] 5 U.S.C.§ 706(2)(D).
[36] Exec. Order No. 12866, 58 F.R. 51735 at Sec. 4(b)-(c) (Oct. 4, 1993).

Through this omission, HHS failed to put impacted entities, including other federal agencies, on notice of possible rulemaking in this area.

Second, prior to publication in the Federal Register, rules must be submitted to the Office of Information and Regulatory Affairs ("OIRA") within the Office of Management and Budget ("OMB") to provide "meaningful guidance and oversight so that each agency's regulatory actions are consistent with applicable law…and do not conflict with the policies or actions of another agency."[37] According to OIRA's website, HHS submitted the proposed rule to OIRA for review on January 12, 2018, one week prior to the proposed rule being issued in the Federal Register.[38] Standard review time for OIRA is upward of 45 days (and often closer to 90 days).[39] One week was plainly insufficient time for OIRA to review the proposed rule and provide "meaningful guidance and oversight."

In particular, it is extremely unlikely that within that one-week timeframe, OIRA could or would have conducted the interagency review necessary to ensure that this proposed rule does not conflict with other federal statutes or regulations. This is evidenced by the NPRM lacking key review and analysis on how the notice and compliance requirements interact with existing law such as EMTALA (discussed in more detail in Section IV. B. of this comment) or Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination based on race, color, religion, sex and national origin. In promulgating a regulation that is inconsistent with federal statutes and regulations, HHS engaged in arbitrary and capricious rulemaking, and their conduct was further compounded by a complete failure by OIRA to engage in appropriate review.

Finally, the proposed rule would also impose burdens that are inconsistent with the Paperwork Reduction Act ("PRA"). The PRA was in part established to minimize the federal paperwork burden for individuals, small businesses, and state, local, and tribunal governments; minimize the cost of collecting and disseminating information; and maximize the usefulness of the information collected by the federal government.[40] For paperwork that is required by any new regulations, agencies must minimize the burden on the public to the extent "practicable"[41] and must obtain OMB approval before requesting or collecting most types of information from the public. This NPRM requires recipients and sub-recipients to post a new notice, as well as requiring certain assurances and certifications from recipients. The costs associated with the paperwork burden created by the proposed rule could be substantial, and the practical utility of the information that HHS seeks may be negligible to the proper performance of the functions of HHS, but it is not clear that OMB has even analyzed the impacts of the NPRM under the PRA.[42]

B. This proposed rule violates the APA because it is not justified by underlying facts and data, and it fails to engage in an appropriate cost-benefit analysis.

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[37] Id. at Sec. 6(b).
[38] OIRA Conclusion of EO 12866 Regulatory Review, *Ensuring Compliance with Certain Statutory Provisions in Health Care; Delegations of Authority*. HHS/OCR. RIN: 0945-ZA03. Received date: 01/12/18. Concluded date: 01/19/18, https://www.reginfo.gov/public/do/eoDetails?rrid=127838.
[39] Exec. Order No. 12866, 58 FR 51735 at Sec. 6(b) (Oct. 4, 1993).
[40] 44 U.S.C. § 3501.
[41] 44 U.S.C. § 3507 (a)(1).
[42] The NPRM currently lacks a PRA control number, which would notify the public that OMB has approved the rule's information collection requirements under the Paperwork Reduction Act of 1995.

Under the APA, "agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" shall be set aside.[43] An agency must provide "adequate reasons" for its rulemaking, in part by "examin[ing] the relevant data and articulat[ing] a satisfactory explanation for its action including a rational connection between the fact found and the choice made."[44] The proposed rule is arbitrary and capricious because HHS failed to consider relevant data and articulate a satisfactory basis for the promulgation of this NPRM. As stated in the proposed regulation itself, HHS OCR only received ten complaints based on religious and moral refusal laws from 2008 to 2016, and only 34 complaints from November 2016 to early January 2018. These numbers pale in comparison to the total number of complaints OCR receives annually alleging civil rights violations and Health Insurance Portability and Accountability Act ("HIPAA") violations. For example, from Oct 1, 2016 through Sept. 30, 2017, OCR received approximately 30,166 complaints.[45] If 34 of them were complaints alleging a violation of religious or moral exemption laws, that constitutes less than one percent of the total volume. These data do not justify or support the NPRM, nor the related addition of a new office dedicated exclusively to these types of complaints.

Further, as the proposed rule details, under the existing regulatory scheme, HHS already investigates complaints, and has found violations and negotiated resolutions. The evidence of past enforcement where complaints were filed and violations found confirms there is no lack of enforcement here that would warrant rulemaking. In addition, HHS' existing grant-making documents already "make clear that recipients are required to comply with the federal health care provider conscience protection laws."[46] The proposed rule is therefore arbitrary and capricious because it is not justified by relevant data or facts.

Additionally, this NPRM is arbitrary and capricious because it fails to adequately assess the costs imposed by this proposed rule by underestimating certain quantifiable costs and completely ignoring the significant additional costs that would result from delayed or denied care. Executive Order 13563 requires that each agency make a "reasoned determination that its benefits justify its costs."[47] It also states that "each agency is directed to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible."[48] But this NPRM makes no attempt to conduct a reasoned cost-benefit analysis. For example, the cost-benefit analysis provides no quantifiable benefit for the rule's very purpose—expanding religious and moral refusal rights—as HHS could not find any quantifiable data to support the purported benefit of such an expansion.

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[43] 5 U.S.C.A. § 706(2)(A).
[44] Encino Motorcars, LLC v. Navarro, 136 S. Ct. 2117, 2125 (June 20, 2016) (citing Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co., 463 U.S. 29, 103 (1983)). Typically, a court will find an agency action to be arbitrary and capricious if the agency "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983) (internal citations omitted); Envtl. Def. Fund, Inc. v. Costle, 657 F.2d 275, 283 (D.C. Cir. 1981) ("While we are admonished from rubber stamping agency decisions as correct, our task is complete when we find that the agency has engaged in reasoned decisionmaking within the scope of its Congressional mandate.") (internal citations and quotations omitted).
[45] U.S. Department of Health and Human Services FY19 Budget in Brief 124, https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf.
[46] Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 76 Fed. Reg. 9968, 9972 (2011).
[47] Exec. Order No. 13563, 76 FR 3821 at Sec. 1(b) (Jan. 18, 2011).
[48] Id. at Sec. 1(c).

More importantly, the cost-benefit analysis omits entirely any mention of the significant costs the rule would impose on women and other patients who are denied access to care, despite well-documented research that shows the significant healthcare costs women experience when they face healthcare denials, discussed in more detail in Section IV. D. of this comment.[49] Service denials result in delays for patients, who must then spend additional time and resources searching for a willing provider. Delays also have the effect of increasing the cost of an abortion.[50] Moreover, delays raise the cost of each step of obtaining an abortion—not just the cost of the procedure, but also incidental costs such as being required to travel farther to obtain an abortion, thereby incurring additional travel and related expenses, such as lost wages and childcare.[51] As a result, healthcare denials that result in a delay in care can significantly drive up the cost of care for a woman seeking an abortion.

Healthcare refusals without adequate safeguards may also have negative consequences on the long-term socioeconomic status of women. A recent study in the American Journal of Public Health found that women who were denied a wanted abortion had higher odds of poverty six months after denial than did women who received abortions, and that women denied abortions were also more likely to be in poverty for four years following denial of abortion.[52] The agency does not even attempt to quantify these broader medical, social, and economic costs that result from service refusals, and entirely fails to take these costs into account in justifying this NPRM. Thus, this NPRM should be withdrawn for failing to consider, and put the public on notice of, all relevant costs.

C. The NPRM is arbitrary and capricious, an abuse of discretion, and not in accordance with law, because it mischaracterizes and inappropriately expands the scope of underlying federal refusal laws.

Although agencies have broad authority to engage in rulemaking, that authority is not without limits. Under the Administrative Procedure Act, "agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," "contrary to a constitutional right," or "in excess of statutory jurisdiction, authority, or limitations" shall be held unlawful and set aside. In proposing an expanded enforcement scheme for the Church amendments (42 U.S.C. § 300a-7), the Coats-Snowe amendment (42 U.S.C. § 238n.) and the Weldon amendment (Consolidated Appropriations Act, 2017, Public Law 115-31, Div. H, sec. 507(d)(1), 131 Stat. 135.), the NPRM inappropriately exceeds the parameters of the plain text of these statutes, as well as their legislative intent, in a manner that violates the APA. As a result, the proposed rule should be withdrawn in its entirety.

i. The NPRM misinterprets, and exceeds the parameters and intent of, the Church amendments.

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[49] National Women's Law Center, *When health care providers refuse: The impact on patients of providers' religious and moral objections to give medical care, information or referrals*, Apr. 2009, https://www.nwlc.org/wp-content/uploads/2015/08/April2009RefusalFactsheet.pdf.
[50] Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground and Supportive States in 2014*, WOMEN'S HEALTH ISSUES (2018), http://www.whijournal.com/article/S1049-3867(17)30536-4/abstract.
[51] Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008*, 22 J. WOMEN'S HEALTH 706 (2013).
[52] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AM. J. PUB. H. 407 (2018), http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304247.

Consisting of four substantive provisions codified at 42 U.S.C. § 300a-7, the Church amendments prohibit recipients of federal funding from discriminating against entities and individuals who refuse to perform, or "assist in the performance" of, sterilizations or abortions on the basis of religious or moral objections. The Church amendments also prohibit discrimination against those who do choose to provide abortion or sterilization. Although the operative text of the proposed rule prohibits, as the Church amendment requires, discrimination on the basis of past performance of abortion or sterilization in addition to refusals to perform these services, the silence on this topic in the proposed rule's preamble speaks volumes. The preamble entirely neglects to mention the Church amendment's protection of individuals and entities that choose to provide abortion and sterilization services, indicating clearly that HHS intends to prioritize enforcement with respect to complaints related to religious and moral refusals over discrimination against providers who choose to give care.[53]

In the NPRM, HHS proposes to define certain terms that appear in the Church amendments in a manner that greatly expands the universe of individuals covered by the statute and controverts the actual text of the statute and the intent of Congress. Therefore, the NPRM is arbitrary and capricious, an abuse of discretion, and is not in accordance with law.

As a threshold matter, the Church amendments are, as discussed further below, specifically and deliberately tailored. Nothing in the statutory text or legislative history supports the broadening of scope attempted by the NPRM. Even what is arguably the most expansive provision, 42 U.S.C. § 300a-7(d), was meant to apply only to biomedical and behavioral research contexts, as it was enacted under the National Research Service Award Act of 1974, under Title II of the Act which was specifically titled "Protection of Human Subjects of Biomedical and Behavioral Research."[54] Legislative debates at the time of passage confirm this limitation. Then-Senator Biden, stating his support for an exemptions amendment to the Biomedical Research Act—which eventually became codified as 42 U.S.C. § 300a-7(c)(2) through 42 U.S.C. § 300a-7(d)—stated the goal of the amendment was to ensure that "no individual or entities shall be required to participate in biomedical research or experimentation if such activities are contrary to the intended participants' religious beliefs or moral convictions."[55] Thus, it is arbitrary and capricious, and not in accordance with law for HHS to conclude that any part of the Church amendments authorize the agency's overbroad interpretations as follows:

"Individual" and "Workforce." Neither "individual" nor "workforce" is defined by the Church amendments. The proposed rule defines "individual" as "member of the workforce of an entity

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[53] The substantive provisions of the Church amendments, which begin at 42 U.S.C. § 300a-7(b), are as follows: § 300a-7(b) states that those receiving federal funds cannot require an individual to "perform or assist in the performance of any sterilization procedure or abortion" if it would be against the individual's religious or moral beliefs, and entities similarly cannot be forced to make their facilities available or provide any personnel for the performance or assistance in the performance of sterilization or abortion. § 300a-7(c) prohibits discrimination in the "employment, promotion, or termination of employment," of physicians or other "health care personnel," and discrimination "in the extension of staff or other privileges," on the basis of one's past performance or past refusal to perform a sterilization or abortion. § 300a-7(c) further specifies that any entity receiving a grant or contract for biomedical or behavioral research is prohibited from discriminating in the same context (employment, staff privileges, etc.) because of a physician or healthcare personnel's past performance or past refusal to perform a sterilization or abortion. § 300a-7(d) states that no individual shall be required to perform or assist in the performance of "any part of a [federally funded] health service program or research activity" if it would be contrary to the individual's religious or moral beliefs. Finally, § 300a-7(e) specifies that no entity that receives certain federal funds may deny admission or otherwise discriminate against any applicant for training or study because of the applicant's unwillingness to participate in the performance of abortions or sterilizations contrary to the applicant's religious or moral beliefs.

[54] National Research Service Award Act of 1974, Pub. L. No. 93-348, 353-54 (1974).

[55] 120 Cong. Rec. 16, 21540 (June 27, 1974) (Statement of Sen. Biden).

or health care entity;" "workforce" is defined as "employees, volunteers, trainees, contractors, and other persons whose conduct, in the performance of work for an entity or health care entity, is under the direct control of such entity or health care entity, whether or not they are paid by the entity or health care entity, as well as health care providers holding privileges with the entity or health care entity." By including volunteers, contractors, and other non-employees within these definitions, the proposed rule attempts to significantly and inappropriately broaden the universe of people who could now claim to be assisting in a procedure under the Church amendments.

The Church amendments' legislative history demonstrates that only hospitals themselves and individual physicians and nurses were intended to be protected by the original statute, now consisting of 42 U.S.C. § 300a-7(b) through 42 U.S.C. § 300a-7(c)(1). On the Senate floor, the amendment sponsors focused on whether federal funding could be used to force religiously affiliated hospitals or individual medical personnel to provide abortions or sterilizations against their beliefs.[56] In clarifying to whom the Church amendments would apply, Senator Frank Church specified that the amendments were "meant to give protection to the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions."[57]

The articulation of "physicians, . . . nurses, . . . hospitals" stands in clear contrast with the NPRM's proposed class of individuals within the workforce. The NPRM's definitions open the door for religious and moral refusals from precisely the type of individuals that the amendments' sponsor sought to exclude. This arbitrary and capricious broadening of the amendments' scope goes far beyond what was envisioned when the Church amendments were enacted.

"Assist in the performance." This term is undefined in the text of the Church amendments. Words that are not terms of art and that are not statutorily defined are customarily given their ordinary meaning.[58] The proposed rule provides a definition of "assist in the performance" that goes far beyond the common understanding of the term. By defining the term as meaning "to participate in any activity with an articulable connection to a procedure, health service, health program, or research activity," the NPRM proposes an unreasonably broad and vague standard that could allow virtually any member of the healthcare workforce to argue that they are assisting in the performance of a procedure, from the nurse who sanitizes instruments to a receptionist scheduling appointments or to a contractor who disposes of a hospital's waste. The phrase "articulable connection to a procedure" also disregards the meaning of the word "performance," attempting to cast a wider net to those not directly responsible for performing the health care service.

Legislative history demonstrates that the NPRM's definition is contrary to the intended scope of "assisting in the performance." On the floor of the Senate, Senator Long asked Senator Church, "[T]his would not, in effect, say that one who sought such an operation would be denied it because someone working in the hospital objected who had no responsibility, directly or indirectly, with regard to the performance of that procedure." Senator Church replied, "The

[56] 119 Cong. Rec. 8, 9595-9596 (1973).
[57] 119 Cong. Rec. 8, 9597 (1973); *see also* statement from Sen. Buckley, 119 Cong. Rec. 8, 9601 ("In this amendment, we seek to protect the right not only of institutions, but of individual doctors and individual nurses.").
[58] In the absence of a statutory definition, "we construe a statutory term in accordance with its ordinary or natural meaning." FDIC v. Meyer, 510 U.S. 471, 476 (1994).

Senator is correct."[59] Senator Church went on to assert: "There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal to perform what would otherwise be a legal operation."[60] The NPRM proposes to broaden the amendments' scope by permitting anyone with a mere "articulable connection" to a procedure to file a complaint. But a connection that is no more than "articulable" is exactly the kind of frivolous objection that the amendment's sponsor sought to avoid. From its inception, the Church amendments have demanded a clear and direct connection to the performance of the procedure—and the NPRM's proposed definition is plainly not in accordance with that statutory intent.

ii. The NPRM misinterprets, conflicts with, and exceeds the parameters of the Coats-Snowe amendment.

The Coats-Snowe amendment (42 U.S.C. § 238n) prohibits governments from discriminating against any "health care entity" that refuses to train for abortion care, or that attends a medical training program that does not provide abortion training or "refer for" training or abortion care. It also prevents a government from denying accreditation of a physician training program based on its refusal to provide abortion training. It is intentionally tailored solely to the context of medical training. As demonstrated below, the proposed rule's definitions of "health care entity" and "referral or refer for" go far beyond the plain language of the Coats-Snowe amendment and the intent of Congress in passing it, and as such the NPRM is not in accordance with law.

"Health care entity." The proposed rule's definition of "health care entity" conflicts with and far exceeds the statutory bounds set by Congress. The Coats-Snowe amendment defines "health care entity" as "an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions."[61] The proposed rule's definition of the same term expands, without justification or rationale, to add healthcare personnel, laboratories, plan sponsors and third-party administrators, as well as components of state and local governments. This definition could allow virtually any staff member of a healthcare facility to refuse to provide or participate in training for abortion care or abortion-related referrals, or to provide such care.

"Referral or *refer for."* This term is undefined in the Coats-Snowe amendment. The proposed rule's definition seeks not only to allow providers to opt out of referring patients to a non-objecting physician, but also to allow providers to withhold any medical information that could lead a patient to choose a healthcare service, activity, or procedure to which the treating physician objects. As explained below, this definition is arbitrary and capricious, and not in accordance with law.

The legislative history of the Coats-Snowe amendment demonstrates an intent to protect, not undermine, access to care. Debates on the Senate floor demonstrate that the amendment was a compromise provision intended to protect women's health while maintaining the status quo for,

[59] 119 Cong. Rec. 8, 9597 (1973).
[60] Id. Sen. Church went on to reiterate that "[t]his amendment makes it clear that Congress does not intend to compel the courts to construe the law as coercing *religious affiliated hospitals, doctors, or nurses* to perform surgical procedures against which they may have religious or moral objection," 9601 (emphasis added); *see also* statement from Sen. Buckley, 119 Cong. Rec. 8, 9601 ("In this amendment, we seek to protect the right not only of institutions, but of individual doctors and individual nurses.").
[61] 42 USC § 238n(c)(2).

not expanding, providers' refusal rights. The amendment was a direct response to a provision passed by the House of Representatives that threatened women's access to care.[62] Senator Olympia Snowe, lead sponsor of the Coats-Snowe amendment, described the amendment's purpose as ensuring access to healthcare services even where a provider opted out:

> "[. . . T]his amendment would not only make sure that women have access to quality health care with the strictest of standards when it comes to quality and safety but it also will ensure that they have access to physicians who specialize in women's health care."[63]

Senator Snowe's remarks demonstrate an intent to protect and prioritize women's access to care, particularly in the context of refusals. In the NPRM, HHS completely fails to address how it will ensure this access to care. Moreover, HHS lacks the authority to interpret the terms "health care entities" or "referral or refer for" so broadly, because the legislative intent of these amendments was to create a targeted, narrow carve out that will still protect women's health. The NPRM's interpretation of the Coats-Snowe amendment is therefore arbitrary and capricious, and not in accordance with law, and the NPRM should therefore be withdrawn in its entirety.

iii. The NPRM misinterprets and exceeds the parameters of the Weldon amendment.

The Weldon amendment prohibits federal funds appropriated annually as part of the HHS Appropriations Act from being made available to any federal agency or program, or state or local government that discriminates against any "institutional or individual healthcare entity" on the basis that the entity does not "provide, pay for, provide coverage of, or refer for abortions."[64] As set forth below, the proposed rule's definitions of "health care entity" and "refer for" arbitrarily and inappropriately exceed both the statutory text and Congressional intent of this amendment.

"Health care entity." The Weldon amendment defines "health care entity" as an "individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."[65] As noted above, the proposed rule goes far beyond this definition, adding healthcare personnel, laboratories, plan sponsors, and third-party administrators, as well as components of state and local governments, to the list of protected parties. This goes directly against Congressional intent. Plan sponsors and third-party

[62] Sen. Snowe: "[I]n the House of Representatives they have already passed legislation that would allow Federal funds to go to an unaccredited institution. [. . .] So the choice was not to address the reality of what is taking place in the House or making sure, more importantly, that the Senate was on record in opposition to that kind of language and developing a compromise with the Senator from Indiana to ensure that we maintained the accreditation standards for all medical institutions to advance the quality health care for women and at the same time to allow training for abortion for those who want to participate in that training or for the institutions who want to provide it. Because that is the way it is done now. That is the status quo, and that is not changing. [. . .] This is a compromise to preserve those standards. This is a compromise to ensure that it does not jeopardize the 273 ob-gyn programs that otherwise would have been affected if this compromise was not before us. That is the risk, and that is why I worked with the Senator from Indiana to ensure that would not happen." 142 Cong. Rec. 38, 2269 (Mar. 19, 1996).
[63] 142 Cong. Rec. 38, 2268 (Mar. 19, 1996).
[64] Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, sec. 507(d)(1), 131 Stat. 135 (2017).
[65] Id.

administrators are not themselves health insurers, health plans, or even health organizations and therefore cannot and should not naturally be considered healthcare entities. By expressly defining the term "health care entity," Congress implicitly rejected the inclusion of the other terms and meanings HHS now attempts to insert. Further, at the time the amendment was adopted, Rep. Weldon himself repeatedly enumerated the entities he intended to protect, and listed only entities that are themselves providers of healthcare, but never the recipients of insurance benefits or purchasers of insurance.[66]

Moreover, the proposed definition contradicts OCR's prior conclusion that the Weldon amendment's protection of health insurance plans "included issuers of . . . plans but not institutions or individuals who purchase or are insured by those plans."[67] Without justification or basis, the NPRM now proposes to newly protect even plan sponsors—e.g., employers or universities—and third-party administrators in this category.[68] An agency can only change an existing policy if it provides a "reasoned explanation" for disregarding or overriding the basis for the prior policy—but HHS never offers this reasoned explanation in the NPRM.[69] Instead, the proposed rule seeks to allow individuals as far removed as lab workers and ambulance drivers to refuse to perform their essential job duties because, for example, the results of analyzing an amniocentesis could lead to a woman choosing an abortion, or transporting a pregnant, miscarrying woman to a hospital could allow the woman's treatment to include a pregnancy termination. The NPRM's proposed definition plainly exceeds the definition that Congress intended and the Department's own prior policy without justification or basis, in a manner that is arbitrary and capricious, and not in accordance with law.

"Referral or *refer for."* This term is undefined in the Weldon amendment. As mentioned previously, terms that are not statutorily defined are customarily assigned their ordinary meanings.[70] Extraordinary interpretations are generally not in accordance with law. The term "referral" in the medical context is understood to mean "A written order from [a] primary care doctor for [the patient] to see a specialist or get certain medical services."[71] When a "deeply held, well-considered personal belief leads a physician to also decline to refer," medical ethics require providers to "offer impartial guidance to patients about how to inform themselves regarding access to desired services."[72] But the proposed rule's definition stretches the plain meaning beyond recognition and in violation of medical practice and principles of medical ethics. HHS proposes that a definition of "referral" would include "the provision of any information…by any method…pertaining to a service, activity, or procedure" when the referring entity "understands that particular health care service, activity, or procedure to be a purpose or possible outcome of the referral."[73]

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[66] 150 Cong. Rec. 135, 10090 (Nov. 20, 2004) (Statement of Rep. Weldon).
[67] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3890 (Jan. 26, 2018).
[68] "Because the Weldon Amendment protects not only the health insurance issuer, but also the health plan itself, it can also be raised, at minimum, by the plan sponsor on behalf of the plan." Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3890 (Jan. 26, 2018).
[69] Encino Motorcars, 136 S. Ct. at 2125-2126.
[70] In the absence of a statutory definition, "we construe a statutory term in accordance with its ordinary or natural meaning." FDIC v. Meyer, 510 U.S. 471, 476 (1994).
[71] Healthcare.Gov, *Glossary: Referral.*, last visited March 22, 2018, https://www.healthcare.gov/glossary/referral/.
[72] American Medical Association, *Code of Medical Ethics Opinion 1.1.7,* AMA CODE OF MEDICAL ETHICS, last visited March 22, 2018 at https://www.ama-assn.org/delivering-care/physician-exercise-conscience.
[73] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3894-95 (Jan. 26, 2018).

With this definition of referral, HHS seeks to allow providers not only to opt out of referring patients to a non-objecting physician, but also to allow healthcare personnel to withhold any medical information that could create even a possibility that the patient would choose a healthcare service, activity, or procedure to which that individual or entity objects. The average reasonable person would not assume that a medical referral includes just about anything that might eventually, down the line, allow the patient to obtain the services they need, nor that a provider could single-handedly decide that a patient may not access the care they need. This definition goes far beyond the common understanding of the term and violates medical ethics in a manner that will cause significant harm to patients. Here and throughout, the NPRM's construction of the Weldon amendment is arbitrary and capricious, and not in accordance with law.

iv. HHS's definition of "discrimination" is arbitrary, capricious, an abuse of discretion, and not in accordance with law.

"Discrimination." In the NPRM, "discrimination" is defined as "to withhold, reduce, exclude, terminate, restrict, or otherwise make unavailable or deny any grant, contract, subcontract, cooperative agreement, loan, license, certification accreditation, employment, title, or other similar instrument, position or status;" withholding . . . "any benefit or privilege . . . utilize any criterion, method of administration, or site selection, including the enactment, application, or enforcement of laws, regulations, policies, . . ., that *tends to* subject individuals or entities to any adverse effect . . . or to *have the effect of* defeating or substantially impairing accomplishment of a health program or activity with respect to individuals, entities, or conduct protected . . . or *otherwise engage in any activity* reasonably regarded as discrimination" (emphasis added).[74]

HHS adopts a definition unsupported by any federal refusal statute. The word "discrimination" is not defined in any of the Church, Coats-Snowe, or Weldon amendments or any of the other underlying statutes the rules purport to enforce. When combined with the definitions of other terms in the NPRM, including "assist in the performance," "referral," and "workforce," this extremely broad definition of discrimination takes on a whole new and unprecedented force, giving HHS authority to take action against recipients whenever virtually any employee who can claim an "articulable connection" to a procedure makes an objection. The proposed rule appears to give these religious and moral refusals precedence over all other interests, taking no account of the negative impact on patients, other employees, or the burdens on health care providers. This is a significant expansion beyond the scope of the underlying statutes that will impact all healthcare providers who receive federal funding through HHS, including, for example, both public and private hospitals, Medicaid/Medicare recipients, and Title X recipients.

As noted above, the authors of federal refusal laws such as Church, Coats-Snowe, or Weldon amendments envisioned granting certain healthcare entities and individuals the option to opt out of providing abortion or sterilization care or coverage, not to control the conduct of others.[75] This proposed definition of discrimination, in contrast, would expand religious and moral refusal

[74] Id. at 3892.
[75] *See, e.g.*, 119 Cong. Rec. 8, 9603 (1973). (Sen. Javits: "I wish to make it clear that that particular amendment [on discrimination] simply will protect anybody who works for that hospital against being fired or losing his hospital privileges if he does not agree with the policy of the hospital and goes elsewhere and does what he wishes to do" Sen. Church: "I am in full accord with that.").

rights at the expense of a protected liberty interest—access to healthcare—with devastating consequences for women and members of the LGBTQ community who may be denied access to necessary and even emergency healthcare, as described in greater detail throughout these comments. Under this definition, important practices and policies that ensure access to healthcare—such as a basic hospital policy requiring that employees must provide care to anyone who walks through the door—could be deemed discriminatory. Further, such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion. Further, compliance with the NPRM, based on what the rules appear to require, is in conflict with other federal antidiscrimination laws, as discussed in greater detail below. It will not be feasible for recipients to comply with the NPRM and, for example, EMTALA, Title VI, Title VII, and a host of other requirements that entities face when seeking accreditation.

To conclude, many of the definitions in the NPRM, but particularly the definitions of "health care entity," "assist in the performance," "individual," "workforce," "referral or refer for," and "discrimination," expand the federal healthcare refusal laws beyond their stated and intended parameters. Together, these definitions significantly and inappropriately broaden the scope and application of the underlying statutes, attempting to extend religious and moral refusal protections to individuals and entities that were plainly not contemplated. These definitions are arbitrary and capricious, and not in accordance with law, and because they inform the entire enforcement scheme proposed by the NPRM, the proposed rule must be withdrawn in its entirety.

III. The NPRM Proposes a Set of Compliance and Enforcement Mechanisms that Are Arbitrary, Capricious, an Abuse of Discretion, and Not in Accordance with Law

A. The NPRM proposes an enforcement scheme that lacks due process and is therefore unconstitutional.

In the proposed rule, HHS states that as a remedial measure for a violation, HHS will consider using all "legal options, up to and including termination of funding and return of funds," which could include "the temporary withholding of cash payments in whole or part, pending correction of the deficiency, the denial of funds and any applicable matching credit in whole or in part, the suspension or termination of the Federal award in whole or in part, the withholding of new Federal financial assistance or other Federal funds from HHS," and other remedies.[76] The NPRM does not include any notice, hearing or appeal procedures to govern such termination or withholding of funds.

The lack of notice, hearing, and appeal procedures violates the due process clause enshrined in the 5th and 14th amendments to the U.S. Constitution.[77] Recipient and sub-recipients of HHS' federal financial assistance have a protected property interest in federal financial assistance,

[76] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3898 (Jan. 26, 2018).
[77] U.S. CONST. amend. V, XIV.

which triggers certain procedural due process requirements.[78] These procedural due process requirements commonly consist of timely and adequate notice, the right to counsel, opportunity to address the fact-finder, an explanation of the decision, and chance for appeal.[79] The fact that HHS is requesting specific comment on whether the proposed rule should establish notice, hearing, and appeal procedures similar to those established in other HHS-administered programs indicates that the agency already is aware of procedural due process requirements, yet has explicitly chosen to exclude due process from its proposed rule. Failure to include mechanisms to ensure due process renders the NPRM unconstitutional. Therefore, the NPRM should be withdrawn in its entirety.

B. Many of the NPRM's proposed enforcement and compliance procedures are coercive, exceed enforcement norms, and create a chilling effect that would harm patients.

The NPRM contains certain proposed enforcement and compliance requirements that are arbitrary and capricious, an abuse of discretion, and not in accordance with law because they are coercive, exceed other enforcement norms, and create a chilling effect.

Restricting a broader range of funds and/or a broader category of entities
In its proposed rule, HHS asserts that, in order to enforce federal healthcare refusal laws, OCR may restrict "a broader range of funds or broader categories of covered entities" for "noncompliant entities."[80] HHS does not clarify what the "broader range of funds" or the "broader categories of covered entities" would encompass. Rather, the deliberate vagueness of the phrase suggests that HHS is attempting to grant itself the power to withhold not only the type of funding used in violation of program terms, but also withhold any other federal funding, even if unrelated to the offense. It also indicates that HHS would like to be free to withhold or terminate funding not only to those entities found to have committed a violation, but also those entities who may somehow be tangentially related to an entity that has been found to have committed a violation.

This proposed text has no basis in the underlying statutes the NPRM seeks to enforce, and in fact OCR has previously found this type of broad withholding of federal funding to raise "substantial questions about constitutionality" under the Spending Clause.[81] In addition, this proposed enforcement mechanism is wholly inconsistent with, and far exceeds, the regulations that govern implementation and enforcement of civil rights laws, *see e.g.* 45 C.F.R. 80. In civil rights enforcement, suspension or termination of federal funding assistance is limited to the particular grantee and the particular program or part thereof in which noncompliance was found.[82] By

[78] *See* Perry v. Sindermann, 408 U.S. 593 (1972); *see also* Citizens Health Corp. v. Sebelius, 725 F.3d 687 (7th Cir. 2013) (holding that a legitimate claim of entitlement "may arise from a contract, a statute, or a regulation, provided the source of the claim is specific enough to require the provision of the benefit on a nondiscretionary basis.").
[79] Goldberg v. Kelly, 397 U.S. 254 (1970).
[80] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3898 (January 26, 2018).
[81] Letter from OCR Director to Complainants (June 21, 2016) available at http://www.adfmedia.org/files/CDMHCInvestigationClosureLetter.pdf. ("A finding that CDMHC has violated the Weldon Amendment might require the government to rescind all funds appropriated under the Appropriations Act to the State of California – including funds provided to the State not only by HHS but also by the Departments of Education and Labor, as well as other agencies. HHS' Office of General Counsel, after consulting with the Department of Justice, has advised that such a rescission would raise substantial questions about the constitutionality of the Weldon Amendment.").
[82] 45 C.F.R. § 80.8.

potentially putting all HHS funding streams at jeopardy if a single refusal violation is found, and by putting similar entities who themselves have not committed a violation at jeopardy, the proposed rule attempts to create a blunt tool with the apparent intention of intimidating federal funding recipients and sub-recipients. Such unusually harsh and coercive compliance mechanisms render this proposed rule arbitrary and capricious, an abuse of discretion, and not in accordance with law.

Proactive reporting requirements

Under the NPRM, if a recipient or sub-recipient is subject to an OCR compliance review, investigation, or complaint filed with OCR based on religious and moral refusal laws, the recipient or sub-recipient must inform any Departmental funding component of such review, investigation, or complaint and must in any new or renewed application disclose and report on the existence of such reviews or complaints for *five years* from such complaints' filing.[83] This applies even when a violation is not found; anyone subject to a Department-initiated compliance review, investigation, or even subject to a complaint would have to undergo this process.

This compliance requirement is dangerous and likely to create a chilling effect, given that the definitions described above broadly expand the universe of those who might file complaints, and given further that anyone can file a complaint on behalf of another covered individual or entity. The proposed rule does not narrow the reporting requirement to credible instances in which the agency concluded that there was a violation; even the most frivolous complaint would have to be disclosed and reported on every funding application for five years. This is again an inappropriate compliance measure that seeks not only to intimidate recipients and sub-recipients, but also encourage outsiders to make complaints in bad faith against healthcare entities in order to mount more regulatory hurdles for such entities. It also raises concerns over whether frivolous complaints could influence a grant recipient's eligibility for future grants. These types of extreme compliance measures have no basis in the underlying statutes, exceed other enforcement norms, and are wholly inappropriate for HHS, whose mission is to ensure that Americans can get the healthcare they need. Therefore, the NPRM should be withdrawn.

IV. The Proposed Rule Should be Withdrawn Because It Harmfully Prioritizes Healthcare Provider Objections Above the Needs of Patients

A. The proposed rule is designed to have a chilling effect on the provision of abortion care.

The proposed rule seeks to intimidate abortion providers by significantly and inappropriately broadening the pool of individuals who may avail themselves of the complaint process. As articulated above, from the overly broad definitions to the excessively punitive enforcement measures, the proposed rule seeks to ensure that virtually anyone in the workforce of a healthcare entity that provides abortions—and even workers outside of an entity's core workforce, such as contractors—would be permitted to file a complaint. The proposed rule seems designed to make providers hesitant to perform abortion care for fear that their funding may be jeopardized by a

[83] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3930 (Jan. 26, 2018).

tenuously connected employee who may not even be involved in the performance of abortion care.

The chilling effect is strengthened by the enhanced compliance requirements the rule proposes. Because many clinics depend heavily on federal financial funds to serve low-income populations in their family planning programs, they may be reluctant to continue offering or referring for abortion services for fear of entrapment by anti-abortion extremists.

The types and varieties of institutions and care potentially affected by this NPRM are numerous. Below are lists of just some of the entities and care that may be affected.

Types and variety of institutions where access to care may be impacted:

- Hospitals
- Nursing facilities
- Family planning centers
- Freestanding ambulatory surgical and emergency centers
- Pharmacies
- HMO medical centers
- Medical laboratories
- Diagnostic imaging and screening centers
- Ambulance services
- Outpatient care centers
- Continuing care retirement communities and hospices
- Colleges, universities, and professional schools
- Individual physicians, nurses, and health practitioners

Types and variety of care potentially affected, including counseling for such care:

- Abortion and post-abortion care
- Miscarriage management and ectopic pregnancy care
- Sterilization care, such as tubal ligation
- Gender confirmation surgery
- Hormone therapy
- Contraceptive care
- Assisted reproductive technologies, such as in-vitro fertilization
- Hysterectomy and other reproductive care
- Amniocentesis and other prenatal diagnostic care
- Advanced directives and end-of-life care
- HIV prophylaxis, including pre-exposure and post-exposure prophylaxis
- Sexually transmitted infections screening and care
- Mental health services

The far reach of this NPRM means anyone receiving federal funding—from hospitals to independent providers—is likely to be impacted. If finalized as written, the rule could ultimately result in barriers to care for women and other individuals at multiple access points in the

healthcare system, compounding limitations to care and making it difficult for some individuals to access care at all.

B. The proposed rule fails to safeguard access to care, including information about available or optimal care and access to emergency treatment.

The proposed rule entirely fails to evaluate or consider the potential impact on access to healthcare. The foreseeable and anticipated result of the proposed rule's attempted vast expansion of religious and moral healthcare refusal rights will likely be that a larger number of individuals will use refusal laws as a basis to deny care—in addition to the number of entities that the rule seeks to intimidate into not providing certain healthcare services at all. In promulgating this rule, HHS is prioritizing the religious and moral beliefs of healthcare providers over the needs of patients in violation of its own mission statement—to "enhance and protect the health and well-being of all Americans."[84]

The proposed rule also fails to ensure the treatment of patients facing emergency health situations, including emergencies requiring miscarriage management or abortion. 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.[85] Every hospital that has a Medicare provider agreement and an emergency room—even those that are religiously-affiliated—is required to comply with EMTALA. Because the proposed rule does not mention EMTALA or safeguard emergency care in any way, it creates confusion that may lead some institutions to mistakenly believe they are not required to comply with EMTALA. As articulated earlier in this comment, failure to comply with EMTALA has resulted in harm to women. Moreover, because religious institutions have violated EMTALA in the past,[86] the NPRM's failure to address a healthcare entity's legal obligation to follow EMTALA's directives is a critical omission.

In adopting the religious and moral refusal laws that the NPRM now misappropriates, Congress explicitly considered and sought to protect against the types of harm that can result from service refusals, particularly in an emergency situation. As previously discussed, congressional records on the Church amendment indicate that some Senators, even back in 1973, anticipated and sought to curb the negative health impacts that the proposed amendment could have in rural and underserved areas, and the problems with informed consent that could arise.[87] Between the limitation on access to care that this NPRM will likely create and the complete failure to address emergency situations, the proposed rule is plainly not in accordance with underlying statutes it seeks to enforce.

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[84] U.S. Department of Health and Human Services, *About HHS*, visited Mar. 26, 2018, https://www.hhs.gov/about/index.html.
[85] *See* 42 U.S.C. § 1395dd(a)-(c).
[86] *See, e.g.* Julia Kaye et al., *Health Care Denied: Patients and physicians speak out about Catholic hospitals and the threat to women's health and lives*, May 2016, https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied.
[87] Senator Church based his amendment, and reassured other Senators, on the assumption that "no area of [my home state] would be without a hospital within a reasonable commuting distance which would perform abortion or sterilization procedures. Moreover, in an emergency situation—life or death type—no hospital, religious or not, would deny such services. There is no problem here."

Even for non-emergency care, the Supreme Court has held that religious objections must be balanced against their impact on women's healthcare. In *Zubik v. Burwell*,[88] the Court reviewed alternative approaches to respecting religious objections while ensuring women maintain seamless contraceptive coverage, and ordered the parties to resolve those cases in a way that ensured there would be no impact on women's access to health care.[89] The Court in *Zubik* required that an accommodation of religious exercise must still ensure that women "receive full and equal health coverage, including contraceptive coverage.'"[90] Similarly, *Burwell v. Hobby Lobby*[91] rejected the notion that for-profit corporations' religious beliefs must be accommodated regardless of the impact—specifically noting that a new accommodation at issue in the case would have an impact on women that "would be precisely zero."[92]

Undeniably, the impact on women's health under this rule would be greater than zero. While abortion is an extremely safe procedure throughout pregnancy,[93] abortion in the earliest stages of pregnancy is safest: major complications in first-trimester abortions occur at a rate of less than 0.5 percent.[94] In fact, a comprehensive report on the safety and quality of abortion care in the United States released by the National Academies of Sciences, Engineering and Medicine this month found that "safety and quality are enhanced when the abortion is performed as early in pregnancy as possible."[95] Denying a woman an abortion—and thus forcing her to carry the pregnancy to term—increases the risk of injury and death. Approximately 28.6 percent of hospital deliveries involve at least one obstetric complication, compared to the one percent to four percent for first-trimester abortion.[96] A woman is 14 times more likely to die from giving birth than as a result of an abortion.[97] Yet the proposed rule is likely to lead to increased delays and denials of abortion care, resulting in increased harm to women.

C. The proposed rule undercuts fundamental principles of patient care.

The proposed rule's new and expanded definitions interact to encourage entities and individuals who seek to refuse care on religious grounds, and intimidate providers who want to provide care.

In addition, the proposed definition of "referral or refer for" puts informed consent at risk. Informed consent is a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health providers and patients and ensure patients have full autonomy over what is to happen to their bodies. Informed consent requires providers to disclose relevant and medically accurate information about treatment choices and alternatives so that

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[88] Zubik v. Burwell, 136 S. Ct. 1557 (2016).
[89] Id. at 1560; Catholic Health Care Sys. v. Burwell, 195 L. Ed. 2d 260 (2016).
[90] *Zubik*, 136 S. Ct. at 1559.
[91] Burwell v. Hobby Lobby, 134 S.Ct. 2751 (2014).
[92] Id.
[93] *See, e.g.*, Advancing New Standards In Reproductive Health (ANSIRH), *Safety of abortion in the United States* (Dec. 2014), https://www.ansirh.org/sites/default/files/publications/files/safetybrief12-14.pdf.
[94] Guttmacher Institute, *Fact sheet: Induced Abortion in the United States* (Jan. 2018), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.
[95] National Academies of Sciences, Engineering and Medicine, *Press Release: The Quality of Abortion Care Depends on Where a Woman Lives, Says One of Most Comprehensive Reviews of Research on Safety and Quality of Abortion Care in the U.S.* (Mar. 16, 2018), http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=24950.
[96] Cynthia J. Berg et al., *Overview of Maternal Morbidity During Hospitalization for Labor and Delivery in the United States,* 113 OBSTETRICS & GYNECOLOGY 1075, 1077 (2009).
[97] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 216-217 & tbl. 1 (2012) (analyzing data from 1998 to 2005).

patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.

The proposed rule puts this important principle at risk by allowing health care entities to opt out of providing any information when the entity understands that an objected-to healthcare service, activity, or procedure is even a "possible outcome of the referral."[98] For example, the proposed rule could allow entities to refuse to provide information about any other entity that might refer for an abortion, or to withhold pertinent medical information about a woman's pregnancy if the provider fears that the woman may choose to seek out an abortion or sterilization provider. It could also allow providers to not inform patients that they are withholding medical information.

Further, the proposed definition could negatively impact states' efforts to increase transparency and informed consent in pregnancy counseling. The proposed rule specifically singles out California's FACT Act, which requires all centers that provide pregnancy counseling to post information about the availability of free or low-cost family planning and abortion services under California's public programs, but targets all states' efforts to regulate fake women's health centers. These fake clinics mislead and misinform women in an attempt to prevent them from accessing abortion care. It is well-documented that many of these so-called "crisis pregnancy centers" operate under false pretenses, luring pregnant women onto their premises with the promise of free medical care and then regaling them with misinformation about abortion care and their pregnancy status.[99] Nonetheless, the rule seeks to allow such fake medical clinics to opt out of providing critical information to patients and continue their practice of deceit.

By allowing providers, including hospital and healthcare institutions, to refuse to provide patients with information, the proposed rule seeks to deprive patients of full information regarding their treatment options. While HHS claims the rule will improve 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.

The proposed rule also contravenes key and well-established principles of quality care: that care must be timely, in the best interest of the patient, and according to medical need.[100] With regards to abortion specifically, the World Health Organization has stated that:

> "Information, counselling and abortion procedures should be provided as promptly as possible without undue delay . . . The woman should be given as much time as she needs to make her decision, even if it means returning to the clinic later. However, the advantage of abortion at earlier gestational ages in terms of their greater safety over abortion at later ages should be explained. Once the decision is made by the woman, abortion should be provided as soon as is possible to do so."[101]

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[98] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3924 (Jan. 26, 2018).
[99] *See, e.g.* Brief For Planned Parenthood Federation of America and Physicians for Reproductive Health As Amici Curiae Supporting Respondents, No. 16-1140, NIFLA v. Becerra, No. 16-1140 (U.S. 2018).
[100] Institute of Medicine (now the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine). *Crossing the Quality Chasm: A New Health System for the 21st Century* (Mar. 2001) http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf.
[101] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd ed.) 36 (2012), http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf.

Moreover, the current proliferation of mergers between Catholic and secular hospitals is resulting in a dangerous spread of healthcare refusals, as the subsidiary secular hospitals agree to operate under the Directives. The number of Catholic owned or affiliated hospitals increased by 22 percent between 2001 and 2016—while the overall number of acute care hospitals decreased by six percent.[102] In 46 geographic regions, hospitals operating under the Directives are now the sole community healthcare providers of short-term acute hospital care; [103] nationwide, one in six acute care hospital beds is in a Catholic owned or affiliated hospital.[104] Under the proposed rule, some patients seeking life-saving treatment may be left with no place to turn for emergency care.

By permitting providers to refuse to provide or refer for care, and utterly failing to build any safeguards for patients seeking care, the proposed rule arbitrarily and capriciously undermines the best interests of the patient.

D. The proposed rule's potential increase in healthcare refusals would increase healthcare costs.

Healthcare refusals can result in significant costs for patients. When a patient is turned away at the doctor's office or a hospital without a referral, they must find a willing provider to access the healthcare they need. This means potentially significant time researching other available providers, and taking additional time off from work for a new appointment. In areas with a limited number of healthcare providers, a patient may need to drive long distances in order to access care, requiring additional expenses for overnight stays and childcare. The additional time and expense falls most heavily on low income individuals and those without the job flexibility to take paid sick time.

There may also be a significant increase in the healthcare costs themselves. For example, a woman who has a cesarean section and wishes to have a post-partum tubal ligation immediately following delivery cannot do so at a Catholic hospital, even though having the procedure at that time is medically recommended, presents fewer risks to the patient, and is more cost-effective than delaying the procedure to a later time. If the patient cannot have the procedure immediately following delivery, she must first recover from the cesarean surgery and then schedule the tubal ligation at least six weeks later when she is busy caring for her newborn. She will be required to go to another hospital and possibly a different doctor, and will have to transfer her medical records.[105]

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[102] Lois Uttley & Christine Khaikin, *Growth Of Catholic Hospitals And Health Systems: 2016 Update Of The Miscarriage Of Medicine Report,* MergerWatch (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=sNLtMbWH41ZXGppQwJUb6n2ztV8%3D.

[103] Id.

[104] Id.

[105] National Women's Law Center, *When health care providers refuse: The impact on patients of providers' religious and moral objections to give medical care, information or referrals* (Apr. 2009), https://www.nwlc.org/wp-content/uploads/2015/08/April2009RefusalFactsheet.pdf. *See also*, Debra B. Stulberg et al., *Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences*, 90 CONTRACEPTION 422 (2014) ("Cesarean delivery in Catholic hospitals raised frustration for obstetrician-gynecologists when the hospital prohibited a simultaneous tubal ligation and, thus, sent the patient for an unnecessary subsequent surgery. [. . .] Some obstetrician-gynecologists reported that Catholic policy posed greater barriers for low-income patients and those with insurance restrictions.").

Because of the national shortage of abortion providers in the United States, a woman who is denied abortion care may also find it difficult to find an available provider in a reasonable timeframe. Eighty-nine percent of counties in the United States do not have a single abortion clinic, and some counties that have a clinic may only provide abortion services on certain days.[106] Several states have only one clinic that provides abortion care.[107] Because of the provider shortage, many women must travel long distances to access care.[108] In addition, in some areas, the shortage results in significantly increased wait times[109] and, in some cases, patients may be turned away altogether.[110]

When women face delays in obtaining an abortion, the logistical and financial burdens they face multiply. On average, a woman must wait at least a week between when she attempts to make an appointment and when she receives an abortion.[111] Delays also have the effect of increasing the cost of an abortion. Abortion in the first trimester is substantially less expensive than in the second trimester: the median price of a surgical abortion at ten weeks is $508, while the cost rises to $1,195 at week 20.[112] The rising cost of abortion as gestational age increases poses a profound challenge to the affordability of the procedure for lower-income women. As one Utah woman explained: "I knew the longer it took, the more money it would cost . . . We are living paycheck to paycheck as it is, and if I [had] gone one week sooner, it would have been $100 less."[113] Moreover, delays raise the cost of each step of obtaining an abortion—not just the cost of the procedure. For example, one recent study found that Utah's mandatory waiting period caused 47 percent of women having an abortion to miss an extra day of work.[114] More than 60 percent were negatively affected in other ways, including increased transportation costs, lost wages by a family member or friend, or being required to disclose the abortion to someone whom they otherwise would not have told.[115] And because many clinics do not offer second-trimester abortions, a woman who has been delayed into the second trimester will typically be required to travel farther to obtain an abortion, thereby incurring additional travel and related costs, such as lost wages.[116] As a result, healthcare denials that result in a delay in care can significantly drive up the cost of care for a woman seeking abortion care.

In addition, healthcare refusals without adequate safeguards may also have negative consequences on the long-term socioeconomic status of women. A recent study in the American

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[106] National Partnership for Women & Families, *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access* 13 (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf.
[107] Id.
[108] Id.
[109] *See generally, e.g.*, Texas Policy Evaluation Project, *Research Brief: Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics* (Oct. 2015), http://sites.utexas.edu/txpep/files/2016/01/Abortion_Wait_Time_Brief.pdf.
[110] *See, e.g.*, Brief for National Abortion Federation and Abortion Providers as Amici Curiae in Support of Petitioners at 20, Whole Woman's Health v. Cole, 136 S. Ct. 499 (2015) (No. 15-274), *sub nom.* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016).
[111] The median is seven days, while the average is 10 days. Moreover, poorer women wait two to three days longer than the typical woman. See Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 338-43 (2006).
[112] Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground and Supportive States in 2014,* WOMEN'S HEALTH ISSUES (2018), http://www.whijournal.com/article/S1049-3867(17)30536-4/abstract.
[113] Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48 PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 179, 184 (2016).
[114] Jessica N. Sanders et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26 WOMEN'S HEALTH ISSUES 483, 485 (2016).
[115] Id.; *Accord* Deborah Karasek et al., *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-hour Mandatory Waiting Period Law*, 26 WOMEN'S HEALTH ISSUES 60 (2016).
[116] Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008*?,22 J. WOMEN'S HEALTH 706 (2013).

Journal of Public Health found that six months after denial of abortion, women were less likely to be employed full time and were more likely to receive public assistance than were women who obtained abortions, differences that remained significant for 4 years.[117] The study also found that women who were denied a wanted abortion were almost four times more likely to be below the federal poverty level compared to those who received an abortion.[118] Women who were denied a wanted abortion were also less likely to achieve aspirational plans for the coming year,[119] and more likely to remain in relationships with partners who subject them to physical violence.[120] Healthcare refusals that lead to delays or effective denials of care, particularly reproductive health care, therefore not only affect women's immediate health costs but also have fundamental negative economic and social consequences over many years—factors that HHS completely fails to acknowledge or take into account in this proposed rule.

The proposed rule's potential impact on women's healthcare, related healthcare costs, and economic security is substantial. Nonetheless, the NPRM entirely disregards these costs, particularly in the cost-benefit analysis portion of the rule. HHS's priorities are clear: to expand the healthcare refusals, no matter the consequence. The NPRM's failure to properly consider the very real and severe costs to women that could result from this regulatory proposal constitutes arbitrary and capricious rulemaking, and therefore the proposed rule should be withdrawn in its entirety.

E. The proposed rule would have negative health impacts on vulnerable populations worldwide.

The proposed rule seeks to expand the definition of healthcare entities in a way that potentially covers global health providers, encouraging individuals working under global health programs funded by HHS to refuse critical care in international settings. By including organizations that receive foreign aid funds through global health programs, the proposed rule extends the harm of refusals to vulnerable populations abroad. For example, in many of the countries where HHS implements global AIDS relief programs ("PEPFAR"), the populations served already face numerous barriers to care, including the broad and harmful refusal provision contained within the statute governing PEPFAR.[121]

The proposed rule opens up an additional front for discrimination against these populations by encouraging individual healthcare providers to deny the information and services they need. Such action undermines the purpose of global health programs and the rights of those they intend to serve. This is particularly harmful in developing countries where many health systems are weak, there are shortages of healthcare providers and supplies, and individuals often travel long

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[117] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AM. J. PUB. H. 407 (2018), http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304247.
[118] Id.
[119] Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC WOMEN'S HEALTH, no.102, 1 (2015).
[120] Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12 BMC MEDICINE no. 144, 1 (2014).
[121] 22 U.S.C. 7631(d) ("(d) Eligibility for assistance: An organization, including a faith-based organization, that is otherwise eligible to receive assistance . . . (1) shall not be required, as a condition of receiving such assistance—(A) to endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS; or (B) to endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection").

distances to obtain the services they need. Many of the individuals that encounter refusals will have nowhere else to go.

F. Provisions in the proposed rule go against HHS' own mission statement/purpose.

By its own statement, HHS' mission is to "enhance and protect the health and well-being of all Americans [. . .] providing for effective health and human services."[122] But the proposed rule does not make even a feeble attempt at addressing how the rule would preserve, much less enhance, the health of patients who are treated by providers who avail themselves of federal refusal laws.

It is well-documented that discrimination already limits access to services for more vulnerable populations, and some religious entities have demonstrated a willingness to flout laws that seek to protect access to care. In the past, HHS' OCR has investigated numerous complaints from transgender patients about being denied certain health services, ranging from routine to life-saving care, due to the patient's gender identity.[123] In one such case, a transgender patient was denied a genetic screening for breast cancer because the insurer said the test was only for women, even though the screening was recommended by a doctor.[124] Similarly, as articulated earlier in this comment, many women seeking emergency care for their pregnancies have had their care severely delayed, or outright denied, at Catholic hospitals.[125] HHS should focus on enforcing EMTALA and other healthcare laws that make sure that patients get the care they need, not encourage entities to refuse to provide care. HHS's failure to ensure that above all, patients receive the care they require indicates that the proposed rule is driven by ideology, instead of HHS' mission to enhance the health of all Americans.

Finally, the proposed rule's preamble fails to clarify protections for individuals and entities whose religious and moral values compel them to provide care—even though the Church amendment's statutory text explicitly protects providers and entities that choose to provide abortion and sterilization services. The imbalance exposes the administration's clear bias against abortion providers and foreshadows an OCR that will enforce federal refusal of care laws with an entirely one-sided focus that seeks to undermine access to care.

V. The Proposed Rule Is Unconstitutional

In additional to the constitutional issues previously raised in this comment, including the proposed rule's violation of due process rights and the substantial questions about constitutionality under the Spending Clause, the proposed rule is likely impermissible because it creates exemptions that run afoul of the Establishment Clause.

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[122] U.S. Department of Health and Human Services, *About HHS*, last visited Mar. 26, 2018, https://www.hhs.gov/about/index.html.
[123] Dan Diamond, *Transgender patients' complaints to HHS show evidence of routine discrimination*, POLITICO, Mar. 7, 2018, https://www.politicopro.com/health-care/article/2018/03/transgender-patients-complaints-to-hhs-show-evidence-of-routine-discrimination-390755.
[124] Id.
[125] *See, e.g.*, Julia Kaye et al., *Health Care Denied: Patients and physicians speak out about Catholic hospitals and the threat to women's health and lives*, May 2016, https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied.

Federal law, and all regulations promulgated under federal law, must comply with the Constitution, including the Establishment Clause, which prohibits the government from creating religious exemptions to neutral, generally applicable rules in a manner that imposes burdens on third parties. [126] Yet that is precisely what the NPRM proposes: HHS seeks to allow providers not only to opt out of providing care, but also to refuse to refer patients to a non-objecting physician and to even withhold information that could lead a patient to choose healthcare to which the provider objects. As a result, this rule would effectively constitute imposing a provider's religious belief on a patient in a manner that burdens the patient, acting as a veto on the patient's access to the care they request and need.

As discussed previously, denials and delays in healthcare, especially reproductive care, result in serious medical and even socioeconomic costs—burdens on third parties that this proposed rule completely fails to mitigate or even account for. But in this case, HHS has chosen to unconstitutionally prioritize certain religious ideologies that would impose harms on women over the government's interest in eliminating discrimination, advancing women's equality, and promoting access to healthcare. By granting a greater universe of objecting institutions and individuals the power to deny healthcare without ensuring that the patients will receive care, and thereby imposing harms on these third parties, the proposed rule violates the Establishment Clause of the U.S. Constitution and therefore should be withdrawn.

VI. Conclusion

In conclusion, we strongly oppose this proposed rule. For all the reasons stated above, we urge HHS to withdraw this regulation in its entirety. Thank you for the opportunity to comment.
Sincerely,

The Center for Reproductive Rights

[126] U.S. CONST. amend. I.

Exhibit 115

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.

For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

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

Exhibit 116

Institute *for*
Policy Integrity
NEW YORK UNIVERSITY SCHOOL OF LAW

March 27, 2018

VIA ELECTRONIC SUBMISSION

U.S. Department of Health and Human Services

Attn: Office for Civil Rights

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (Jan. 26, 2018); RIN 0945-ZA03

The Institute for Policy Integrity ("Policy Integrity") at New York University School of Law[1] respectfully submits the following comments to the Department of Health and Human Services ("HHS" or "the Department") regarding its proposed rule on statutory conscience protections in health care ("Proposed Rule").[2] Policy Integrity is a non-partisan think tank dedicated to improving the quality of government decisionmaking through advocacy and scholarship in the fields of administrative law, economics, and public policy.

Our comments focus, first, on HHS's failure to provide a reasoned explanation for disregarding relevant prior findings and, second, on serious errors and oversights in the Department's Regulatory Impact Analysis for the Proposed Rule. Specifically, we note the following:

- HHS disregards, without explanation, concerns that it raised in its 2011 rulemaking on conscience protections ("2011 Rule"), such as the possibility that an overly broad conscience protections rule would interfere with patients' ability to offer informed consent and the possibility that an overly broad rule would lead providers to believe—mistakenly—that statutory conscience protections allow them to discriminate against certain types of patients.
- HHS's Regulatory Impact Analysis ignores the Proposed Rule's potentially substantial indirect costs, such as reduced access to health care for patients and increased personnel expenses for providers.
- The Regulatory Impact Analysis fails to assess the distributional impacts of the Proposed Rule.
- The Regulatory Impact Analysis underestimates the number of entities covered by the Proposed Rule's assurance and certification requirement and, as a result, understates the Proposed Rule's direct compliance costs.

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[1] This document does not purport to present New York University School of Law's views, if any.

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

I. HHS Fails to Provide a Reasoned Explanation for Disregarding Findings It Made in the 2011 Rule.

This is not HHS's first rulemaking on conscience protections. In 2008, the Department finalized a regulation ("2008 Rule") that, among other things, purported to clarify the scope of conscience protections under the Church Amendments, Section 245 of the Public Health Service Act, and the Weldon Amendment by expansively defining certain statutory terms.[3] HHS subsequently rescinded all of the 2008 Rule's definitions in the 2011 Rule, citing concerns about their potential to (1) compromise patients' ability to offer informed consent, (2) cause confusion about the scope of statutory protections, and (3) inadvertently encourage providers to discriminate against certain categories of patients.[4]

When an agency amends, suspends, or repeals a rule, the agency must provide "a reasoned explanation . . . for disregarding facts or circumstances that underlay or were engendered by the prior policy."[5] Underlying the 2011 Rule was a conclusion by HHS that expansive definitions of statutory terms would compromise patients' ability to offer informed consent and foster confusion and discrimination. Accordingly, before it can adopt the Proposed Rule, which defines statutory terms even more broadly than the 2008 Rule did, the Department must acknowledge its prior concerns about expansive definitions and explain either why those concerns are not implicated by the definitions proposed here or why the Proposed Rule is justified despite those concerns. In the absence of such an explanation, the Proposed Rule is arbitrary and capricious.

HHS Disregards Its Prior Findings on the Potential for Expansive Definitions to Compromise Patients' Ability to Provide Informed Consent

When it rescinded the majority of the 2008 Rule in 2011, HHS did so, in part, to "clarify any mistaken belief that [the 2008 Rule] altered the scope of information that must be provided to a patient by their provider in order to fulfill informed consent requirements."[6] The 2011

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[3] Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072, 78,073 (Dec. 19, 2008) (hereinafter "2008 Rule").

[4] Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 76 Fed. Reg. 9968, 9973-74 (Feb. 23, 2011) (hereinafter "2011 Rule").

[5] *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 516 (2009).

[6] 2011 Rule, 76 Fed. Reg. at 9973.

Rule emphasized that making a patient aware of all available health care options is "crucial to the provision of quality health care services."[7]

The Proposed Rule is likely to limit patients' awareness of their health care options to an even greater extent than the 2008 Rule would have.[8] For example, the Proposed Rule suggests that a provider has no obligation to offer patients a disclaimer regarding health care procedures to which the provider has a religious or moral objection.[9] In other words, providers need not warn patients that they are not being informed of all available treatment options. And yet HHS fails even to acknowledge its 2011 finding that a conscience protections rule could not properly "alter[ ] the scope of information that must be provided to a patient,"[10] much less explain why the Department no longer holds that view.

HHS Disregards Its Prior Findings on the Potential for Expansive Definitions to Cause Confusion About the Scope of Statutory Protections

The 2011 Rule highlighted commenters' concern that the definitions in the 2008 Rule "were far broader than scope of the federal provider conscience statutes."[11] In rescinding those definitions, the Department noted its agreement that the definitions "may have caused confusion regarding the scope" of statutory protections.[12]

Definitions included in the Proposed Rule are even broader than those adopted in 2008. For example, whereas the 2008 Rule interpreted statutory protections against "assist[ing] in in the performance" of an objectionable procedure to encompass any action with a "reasonable" connection to that procedure,[13] the Proposed Rule requires only an "articulable" connection to the procedure.[14] But the Proposed Rule nevertheless fails to acknowledge HHS's prior finding as to the potential for broad definitions to cause confusion. Nor does the Department explain why the Proposed Rule is justified in spite of this potential for confusion.

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[7] *Id.*

[8] Proposed Rule, 83 Fed. Reg. at 3924.

[9] *See id.* at 3894-95 (defining "referral or refer for" to include "disclaimers," and noting that referral was not defined in the 2008 Rule).

[10] 2011 Rule, 76 Fed. Reg. at 9973.

[11] *Id.*

[12] *Id.*

[13] 2008 Rule, 73 Fed. Reg. at 78,097.

[14] Proposed Rule, 83 Fed. Reg. at 78,090-91.

HHS Disregards Its Prior Findings on the Potential for Expansive Definitions to Encourage Discrimination Against Categories of Patients

HHS's 2011 decision to rescind the definitions in the 2008 Rule was also motivated by concern that the definitions would lead providers to believe, incorrectly, that statutory protections extended not just to refusals to perform particular procedures, but also to refusals to care for particular types of patients. As the Department explained in the 2011 Rule, statutory conscience protections "were never intended to allow providers to refuse to provide medical care to an individual because the individual engaged in behavior the health care provider found objectionable."[15] But the Department agreed with commenters that the 2008 Rule could nevertheless give the impression that "Federal statutory conscience protections allow providers to refuse to treat entire groups of people based on religious or moral beliefs."[16] As a result, HHS feared that the 2008 Rule could reduce access to "a wide range of medical services, including care for sexual assault victims, provision of HIV/AIDS treatment, and emergency services."[17]

Again, the definitions in the Proposed Rule are even broader than those that caused the Department concern in 2011 and are thus likely to give rise to the same harmful misimpressions about the scope of statutory conscience protections. But the Department neither acknowledges its prior concerns regarding the inadvertent encouragement of discrimination nor explains why proceeding with the Proposed Rule is reasonable despite those concerns.

II. HHS Fails to Consider the Proposed Rule's Indirect Costs

A rational cost-benefit analysis considers both the direct *and* indirect effects of a proposed rule. To that end, Executive Order 12,866 requires agencies to consider not just "direct cost . . . to businesses and others in complying with the regulation," but also "any adverse effects" the rule might have on "the efficient functioning of the economy, private markets . . . health, safety, and the natural environment."[18] Longstanding guidance on regulatory impact analysis from the White House Office of Management and Budget similarly instructs agencies to "look beyond the direct benefits and direct costs of [their] rulemaking and consider any important

[15] 2011 Rule, 76 Fed. Reg. at 9973-74.

[16] *Id.* at 9973.

[17] *Id.* at 9974.

[18] E.O. 12,866 § 6(a)(3)(C)(ii).

ancillary benefits and countervailing risks."[19] The Supreme Court, too, has made clear that "'cost' includes more than the expense of complying with regulations" and that "any disadvantage could be termed a cost."[20]

Despite HHS's clear obligation to consider indirect consequences, the Regulatory Impact Analysis for the Proposed Rule assesses only direct compliance costs and ignores the ways in which the Proposed Rule is likely to reduce patients' access to health care and increase providers' personnel expenses.

HHS Fails to Consider Costs to Patients from the Express Denial of Medical Services

For a variety of reasons, the Proposed Rule is likely to reduce the availability and consumption of medical services, negatively affecting patient health and wellbeing. As discussed in Section I of these comments, the Proposed Rule's expansive definitions of statutory terms are likely to lead some providers to adopt a much broader interpretation of statutory conscience protections than Congress intended. This, in turn, will increase the frequency with which patients are denied care due to a provider's religious or moral objections. Such denials can impose a variety of costs—financial, physical, and psychological—on patients.

At minimum, a patient denied care must incur the cost of seeking out an alternative provider. Assuming patients typically choose the most convenient healthcare provider available, a second-choice provider may be farther away than the first. Traveling farther away, the patient loses time and money spent on transportation, and may be required to request time off from work or pay for childcare services. For some patients, these costs may be insurmountable.

Furthermore, some patients who are denied care may be too discouraged to seek out alternative sources of healthcare services. These patients may eschew treatment altogether, leading to negative health consequences.

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[19] Office of Mgmt. & Budget, Circular A-4 (2003), https://obamawhitehouse.archives.gov/omb/circulars_a004_a-4/.

[20] *Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015); *see also Competitive Enter. Inst. v. Nat'l Highway Traffic Safety Admin.*, 956 F.2d 321, 326-27 (D.C. Cir. 1992) (striking down fuel-efficiency rule for failure to consider indirect safety costs); *Corrosion Proof Fittings v. EPA*, 947 F.2d 1201, 1225 (5th Cir. 1991) (holding that EPA was required to consider the indirect safety effects of substitute options for car brakes when banning asbestos-based brakes under the Toxic Substances Control Act).

Finally, the Proposed Rule may discourage some patients from seeking medical services in the first place, simply because they *fear* being rejected by a provider. This assumption is reciprocal to the Department's assumption that some potential healthcare providers are currently (absent the Proposed Rule) discouraged from entering the profession because they fear they will be discriminated against for their religious and moral convictions.[21]

HHS Fails to Consider Costs to Patients from the Undisclosed Denial of Medical Services

The Proposed Rule's likely health costs extend beyond patients who are (or who fear that they will be) expressly denied care. As explained in Section I of these comments, the Proposed Rule encourages providers not merely to refuse to provide referrals for procedures or services to which they object, but also to refuse to warn patients that the provider is declining to recommend such treatments. A patient who does not realize she is being denied information about a particular health care option might choose an alternative that is less beneficial to her health or wellbeing.[22]

HHS Fails to Consider Indirect Personnel Costs for Providers

In addition to imposing health costs on patients, the Proposed Rule may indirectly increase personnel costs for some health care entities. For example, if the Proposed Rule causes support staff at a given health care facility to decline to perform services that they previously performed (or to decline to treat patients whom they previously treated), the facility will need to pay for additional labor to meet the same level of demand.

[21] Proposed Rule, 83 Fed. Reg. at 3916.

[22] The Department solicits comment on methodologies that can be used to quantify ancillary health costs. There are a number of ways to assess such impacts, including: retrospective cohort studies (e.g., studying the conditions of women's health in the 1960's and 1970's when information on abortion was limited); cohort studies in other countries or states where abortion counseling and referral is restricted; prospective cohort studies (i.e., a pilot program testing the regulation on a subset of the population); self-report surveys administered to a sample population of women (assessing, for example, their awareness of the existence of and details of abortions procedures); estimations of the potential effects by using statistics in the current environment as indicators; or any other of a number of epidemiological and other studies that are routinely performed by public health professionals when evaluating policies that affect public health.

III. HHS Fails to Consider the Proposed Rule's Distributional Impacts

Executive Order 12,866 requires agencies to "consider . . . distributive impacts" that will result from a proposed regulatory action.[23] In addition to failing to take the aforementioned ancillary costs into consideration, the Department has failed to consider how these costs will burden certain groups disproportionately. The Department's failure to consider such distributional impacts is particularly egregious given that it lists the promotion of "a society free from discrimination" as one of the chief benefits of the Proposed Rule.[24] HHS cannot rationally tout the Proposed Rule's potential to reduce discrimination against religious health care providers while ignoring its potential to increase discrimination against other groups.[25]

Specifically, the Department should consider whether and to what extent the Proposed Rule will disproportionately burden the following subpopulations:

- Immigrant Women: Recent immigrants may be less well informed on the availability of reproductive health care in the U.S., and therefore in greater need of the counselling and referral services that the Proposed Rule covers.

- Rural Women: Increasing the incidence of health care providers refusing to provide counseling or referrals may create a greater problem for women who live in rural areas than for women at large, due to the increased search and travel costs associated with finding an alternative provider in rural areas.

- Low-Income Women: Women with lower incomes have fewer resources available to allocate to transportation and child care. If refused counseling or referral services, these women may suffer greater costs when seeking alternative health care providers. The refusal may even result in an insurmountable obstacle to obtaining the health service sought.

- Women of Color: Women of color disproportionately earn lower incomes and live in underserved areas. If refused counseling or referrals, these women may experience greater burdens to seek alternative health care providers.

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[23] E.O. 12,866 § 6(b)(5).

[24] Proposed Rule, 83 Fed. Reg. at 3903.

[25] *Michigan v. EPA*, 135 S. Ct. 2699, 2707 (noting that "reasonable regulation ordinarily requires paying attention to the advantages *and* the disadvantages of agency decisions"); *Sierra Club v. Sigler*, 695 F.2d 957, 979 (5th Cir. 1983) (an agency "cannot tip the scales . . . by promoting [an action's] possible benefits while ignoring [its] costs.").

- LGBTQ Individuals: As discussed in Section I, the Proposed Rule, like the 2008 Rule, may lead health care workers to believe they can permissibly refuse to provide any type of medical service to gay or transgender individuals (or their families) based on moral or religious objections. Such refusals would decrease the quantity and quality of health care available to that population.

- Individuals with HIV/AIDS: Similarly, the Proposed Rule may lead health care workers to believe that they can permissibly refuse to provide any type of medical service to individuals with HIV/AIDS. Again, such refusals would decrease the quantity and quality of health care available to that population.

- Interracial/Interfaith Families: Finally, the Proposed Rule may lead health care workers to believe that they can permissibly refuse to provide any type of medical services to interracial or interfaith families because they morally object to such relationships. As with LGBTQ patients and HIV-positive patients, this misimpression could result in reduced access to health care for interracial and interfaith families.

IV. HHS Underestimates the Number of Entities Affected by the Proposed Rule and, as a Result, Underestimates the Proposed Rule's Compliance Costs

In addition to overlooking the Proposed Rule's indirect costs, HHS also underestimates the Proposed Rule's *direct* costs. Section 88.4 of the Proposed Rule requires certain recipients of HHS funding "to submit written assurances and certifications of compliance" with statutory conscience protections.[26] In calculating compliance costs for this assurance and certification requirement, the Department estimates that the requirement would apply to between 94,279 and 152,519 individuals and entities.[27] But that estimate excludes a large number of individuals and entities that, under a plain reading of the Proposed Rule, would in fact be required to submit assurances and certifications.[28]

HHS assumes that "all physicians" will be exempt from complying with the assurance and certification requirement, either because they do not accept HHS funds or because they "meet the proposed criteria for exemption . . . in proposed § 88.4(c)(1)."[29] But § 88.4(c)(1) exempts physicians and physician offices only if they (1) participate in Medicare Part B and

[26] Proposed Rule, 83 Fed. Reg. at 3896.

[27] *Id.* at 3910.

[28] *Id.* at 3910, 3915.

[29] *Id.* at 3909-10.

(2) "are not recipients of Federal financial assistance or other Federal funds from the Department through another instrument, program, or mechanism."[30] It is patently unreasonable for the Department to assume that this exemption encompasses every physician who receives HHS funds. Some physicians, for example, accept both Medicare *and* Medicaid funding.

HHS makes a similar error in estimating the number of individuals and entities that would be exempt from the assurance and certification requirement due to § 88.4(c)(2), which exempts recipients of funding under certain grant programs administered by the Administration for Children and Families that have a purpose unrelated to health care provision or medical research. The Department assumes that "all persons and entities that provide child and youth services . . . [and] all entities providing services for the elderly and persons with disabilities . . . would fall within this exemption."[31] As with the exemption for physicians, however, the § 88.4(c)(2) exemption is unavailable if HHS money is accepted from any other source. It seems unlikely that *no* entities that provide services for children, the elderly, or the disabled receive HHS funding from *any* source other than non-healthcare-related grant programs administered by the Administration for Children and Families.

Because it underestimates the number of entities that will be obligated to comply with the Proposed Rule's assurance and certification requirement, HHS also underestimates the Proposed Rule's total compliance costs.

Respectfully,

Michael Domanico
Theodore Gifford
Jack Lienke
Jason A. Schwartz

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[30] *Id.* at 3929.

[31] *Id.* at 3910.

Exhibit 117

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.

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[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

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[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 118

May 2011: National poll shows majority support healthcare conscience rights, conscience law

Highlights of *the polling company, inc*. Phone Survey of the American Public

On May 3, 2011, the Christian Medical Association and the Freedom2Care coalition released the results of a nationwide, scientific poll conducted April 29-May 1, 2011 by the polling company™, inc./ WomanTrend. Survey of 1000 American Adults, Field Dates: April 29-May 1, 2011, Margin of Error=±3.1.

1. **77%** of American adults surveyed said it is either "very" or "somewhat" important to them that **"**that healthcare professionals in the U.S. are **not forced to participate** in procedures or practices to which they have **moral objections**." **16%** said it is not important.

ALL		*PRO-CHOICE* (n=465)	*PRO-LIFE* (n=461)
77%	Total **important** (net)	68%	85%
52%	Very important	42%	64%
25%	Somewhat important	26%	21%
16%	Total **not important** (net)	24%	8%
8%	Not too important	11%	5%
8%	Not at all important	13%	3%
8%	Do not know/depends	8%	6%
1%	Refused	*	

2. **50%** of American adults surveyed "strongly" or "somewhat" support "a **law** under which federal agencies and other government bodies that receive federal funds could **not discriminate** against hospitals and health care professionals who **decline to participate in abortions**." **35%** opposed.

ALL		*PRO-CHOICE* (n=465)	*PRO-LIFE* (n=461)
50%	Total **support** (net)	45%	58%
29%	Strongly support	20%	40%
21%	Somewhat support	25%	18%
35%	Total **oppose** (net)	43%	32%
14%	Somewhat oppose	20%	10%
21%	Strongly oppose	23%	22%
7%	It depends/need more info.	7%	5%
7%	Do not know	6%	5%
1%	Refused	1%	1%

April, 2009: Two National Polls[1] Reveal Broad Support for Conscience Rights in Health Care

Highlights of *the polling company, inc.* Phone Survey of the American Public

39% Democrat • 33% Republican • 22% Independent

1. **88%** of American adults surveyed said it is either "very" or "somewhat" **important to them that they share a similar set of morals as their doctors**, nurses, and other healthcare providers.
2. **87%** of American adults surveyed believed it is important to "make sure that healthcare professionals in America are **not forced to participate** in procedures and practices to which they have moral objections."
3. Support for the conscience protection regulation (rule finalized Dec. 2008):
   - **63% support conscience protection regulation**
   - 28% oppose conscience protection regulation
4. Support for Obama administration proposal to eliminate the new conscience protection regulation:
   - 30% support Obama administration proposal
   - **62% oppose Obama administration proposal**
5. Likelihood of voting for current Member of Congress who supported eliminating the conscience rule:
   - 25% more likely to vote for Member who supported eliminating rule
   - **54% less likely to vote for Member who supported eliminating rule**
6. "In 2004 the Hyde-Weldon Amendment was passed. It ruled that taxpayer funds must not be used by governments and government-funded programs to discriminate against hospitals, health insurance plans, and healthcare professionals who decline to participate in abortions. Do you support or oppose this law?"
   - **58% support Hyde-Weldon Amendment**
   - 31% oppose Hyde-Weldon Amendment

Highlights of Online Survey of Faith-Based Professionals

2,865 faith-based healthcare professionals

1. **Over nine of ten** (91%) faith-based physicians agreed, "I would **rather stop practicing medicine** altogether than be forced to violate my conscience."
2. **32%** of faith-based healthcare professionals report having "been **pressured to refer a patient** for a procedure to which [they] had moral, ethical, or religious objections."
3. **39%** of faith-based healthcare professionals have "experienced pressure from or **discrimination by faculty** or administrators based on [their] moral, ethical, or religious beliefs"
4. **20%** of faith-based medical students say they are "**not pursuing a career in Obstetrics or Gynecology**" because of perceived discrimination and coercion in that field.

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[1] Results of both 2009 surveys released April 8. On behalf of the Christian Medical Association, the polling companyTM, inc./ WomanTrend conducted a nationwide survey of 800 American adults. Field Dates: March 23 -25, 2009. The overall margin of error for the survey is ± 3.5% at a 95% confidence interval. The polling companyTM, inc./ WomanTrend also conducted an online survey of members of faith-based organizations, fielded March 31, 2009 to April 3, 2009. It was completed by 2,298 members of the Christian Medical Association, 400 members of the Catholic Medical Association, 69 members of the Fellowship of Christian Physicians Assistants, 206 members of the Christian Pharmacists Fellowship International, and 8 members of Nurses Christian Fellowship. http://www.freedom2care.org/learn/page/surveys

Freedom2Care www.Freedom2Care.org and The Christian Medical Association www.cmda.org

April 2009 Phone Survey of the American Public

Americans of all characteristics and politics seek shared values with healthcare professionals.

Fully 88% of American adults surveyed said it is either "very" or "somewhat" important to them that they enjoy a similar set of morals as their doctors, nurses, and other healthcare providers. Intensity was strong, as 63% described this as "very" important while at the other end of the spectrum, just 6% said it is "not at all important," a ratio of more than 10-to-1.

Voters will punish politicians who fail to defend healthcare providers' conscience rights.

Finally, when asked how they would view their Member of Congress if he or she voted against conscience protection rights, 54% indicated they would be less likely to back their United States Representative. In fact, 36% said they would be much less likely, a figure three times greater than the 11 % who said they would be much more likely. Furthermore, 43% of respondents who said they voted for President Obama indicated that they would be less inclined to back a Member of Congress if he or she opposed conscience protection rights.

Healthcare providers' conscience protections are viewed as an inalienable right.

A sizable 87% of American adults surveyed believed it is important to "make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections." 65% of respondents considered it very essential. Also joining with these majorities were 95% of respondents who self-identified as "pro-life," 78% who considered themselves "pro-choice," 94% who voted for Senator McCain in November 2008 and 80% who cast a ballot for (now) President Obama.

Americans oppose forcing healthcare providers to act against their consciences...

A majority (57%) of American adults opposed regulations "that require medical professionals to perform or provide procedures to which they have moral or ethical objections." In contrast, 38% favored such rules. A full 40% strongly objected to the rules while just 19% strongly backed them. A majority of conservative Republicans (69%), moderate Republicans (69%), and conservative Democrats (59%), as well as the plurality of liberal/moderate Democrats (49%), joining together to reject policies to that require doctors and nurses to act against their personal moral code or value set.

...Support laws that protect them from doing so...

Without any names or political parties being mentioned, support for the new conscience protection rule outpaced opposition by a margin of more than 2-to-1 (63% vs. 28%). Intensity favored the rule, with 42% strongly backing it and 19% strongly rejecting it. Endorsements for the rule spanned demographic and political spectra, with majorities in all cohorts offering their support. In fact, even 56% of adults who said they voted for President Obama last fall and 60% of respondents who self-identified as "pro-choice" said they favor this two-month old conscience protection rule.

... And oppose any efforts to remove such rules.

Opposition to revocation of the conscience protection rule outpaced support by a margin of more than 2- to-1 (62% vs. 30%). Intensity favored retention of the rule (44% strongly opposing rescission versus 17% strongly supporting it). There was consistent demographic alignment and cohesiveness across political lines, as 52% of self-identified Democrats, 67% of self-identified Independents, and 73% of self- identified Republicans, as well as 50% of liberals, 65% of moderates, and 69% of conservatives also opposed nullification. A narrow majority (53%) of people who considered themselves to be "pro-choice" opposed rescission. Notably, a small number

(7%) were ambivalent or undecided, saying they did not know or lacked the information to render an opinion one way or the other.

Online Survey of Faith-Based Medical Professionals

1. Medical access will suffer if doctors are forced to act against their moral and ethical codes.

In the survey of 2,865 members of faith-based organizations, doctors and other medical professionals voiced their concerns that serious consequences could occur if doctors are forced to participate in or perform practices to which they have moral or ethical objections. Nearly three-quarters (74%) believed that elimination of the conscience protection could result in "fewer doctors practicing medicine," 66% predicted "decreased access to healthcare providers, services, and/or facilities for patients in low-income areas," 64% surmised "decreased access to healthcare providers, services, and/or facilities for patients in rural areas," and 58% hypothesized "fewer hospitals providing services."

Asked how rescission of the rule would affect them personally, 82% said it was either "very" or "somewhat" likely that they personally would limit the scope of their practice of medicine. This was true of 81% of medical professionals who practice in rural areas and 86% who work full-time serving poor and medically-underserved populations.

The conscience protection rule is fundamental and necessary in the medical profession.

Fully 97% of members who participated in the survey supported the two-month-old conscience protection clause and 96% objected to rescission of the rule. 91% of physicians agreed, "I would rather stop practicing medicine altogether than be forced to violate my conscience." The Department of Health and Human Services has asked whether the objectives of the conscience protection rule can be achieved "through non-regulatory means, such as outreach and education." Nearly nine-in-ten (87%) members surveyed – those who are on the ground, in hospitals and clinics across the country – felt "outreach and education" alone were insufficient to accomplish the goal. Ninety-two percent declared the codification of conscience protection to be necessary (83% "very" and 9% "somewhat") based on their knowledge of "discrimination in healthcare on the basis of conscience, religious, and moral values."

Discrimination is widespread in education and professional practice.

Asked to assess their educational experiences:

- 39% have "experienced pressure from or discrimination by faculty or administrators based on [their] moral, ethical, or religious beliefs"
- 33% have "considered not pursuing a career in a particular medical specialty because of attitudes prevalent in that specialty that is not considered tolerant of [their] moral, ethical or religious beliefs."
- 23% have "experienced discrimination during the medical school or residency application and interview process because of [their] moral, ethical or religious beliefs."

Asked to assess their professional experiences:

- 32% have "been pressured to refer a patient for a procedure to which [they] had moral, ethical, or religious objections."
- 26% have "been pressured to write a prescription for a medication to which [they] had moral, ethical, or religious objections."
- 17% have "been pressured to participate in training for a procedure to which [they] had moral, ethical, or religious objections."
- 12% have "been pressured to perform a procedure to which [they] had moral, ethical, or religious objections."

Freedom2Care www.Freedom2Care.org and The Christian Medical Association www.cmda.org

Discrimination is forcing faith-based medical students to shun careers in Obstetrics and Gynecology.

- 20% of students surveyed agreed with the statement, "I am **not pursuing a career in Obstetrics or Gynecology** mainly because I do not want to be forced to compromise my moral, ethical, or religious beliefs by being required to perform or participate in certain procedures or provide certain medications."
- **96%** of medical students support (90% "Strongly Support") the conscience protection regulation.
- 32% of medical students say they "have experienced pressure from or **discrimination by faculty** or administrators based on your moral, ethical, or religious beliefs."

Freedom2Care www.Freedom2Care.org and The Christian Medical Association www.cmda.org

Exhibit 119

DEPARTMENT OF HEALTH & HUMAN SERVICES

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OFFICE OF THE SECRETARY

Office for Civil Rights, Region IV
61 Forsyth Street, Suite 3B70
Atlanta, Georgia 30303

January 26, 2011

Matthew Bowman, Esq
Alliance Defense Fund
801 G Street N.W., Suite 509
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Julia Caldwell Morris, Deputy General Counsel
Sheree Wright, Sr. Associate General Counsel
Vanderbilt University
Office of General Counsel
2100 West End Ave., Suite 750
Nashville, TN 37203

Re: Transaction - 11-122388
Ann Marie Dust v Vanderbilt University

Dear Mr. Bowman, Ms. Morris, and Ms. Wright:

The Office for Civil Rights (OCR) has completed its investigation of the complaint filed against Vanderbilt University. The OCR has jurisdiction over programs and entities that receive Federal financial assistance from HHS in cases involving discrimination based on race, color, national origin, age, disability and, under certain circumstances, sex and religion. OCR also has been designated to receive complaints of discrimination and coercion that violate the Church Amendments, 42 U.S.C. §300a-7, and its implementing regulation, 45 C.F.R. Part 88. As a recipient of Federal financial assistance Vanderbilt University is obligated to comply with 42 U.S.C. § 300a-7 and its implementing regulation.

Issue Presented

The Alliance Defense Fund (Complainant) filed a complaint on behalf of [redacted] (Affected Party) against Vanderbilt University (Covered Entity) on January 11, 2011. The complaint alleged a violation of the Alleged Party's federal rights of conscience under 42 U.S.C. § 300a-7 and was filed with this office pursuant to 45 C.F.R. Part 88. Specifically, the complaint alleges that as a condition to admission to Vanderbilt University's Nurse Residency Program, applicants must in writing, promise that they will assist in termination of pregnancy procedures during their employment in the residency program, or their application for the program will be denied.

Discussion

On January 19, 2011, OCR notified the Covered Entity of the complaint filed against it by telephone. The Covered Entity provided OCR with assurances that it does not require nurses or

others to perform or participate in the performance of termination of pregnancy procedures if it is inconsistent with their religious or moral beliefs. The Covered Entity explained that if an employee raises an objection to participating in the performance of a termination of pregnancy, the employee may request an accommodation.

In order to resolve this matter, the Covered Entity has provided OCR with documentation that it has voluntarily taken the following corrective actions:

1. The Covered Entity emailed a clarification to all active nurse residency candidates [candidates who already submitted an online application and who met the basic qualifications for the position] concerning its policies regarding participation in termination of pregnancy and accommodations for religious beliefs or moral convictions.
2. The Covered Entity has eliminated the previous acknowledgment form from its Nurse Residency Program Application Packet and replaced it with a notice form that clarifies its policies regarding participation in termination of pregnancy and accommodations for religious beliefs or moral convictions.
3. Revised information packets and the clarification were sent to new candidates, including the Affected Party, on January 13, 2011.

On January 25th, OCR contacted the Complainant. The Complainant, who had expressed satisfaction with the measures taken by the Covered Entity in the [redacted] edition of *The Tennessean,* informed OCR that the Complainant had withdrawn the complaint based on those steps. The Complainant faxed to OCR a copy of the withdrawal letter dated January 12th, which OCR had not previously received.

Based on the foregoing voluntary corrective action, OCR is closing this matter. The closure of this case is not intended and should not be construed to cover any other issues regarding compliance with 45 C.F.R. Part 88 that may exist but were not specifically addressed during our investigation.

OCR shall place no restriction on the publication of the contents of this letter and may release this document and related materials consistent with the Freedom of Information Act, 5 U.S.C Section 522, and its implementing regulation 45 C.F.R. Part 5.

Thank you for your cooperation. If you have any questions, please do not hesitate to contact [redacted].

Sincerely,

Roosevelt Freeman
Regional Manager

Exhibit 120

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Chicago Office
233 North Michigan Avenue, Suite 240
Chicago, IL 60601

Kansas City Office
601 East 12th Street, Room 353
Kansas City, MO 64106

Office for Civil Rights
Midwest Region
Website: http://www.hhs.gov/ocr
Voice - (800) 368-1019
TDD - (800) 537-7697

April 18, 2017

[redacted]

OCR Transaction Number: 17-259696

Dear [redacted]

Thank you for your letter received on January 19, 2017 by the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR). In your complaint, you state that CVS Caremark discriminated against you when it continuously sent you literature describing contraceptives after you advised CVS Caremark that your sincerely held religious beliefs and practices don't allow for the funding of, or association with, contraceptives.

Among other things, OCR enforces Federal civil rights laws that prohibit discrimination in the delivery of health and human services because of race, color, national origin, age, disability, and, under certain circumstances, sex and religion. OCR has also been designated to receive complaints brought pursuant to the Federal health care provider conscience protection statutes, which prohibit recipients of certain HHS FFA from discriminating against health care providers and health care personnel because of their refusal or willingness to participate in certain health care services they find religiously or morally objectionable.

We have carefully reviewed your complaint and we are closing this case without further investigation because you have not raised facts sufficient to support a claim of discrimination on the basis of your religious beliefs or moral convictions under the laws OCR enforces.

OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR. Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

We regret we are unable to assist you further. Thank you.

Sincerely,

Steven M. Mitchell
Acting Regional Manager

[redacted] | My Workspace | Reference Library | Guidance | Correspondence Tracking | Reports | Logout

Case Number | Search

Advanced PIMS Cases | Advanced PIMS Documents

Home | Intake | Assignments | Unassigned Cases | Quick Stats | User Stats | Dashboard | Admin

Contact PIMS Support | Font Size A A A

Case: [redacted] vs CVS Caremark **Receipt Date:** 01/19/2017 **Case Age:** 89

Case Status: Closed

Case Processes

- Validation ✓
- Strategy ✓
- Investigation
- Monitoring
- Core Data
- Approval Area
- Closure
- Anytime Processes

Legend

- Section complete
- Information missing
- Error in section
- Section locked
- Section unlocked

Case Proc. Summary | Case Folder | Staff Assign | Letter Gen. | Case Notes | Case References | Contact | Collaborate | ROC | Timeline

Closure:

Administrative Closure

Closure Type:

- (•) - No Selection -
- ( ) Civil Rights violation alleged - Technical Assistance Provided
- ( ) Closed Due to a Court Order Decision About this Subject matter
- ( ) Complainant has elected EEOC to investigate
- ( ) Complaint Not Complete
- ( ) Complaint Not Timely
- ( ) Complaint Withdrawn
- ( ) Consolidated into Existing complaint or Compliance Review or a new Compliance Review started
- ( ) Delete Case
- ( ) FMCS - resolved case after mediation
- ( ) No CRF violation alleged by facts presented
- ( ) No Jurisdiction - No Civil Rights violation alleged by facts presented
- ( ) No Jurisdiction - No Covered Entity (Civil Rights)
- ( ) Referral to other Agency

Send For Admin Closure

Investigated Closure

There is no Authority, Issue and Basis in this case at the time.
View required authorities for program areas.

Send for Closure Approval

Closure Information

Closure Comments: Art,
Based on Case notes, OCR will not investigate this complaint.

Closure Tracking:

Approver	Status	Review Date	Comments
[redacted]	Approve	04/18/2017	
[redacted]	Decline	03/09/2017	Okay [redacted] let's reach out to CVS Caremark and ask if it is a recipient or sub-recipient of the...

Update | Reset

Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W. - Washington, D.C. 20201
Contact PIMS Support

Exhibit 121

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME [redacted]

YOUR LAST NAME [redacted]

H[redacted]LL PHONE (Please include area code)

W[redacted]E (Please include area code)

S[redacted]

CITY [redacted]

S[redacted]

ZIP [redacted]

E-MAIL ADDRESS (If availa[redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME

LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

Department of Health and Human Services

STREET ADDRESS

200 Independence Avenue, S.W.

CITY

Washington

STATE

District Of Columbia

ZIP

20201

PHONE (Please include area code)

(877) 696-6775

When do you believe that the discrimination occurred?

LIST DATE(S)

01/19/2018

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

I just was made aware of the following -

A new federal unit that is being created under the ruse of freedom of conscience will jeopardize health care. The Conscience and Religious Freedom Division in the Office for Civil Rights at the Department of Health and Human Services will help and encourage health care providers who refuse "to perform, accommodate, or assist with certain health care services on religious or moral grounds."

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE [redacted]

DATE *(mm/dd/yyyy)*

01/19/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of poss ble discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☒ Other (specify): FFRF

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement
Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including he time for reviewing instruc ions, gathering the data needed and entering and reviewing the information on he completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

☐ **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☒ **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 01/19/2018

**Please sign and date* [redacted] *mitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

I just was made aware of the following -

A new federal unit that is being created under the ruse of freedom of conscience will jeopardize health care. The Conscience and Religious Freedom Division in the Office for Civil Rights at the Department of Health and Human Services will help and encourage health care providers who refuse "to perform, accommodate, or assist with certain health care services on religious or moral grounds." Under the new policy, medical professionals — nurses, doctors, pharmacists — may deny treatment to transgender or other individual patients, refuse to take part in abortions, decline to give women birth control or provide any other health care they claim a religious or "moral" objection to.

This is an appalling, unethical abuse of "religious freedom" to impose archaic religious ideals on citizens in order to deny them civil liberties and health care.

Exhibit 122

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
H CELL PHONE (Please include area code)	W HONE (Please include area code)
([redacted]	
ST [redacted]	CITY [redacted]
ST [redacted]	E-MAIL ADDRESS (If availa [redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

United States Government

STREET ADDRESS	CITY	
1600 Pennsylvania Ave	Washington	
STATE	**ZIP**	**PHONE (Please include area code)**
District Of Columbia	20003-3228	

When do you believe that the discrimination occurred?

LIST DATE(S)

01/20/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

The Current Administration has allowed religious Zealots to run health information agencies to the point that important information about the importance of Women's Health (including Reproductive Choice), Vaccination importance and the ability to refuse treatment to as well as the lack of important information about the need for scientific, evidence based treatments is felt to be not recognized.

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	01/20/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of poss ble discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including he time for reviewing instruc ions, gathering the data needed and entering and reviewing the information on he completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 01/20/2018

**Please sign and date* [redacted] *ed to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

The Current Administration has allowed religious Zealots to run health information agencies to the point that important information about the importance of Women's Health (including Reproductive Choice), Vaccination importance and the ability to refuse treatment to as well as the lack of important information about the need for scientific, evidence based treatments is felt to be not recognized.

This goes against every belief that I, as a trained healthcare provider have.

This current administration would rather that Sharia law type restrictions will keep Americans healthy, this is a fallacy

We MUST be able to challenge stupidity and ignorance. I am offended and clearly discriminated against if I am not allowed to provide patients with evidence based information and DEMAND that the government change all of the policies that continue to challenge my civil rights as a citizen of the United States of America.

Exhibit 123

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
H[redacted]ELL PHONE (Please include area code)	W[redacted]PHONE (Please include area code)
[redacted]	
S[redacted]	CITY [redacted]
ST[redacted]	E-MAIL ADDRESS (If availa[redacted]
[redacted] [redacted]	[redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☒ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

NIH

STREET ADDRESS	CITY
NCCIH, 9000 Rockville Pike, Bethesda, Maryland 20892	Bethesda

STATE	ZIP	PHONE (Please include area code)
Maryland	20892	

When do you believe that the discrimination occurred?

LIST DATE(S)

09/21/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

I made a cure for cancer last year,

I had a website an app, twitter, and facebook page.

I submitted a health claim petition that was denied w/o review

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	01/23/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of poss ble discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☐ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☒ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement
Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including he time for reviewing instruc ions, gathering the data needed and entering and reviewing the information on he completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

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After reading the above information, please check ONLY ONE of the following boxes:

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[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 01/23/2018

**Please sign and date* [redacted] *ed to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted]

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If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

I made a cure for cancer last year,

I had a website an app, twitter, and facebook page.

I submitted a health claim petition that was denied w/o review

I submitted the structure function claims

and even had a pre-IND meeting, but then the FDA coerced me and threatened with a malicious libel of fraud, and forced me to delete my site www.mightyhoney.org my app, my twitter and facebook.

So one aspect is religious discrimination,

i had advertised "a divine cure for cancer" as honey and certain herbs and spices (which are GRAS and permitted) by the CFR are in my tradition,

I had provided cutting edge research to them as well.

I believe this is a violation of my free speech rights whether commercial or religious.

In this case it quite egregious and causing deaths of many people.

so I would like compensation from FDA for coercion, violating my religious freedom, conscience, behaving like mafia (RICO)

and for the NIH for violating my civil rights, and not providing me a grant, that is necessary for their own onerous and corrupt rules.

Many NIH employees were negligent, actually ALL that I met but specifically [redacted].

U.S. FOOD & DRUG ADMINISTRATION

Online Advisory Letter Reference # [redacted]

December 6, 2017

[redacted]

RE: MightyHoney

Dear [redacted]:

This letter is to advise you that the U.S. Food and Drug Administration (FDA) reviewed your website at [redacted] in November 2017 and has found that you take orders there for MightyHoney. Various claims and statements made on your website and/or in other labeling establish that this product is a drug as defined in 21 U.S.C. § 321(g)(1)(B) because it is intended for the treatment, cure, mitigation, or prevention of disease. For example, your website recommends or suggests the use of MightyHoney to treat or cure cancer, rheumatoid arthritis, diabetes, asthma, infectious disease, Parkinson's disease, epilepsy, dementia, and depression. As explained further below, the introduction of this product into interstate commerce for such uses violates the Federal Food, Drug, and Cosmetic Act.

This product is also a new drug as defined under 21 U.S.C. § 321(p) because it is not generally recognized as safe and effective for the uses recommended or suggested in its labeling. Before a new drug may be marketed or otherwise introduced into interstate commerce, it must be approved by FDA on the basis of scientific data demonstrating that the drug is safe and effective under the conditions of use in its labeling. See 21 U.S.C. §§ 355(a) and 331(d). Your drug product does not have a FDA-approved application as required by 21 U.S.C. § 355.

We advise you to review all materials through which you communicate to consumers the intended uses of your products, and to either submit a new drug application (NDA) for products intended for use in treating, curing, mitigating, diagnosing, or preventing a disease or, alternatively, remove all statements indicating that your products are intended for such uses. This would include reviewing your websites, product labels, catalogs, brochures, flyers, package inserts, audio and video, e-commerce and social media accounts you operate (e.g., Amazon, eBay, Facebook and Twitter accounts), as well as any other promotional materials, and removing product claims, consumer testimonials, metatags, and anything else that states or implies that your products are useful in treating, curing, mitigating, diagnosing, or preventing diseases.

For more information on the types of claims that can be used for conventional foods and dietary supplements, please see:

- 21 CFR 101.93
- https://www.fda.gov/Food/IngredientsPackagingLabeling/LabelingNutrition/ucm2006881.htm

- https://www.fda.gov/food/ingredientspackaginglabeling/labelingnutrition/ucm111447.htm

Within 30 calendar days of the date of this letter, please correct the violations described in this letter and **notify FDA**, via electronic mail at FDAadvisory@fda.hhs.gov or via mail to ORA Health Fraud, 12420 Parklawn Drive, #4041, Rockville, MD 20857, that the violations have been corrected. Include the Online Advisory Letter Reference number (located in the upper right portion of this letter) in all your communications to FDA regarding this matter.

After 30 days from the date of this letter, if your website or other labeling continue to demonstrate that your products are intended to treat, cure, mitigate, or prevent diseases, the name of your firm and this letter will be posted on the FDA webpage for unapproved new drugs illegally marketed for serious diseases.

This letter is not intended to be an all-inclusive review of your website(s) or a list of all violations of law that exist in connection with your products, your website(s) and other product labeling, or at your facilities. FDA expects you to take the necessary steps to ensure that all your products comply with the laws and regulations enforced by FDA.

Sincerely,

Health Fraud Team
Office of Enforcement and Import Operations
Office of Regulatory Affairs
U.S. Food and Drug Administration

STEPS TO CORRECT CITED VIOLATIONS

1) Within 30 calendar days of the date of this letter,

   a) Correct all violations described in the letter, and
   b) Notify FDA in writing of the corrections completed in response to this letter.

      - Email this information to FDAadvisory@fda.hhs.gov (preferred) or you may mail your written response to ORA Health Fraud, 12420 Parklawn Drive, #4041, Rockville, MD 20857.

      - Include the Online Advisory Letter Reference number (located in the upper right portion of this letter) in all your communications to FDA.

2) After 30 calendar days, **if you have not corrected the violations** described in this letter, the name of your firm and this letter will be posted on FDA's webpage, www.fda.gov/ICECI/EnforcementActions/AdvisoryLetters/default.htm

Exhibit 124

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME [redacted] | YOUR LAST NAME [redacted]

H[redacted] / CELL PHONE (Please include area code) | W[redacted]NE (Please include area code)

S[redacted] | CITY [redacted]

S[redacted] | ZIP [redacted] | E-MAIL ADDRESS (If availa[redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME | LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

[redacted]

STREET ADDRESS [redacted] | CITY [redacted]

STATE [redacted] | ZIP [redacted] | PHONE (Please include area code) ([redacted]

When do you believe that the discrimination occurred?

LIST DATE(S)

05/26/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

My son was born At Northside Hospital in Atlanta Georgia on [redacted].

I refused the New Born Screening Test (also known as PKU) on religious grounds.

I was questioned by pediatrician [redacted] as to the specific reason for refusing the procedure. I clearly explained that the procedure is against my religious beliefs, and

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE [redacted] | DATE *(mm/dd/yyyy)* 01/25/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement
Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 01/25/2018

**Please sign and date sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: ([redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

My son was born At Northside Hospital in Atlanta Georgia on [redacted].

I refused the New Born Screening Test (also known as PKU) on religious grounds.

I was questioned by pediatrician [redacted] as to the specific reason for refusing the procedure. I clearly explained that the procedure is against my religious beliefs, and that it was my understanding that Georgia law permits religious exemptions to the procedure.

At this point, he made it very clear that he did not respect my religious beliefs, and remarked that he believes in "Science". He also explained incorrectly, that Georgia law does not permit religious exemptions to the procedure.

He threatened that if I refused, he would call child services, and my child may be removed from my custody.

Out of fear, I was coerced into consenting to the procedure.

Exhibit 125

FAX Transmission from Library Document Station 5131

To:	**OCR**	From:	[redacted]
Fax:	[redacted]	Pages:	**2 + Coversheet**
Date:	**2/13/2018**	eMail:	[redacted]**@YAHOO.COM**

Comments: **REQUEST FOR INVESTIGATION AND RECORDS**

Form Approved: OMB No. 0945-0002
Expiration Date: 04/30/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

Civil Rights Discrimination Complaint

YOUR FIRST NAME [redacted] | YOUR LAST NAME [redacted]

HOME PHONE (Please include area code) [redacted] | WORK PHONE (Please include area code)

STREET ADDRESS [redacted] | CITY Aurora

STATE CO | ZIP 80044 | E-MAIL ADDRESS (If available) [redacted]@yahoo.com

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME | LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☒ Race / Color / National Origin ☒ Age ☐ Religion / Conscience ☒ Sex
☒ Disability ☐ Other (specify): Biomedical / Telemedicine

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON / AGENCY / ORGANIZATION State of Colorado - Dept of Personnel & Admin (CDOT) CDPHE

STREET ADDRESS [redacted] | CITY Denver

STATE CO | ZIP 80202 | PHONE (Please include area code) [redacted]

When do you believe that the occurred?

LIST DATE(S) 10/2008 – 2/2018

Describe briefly what happened. How and why do you believe you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed) Identity Theft w/i St employment and false BH overacting (ED/psych) led to health care fraud, medicare/medicaid fraud and terminal injuries due to Biomedical abuses, Hippa violations

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email [redacted]

DATE 2/13/18

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: www.hhs.gov/ocr/civilrights/complaints/index.html. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

HHS-700 (10/17) (FRONT)

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for OCR to communicate with you about this complaint? (*Check all that apply*)

☐ Braille ☑ Large Print ☐ Cassette tape ☑ Computer diskette ☑ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME [redacted] LAST NA [redacted]

HOME PHONE (*Please include area code*) [redacted] WORK PHONE (*Please include area code*) [redacted]

STREET ADDRESS [redacted] CITY Fountain

STATE CO ZIP 80817 E-MAIL ADDRESS (if available) [redacted]@yahoo.com

Have you filed your complaint anywhere else? If so, please provide the following. (*Attach additional pages as needed*)

PERSON / AGENCY / ORGANIZATION / COURT NAME(S)

DATE(S) FILED | CASE NUMBER(S) (If known)

To help us better serve the public; please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (*select one*)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (*select one or more*)
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☒ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (If other than English):

How did you learn about the Office for Civil Rights?

☑ HHS Website /Internet Search ☐ Family / Friend /Associate ☑ Religious /Community Org ☑ Lawyer /Legal Org ☐ Phone Directory ☐ Employer
☑ Fed /State/Local Gov ☑ Healthcare Provider /Health Plan ☐ Conference /OCR Brochure ☐ Other(*specify*):

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail this complaint form to this address.**

HHS-700 (10/17) (BACK)

02/13/2018 1:50 PM FAX 2026193818 OFFICE FOR CIVIL RIGHTS P.0001

****
*** Receive Results ***
****

Receive job successful.

Job No.	5236
Address	
Name	
Start Time	02/13 01:47 PM
Call Length	03'27
Sheets	3
Result	OK

Exhibit 126

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
H[redacted] / CELL PHONE (Please include area code)	W[redacted] ONE (Please include area code)
S[redacted]	CITY: Pocono Lake
ST: Pennsylvania	ZIP: 18347
E-MAIL ADDRESS (If available): [redacted]	

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☒ Race / Color / National Origin ☒ Age ☒ Religion / Conscience ☐ Sex
☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION: Humana

STREET ADDRESS	CITY
Humana Florida, p.O. Box 371400	Pittsburgh
STATE: Pennsylvania	ZIP: 15250
PHONE (Please include area code)	

When do you believe that the discrimination occurred?

LIST DATE(S): 01/01/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

I signed up for Florida Humana in January 2017 I was not told that I had to take prescription coverage.

I do not use prescriptions. I have never paid more than $8 per month for any prescriptions.

I am 80 years old and did not understand. I do not want prescription coverage now or any other time.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	02/27/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

Medicare

DATE(S) FILED	CASE NUMBER(S) (If known)
01/19/2018	[redacted]

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☐ Not Hispanic or Latino

RACE (select one or more)

☒ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement
Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 02/27/2018

**Please sign and date* [redacted] *ed to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted] Pocono Lake, Pennsylvania,

Telephone Number: [redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

I signed up for Florida Humana in January 2017 I was not told that I had to take prescription coverage.

I do not use prescriptions. I have never paid more than $8 per month for any prescriptions.

I am 80 years old and did not understand. I do not want prescription coverage now or any other time.

I don't believe in taking prescriptions.

It is totally lubricious that I should pay $52 a month for the rest of my life.

Exhibit 127

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
HOME / CELL PHONE (Please include area code)	WORK PHONE (Please include area code)
[redacted]	
STREET ADDRESS	CITY
[redacted]	[redacted]
STATE	ZIP	E-MAIL ADDRESS (If available)
[redacted]	[redacted]	[redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex
☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

Washington State Department of Corrections

STREET ADDRESS	CITY
7345 Linderson Way SW	Tumwater
STATE	ZIP	PHONE (Please include area code)
Washington	98501	(360) 725-8213

When do you believe that the discrimination occurred?

LIST DATE(S)

10/02/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

No reasonable accommodation provided for my religious objection to prescribing hormones to men wanting to transition into women. When other providers offered to prescribe hormones to these patients under my care they were told by DOC leadership that they could not see my patients and no accommodation has been provided. Attached is a more detailed account as well as emails from my Facility Medical director, Chief medical officer, and the health care authority.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	03/06/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

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☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

EEOC, DOC internal discrimination complaint

DATE(S) FILED	CASE NUMBER(S) (If known)
02/06/2018, 11/16/2017	null, null

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

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Office for Civil Rights
Centralized Case Management Operations
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Burden Statement
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HHS-699 (7/09) (BACK)

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Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 03/06/2018

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

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(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
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CAN I SEE MY OCR FILE?

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If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

-April 2017 - Offender Approved by gender dysphoria Care Review Committee (CRC) for hormone therapy. My religious conviction will not allow me to prescribe hormones for this indication. [redacted] provided a reasonable accommodation at that time by taking over the management of this element of the patient's healthcare request.
-September 28th forwarded KITE from NEW offender requesting renewal of hormones for GD to [redacted]
-September 29th 2017 - Annual DOC health care provider meeting. Three hours of education on Gender dysphoria (GD).
-October 2nd - Noticed KITE response from [redacted] to offender saying "follow up with PCP." [redacted] volunteered to manage this issue for the patient.
-October 4th - Medical provider meeting: [redacted] read a series of scenarios asking the providers about religious ethics in the medical field. She gave an example of a Muslim working as a hospitalist who morally objected to hospice care because he viewed it as similar to euthanasia. She gave another example of a Jehovah's Witness working in an ER who morally objected to blood transfusions. (Both of these scenarios are extreme situations that would never happen. You would never encounter a hospitalist who wouldn't be ok with hospice and you would never find an ER provider who was not ok with blood transfusions.) In both of these scenarios she emphasized the "undue hardship" that would be placed on the conscientious objector's colleagues. These were directed at me in front of my colleagues.
-October 9th - Had in person conversation with [redacted] regarding treatment of GD. She stated that it would be the expectation of the provider on site to prescribe hormones and if I decided to stay working for the DOC than I would be expected to prescribe. I expressed that it is not an option for me to prescribe for this due to my conscience and religious beliefs. I expanded that other providers have already offered to do this. (See email chain started on October 9th titled "conversation with [redacted]")
-October 12th - Email from [redacted] forwarding an email to [redacted] and myself stating "forwarding to his primary care providers." [redacted] replied to the email.
-October 18th - Forwarded KITE from offender regarding GD to [redacted] and [redacted]. Phone call with [redacted] (CMO) (@10:44 on state phone) and [redacted] (@13:02pm on work phone [redacted] Told them individually that this is a personal religious conviction that causes me to not be able to prescribe hormones for this indication but that I have found ways to mitigate this through other providers. Both of them stated that if I were to stay with the department I would be expected to prescribe this medication. If they were to allow this then it would be a slippery slope for anyone with religious convictions to not follow department policy.
-October 24th - Email from [redacted] to [redacted] stating "this is [redacted] patient and he needs to see the patient."
-October 26th around 1500 - [redacted] called [redacted] and ordered her not to prescribe any hormone therapy for inmates at IMU and to call her if I asked her to do so. Email from [redacted] with a KITE to the offender stating "Per [redacted], [redacted] is your provider while you are in the IMU"…
-October 31st - Received call from [redacted] who told me that [redacted] called her and told her she was "forbidden" from seeing my patients.
-December 11th - Email from [redacted] stating that the department cannot accommodate to my religious conviction.

-January 4th – Phone call from internal discrimination stating that there will not be an investigation as this is clearly under the rules of discrimination for Washington State.
March 6th – Received call from [redacted] (Program Manager - Diversity & Recruitment) and he states that [redacted] did not believe that my accommodation was reasonable. He did not really address my questions as to why beyond referencing policy 100.500 as their rational. That in some way I was being discriminatory. Did not feel like they addressed the fact that they are refusing to let me refer patients based on a religious belief.

I have never been discriminatory to any patient. In fact, I saw this particular patient regarding other medical issues. I told him that his hormone management would be managed by [redacted] and [redacted]. He was fine with this. I am unable to prescribe or order laboratory tests for this indication because of my conscience and religious objections and it is getting to the point where I am feeling discriminated against for my beliefs. Telling all the other providers that they cannot see any of my patients is discriminatory because this has not been done to any other providers and the reason is because of my religious belief. I am providing access to care and there are willing prescribers to manage this low acuity issue in a small subset of inmates and clearly does not pose undue hardship on anyone. There had been reasonable accommodation for this in the past but is now being taken away. I feel like [redacted] and DOC health services leadership is placing undue burden on me and is being irresponsible by knowing what I have said yet continuing to pass the issue to me as if I am going to change my mind on my deeply held convictions. Attempting to force my hand is creating a hostile work environment for me.

[redacted]

From: [redacted]
Sent: Monday, December 11, 2017 4:51 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Conscientious objection.

Hi [redacted]

My apologies. [redacted] and I have been playing "phone tag" due to our busy schedules.

After consultation with DOC Leadership, it will continue to be an expectation that you provide all health care to your patient panel. Passing patient care to another clinician due to personal beliefs is not something that the Department cannot support.

While I do respect your personal beliefs, this is something that we cannot accommodate.

[redacted]

From: [redacted]
Sent: Friday, December 08, 2017 2:03 PM
To: [redacted]
Subject: Conscientious objection.

[redacted]

I wanted to hear from you what your understanding is of my consciences objection to prescribing hormone therapy for transgender individuals. I know that [redacted] was supposed to reach out to you but I have not heard back yet. Is it still leadership's stance that if I stay employed with the DOC I will be expected to prescribe hormones for this indication and that no reasonable accommodation will be provided?

Thanks,

[redacted]

[redacted]

Monroe Correction Complex

Phone: [redacted]

[redacted]

From: [redacted]
Sent: Thursday, October 26, 2017 8:26 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted]

Hello,
I want to remind us all that every medical practitioner is expected to uphold the mission of the DOC and provide care to their patients as consistent with Department policies. No one practitioner is allowed to pick and choose those conditions within appropriate scope of practice that they will and will not treat. It is the responsibility of each provider to fully manage each patient's medical needs within their capabilities, escalating or referring care to specialists as appropriate. Intentionally failing or refusing to fully manage each patient's medical needs impedes the care of the patient and may lead to corrective or disciplinary action. Please note that referrals to other providers to manage these patients creates extra work burden for one's colleagues and can create a sense that the patient is being treated differently than others.

[redacted]
Chief Medical Officer
Health Services Division
Department of Corrections
Tumwater, WA 98504-1123

From: [redacted]
Sent: Wednesday, October 25, 2017 12:24 PM
To: [redacted]
Cc: [redacted]
K. [redacted]
Subject: RE: [redacted]

As discussed, you've received training on how to manage these patients, and it is expected of the midlevel providers to provide their direct care. It is not appropriate to wash your hands of this issue, which is what you are seeking to do by sending all these kites to me.

From [redacted]
Sent: Wednesday, October 25, 2017 12:21 PM
To: [redacted]
Cc: [redacted]
Subject: [redacted]

[redacted]

From: [redacted]
Sent: Tuesday, October 10, 2017 7:42 PM
To:
Subject: [redacted]

I will be at MCC again this week both Wednesday 10/11 and Thursday 10/12. I will attempt to stop by and see you then.

[redacted] Union Representative
Teamsters Local Union No. 117

[redacted]
We build unity and power for all working people to improve lives and lift up our communities. This is our Union.

Teamsters Local Union No. 117 Confidentiality Statement

This message and any attached files might contain confidential information protected by federal and state law. The information is intended only for the use of the individual(s) or entities originally named as addressees. The improper disclosure of such information may be subject to civil or criminal penalties. If this message reached you in error, please contact the sender and destroy this message. Disclosing, copying, forwarding, or distributing the information by unauthorized individuals or entities is strictly prohibited by law.

-----Original Message-----
From: [redacted]
Sent: Tuesday, October 10, 2017 8:28 AM
To: [redacted]
Subject: FW: Conversation with [redacted]

[redacted]
I am not sure what your role is but I am seeking some legal counsel as I am a teamsters member. Below is a conversation that has started surrounding the gender dysphoria issue in our state. I am a medical provider at Monroe Correctional Complex. I am a blue badge employee and have been for 2 years. The issue is this: I am ethically opposed to prescribing hormone therapy to men for the purpose of "treating" their gender dysphoria but it is the DOCs mission to do this. I am essential being told that I will need to prescribe these medications or find another Job. Do you have any suggestions on a route I should take

[redacted]
I included you because you are my union representative. Feel free to stop by the IMU to discuss further

-----Original Message-----
From: [redacted]
Sent: Tuesday, October 10, 2017 8:04 AM
To: [redacted]
Cc: [redacted]
Subject: Re: Conversation with [redacted]

Hi [redacted]

That's not quite what I said, but if it's what you took away from that conversation, please let me clarify.

You are not being asked to leave. What I said was that as an employee acting on behalf of the state, you are expected to carry out the mission of DOC, which includes providing hormone treatment for gender dysphoria. If you are unwilling to do this, then you need to examine whether DOC is the right place for you.

But as long as you continue in your role as a medical provider for DOC, you will be expected to provide this care.

Your personal beliefs do not enter into the issue, though I do recognize that your decision will be determined by them. And no one is happy that you may choose to leave.

However, if you determine that you cannot support DOC's mission in this regard, we will support you in seeking other employment, and provide an excellent recommendation.

I hope this clarifies things.

Thanks,
[redacted]

Sent from my iPhone

> On Oct 9, 2017, at 9:25 PM, [redacted]
>
> I had a conversation with [redacted] today and I wanted to make sure that I am understanding what you all decided.
>
> Essentially, it is now part of the DOCs mission to treat transgender individuals with hormone therapy and this therapy will be issued by the provider onsite once approved by the gender dysphasia CRC. And if i, the prescriber, cannot align myself with this mission due to my strong conviction that this is harmful to my patients in a medical, social, biblical, and biologic way, I will be asked to find a job elsewhere.
>
> Is this accurate?
>
> Anyone feel free to answer.
>
> Sent from my iPhone

The Washington Department of Corrections is increasing the security level for email messages containing confidential or restricted data. A new Secure Email Portal is being implemented. Outbound email messages from DOC staff that contain confidential or restricted data will be routed to the portal. A notification of the secured message will be delivered to the recipient.

Click on the following web link for more information. http://doc.wa.gov/information/secure-email.htm

[redacted]

From: [redacted]
Sent: Thursday, October 19, 2017 12:04 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Conversation with [redacted]

Sorry- this was stuck in my outbox from yesterday.

From: [redacted]
Sent: Thursday, October 19, 2017 12:03 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Conversation with [redacted]

[redacted]

Good speaking with you today. I understand your position and I hope I have been able to clearly articulate the importance of DOC practitioners adhering to the Department policy in treating pat6ients. As we discussed, the next step is for you to speak with [redacted]. I copy both of them as well as their assistants here.
best,
[redacted]

From: [redacted]
Sent: Monday, October 16, 2017 10:40 PM
To: [redacted]
Subject: Re: Conversation with [redacted]

[redacted] I initially told you that tomorrow might work for me but I actually will not be in tomorrow. I should be in on Wednesday however if you want to talk. Let me know. We could also just do a phone call sometime
Thanks,
[redacted]

Sent from my iPhone

On Oct 11, 2017, at 10:44 AM, [redacted] wrote:

> Hi [redacted]
> [redacted] is out of the office so I will respond.
> Thank you for reaching out and sharing your understanding of the conversation you had with [redacted] regarding the treatment of Gender Dysphoria within the Department of Corrections. It is true that it is DOC policy to provide medically appropriate treatment to individuals with Gender Dysphoria as approved by the Gender Dysphoria Care Review Committee. This includes hormonal treatment according to guidelines consistent with community practice.
> I am happy to meet and discuss your concerns with you. I could come out to Monroe next week on a mutually agreeable date.
> best,
>
> [redacted]
> Chief Medical Officer
> Health Services, Department of Corrections

From: [redacted]
Sent: Monday, October 09, 2017 9:25 PM
To: [redacted]
(DOC)
Subject: Conversation with [redacted]

I had a conversation with [redacted] today and I wanted to make sure that I am understanding what you all decided.

Essentially, it is now part of the DOCs mission to treat transgender individuals with hormone therapy and this therapy will be issued by the provider onsite once approved by the gender dysphasia CRC. And if i, the prescriber, cannot align myself with this mission due to my strong conviction that this is harmful to my patients in a medical, social, biblical, and biologic way, I will be asked to find a job elsewhere.

Is this accurate?

Anyone feel free to answer.

Sent from my iPhone

I understand. I will manage these patient by continuing to refer them to either you or one of the other providers in a timely manner just like is done with the hepatitis C patients.

From: [redacted]
Sent: Wednesday, October 25, 2017 12:03 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted]

[redacted]

As you've been told separately by me, [redacted] you are expected to manage patients' transgender issues while they reside on your unit, as is expected of all providers.

Thanks,

[redacted]
Facility Medical Director, MCC
[redacted]

From [redacted]
Sent: Wednesday, October 25, 2017 9:50 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted]

I did see the patient in regard to his Ensure request and ear pain. I told him that [redacted] would be managing his transgender issue. He had no issue with another provider seeing him for this. He was quite frustrated that he only received 2 responses from the 12 kites he has sent. Please see this patient at your convenience.
Thanks.
[redacted]

From: [redacted]
Sent: Wednesday, October 25, 2017 8:30 AM
To [redacted]
Subject: FW: [redacted]

He[redacted]
FYI
Thanks,

[redacted]

From: [redacted]
Sent: Tuesday, October 24, 2017 4:10 PM
To: [redacted]
Subject: RE: [redacted]

This is [redacted]atient and he needs to see the patient.

From: [redacted]
Sent: Tuesday, October 24, 2017 3:00 PM
To: [redacted]
Cc [redacted]
Subject: FW: [redacted]

Hi [redacted],
Would you like me to see [redacted] in the IMU or would you like to?
Thanks,
[redacted]

From [redacted]
Sent: Tuesday, October 24, 2017 11:32 AM
To: [redacted]
Subject: RE: [redacted]

Not sure. I asked this morning but they don't know. Could be for a few more weeks.

From: [redacted]
Sent: Tuesday, October 24, 2017 11:32 AM
To [redacted]
Subject: RE: [redacted]

Any idea on how long she will be in the IMU?

From [redacted]
Sent: Tuesday, October 24, 2017 11:19 AM
To: [redacted]
Subject: [redacted]

[redacted]
Is wanting some follow up regarding his hormones. He is not happy that his testosterone is so high. Ill defer to you.

No reasonable accommodation provided for my religious objection to prescribing hormones to men wanting to transition into women. When other providers offered to prescribe hormones to these patients under my care they were told by DOC leadership that they could not see my patients and no accommodation has been provided. Attached is a more detailed account as well as emails from my Facility Medical director, Chief medical officer, and the health care authority.

Exhibit 128

On or about July 2017 the above named posted medical records and social security information regarding my person on social media (Facebook) under [redacted]

Clear violation of my hippa rights and ss rights

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	[redacted]
HOME / CELL PHONE (Please include area code)	WORK PHONE (Please include area code)
[redacted]	
STREET ADDRESS	CITY
[redacted]	[redacted]
STATE	ZIP
[redacted]	[redacted]

E-MAIL ADDRESS (If available): [redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☐ Religion / Conscience ☐ Sex
☐ Disability ☒ Other (specify): mdeical and social security number violation

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

[redacted]

STREET ADDRESS	CITY
[redacted]	[redacted]
STATE	ZIP
[redacted]	[redacted]

PHONE (Please include area code)

When do you believe that the discrimination occurred?

LIST DATE(S)

07/03/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

On or about July 2017 the above named posted medical records and social security information regarding my person on social media (Facebook) under Melanie Little.

Clear violation of my hippa rights and ss rights

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE	DATE *(mm/dd/yyyy)*
[redacted]	03/08/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☒ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement
Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 03/08/2018

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted]

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

Exhibit 129

Form Approved: OMB No. 0945-0002
Expiration Date: 04/30/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

Civil Rights Discrimination Complaint

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	N/A
HOME PHONE (*Please include area code*)	WORK PHONE (*Please include area code*)
	[redacted]
STREET ADDRESS	CITY
[redacted]	
STATE	ZIP
[redacted]	

Are you filing this complaint for someone else? ☑ Yes ☐ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME
American Association of ProLife Ob-Gyn	

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ■ Religion / Conscience ☐ Sex
☐ Disability ☐ Other (specify):

Who or what agency or organization do you believe discriminated ag

PERSON / AGENCY / ORGANIZATION: [redacted]

STREET ADDRESS	
409 12th Street SW	Washington
STATE	ZIP
D.C.	20024

PHONE (*Please include area code*): (202) 638-5277

When do you believe that the occurred?

LIST DATE(S)

Starting November 2007 to present

Describe briefly what happened. How and why do you believe you have been discriminated against? Please be as specific as possible.

(Attach additional pages as needed)

Please see letter attached stating specifics

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE

DATE 3/23/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for OCR to communicate with you about this complaint? (*Check all that apply*)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (*Please include area code*)	WORK PHONE (*Please include area code*)

STREET ADDRESS		CITY
STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (*Attach additional pages as needed*)

PERSON / AGENCY / ORGANIZATION / COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public; please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (*select one*)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (*select one or more*)

☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other than English):

How did you learn about the Office for Civil Rights?

■ HHS Website /Internet Search ☐ Family / Friend /Associate ☐ Religious /Community Org ☐ Lawyer /Legal Org ☐ Phone Directory ☐ Employer

☐ Fed /State/Local Gov ☐ Healthcare Provider /Health Plan ☐ Conference /OCR Brochure ☐ Other(*specify*):

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services

Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail this complaint form to this address.**

HHS-700 (10/17) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights and Protecting Personal Information in Complaint Investigations for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

☒ **CONSENT**: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☐ **CONSENT DENIED**: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: Date: 3/23/2018

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Pl[redacted]

Address:

Telephon

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

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OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

THOMAS MORE SOCIETY
A National Public Interest Law Firm

March 23, 2018

Via US Mail & email: ocrmail@hhs.gov

U.S. Department of Health and Human Services
Office of Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201

Re: Violations of Conscience Rights of Physicians

Dear members of the Office of Civil Rights for the Department:

We write on behalf of our client, American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG") and its Executive Director, [redacted] M.D., seeking the assistance of the Office of Civil Rights to investigate ongoing efforts by the American College of Obstetricians and Gynecologists ("ACOG") and its lobbying sister organization American Congress of Obstetrics and Gynecology ("The Congress") to stifle and countermand conscience rights of pro-life physicians to decline to perform, participate in, or assist in the performance of abortion practices because of their conscience and/or religious opposition to such practices.

AAPLOG is a nonprofit professional medical organization consisting of approximately 4,000 obstetrician-gynecologist members and associates practicing medicine in the United States and in several foreign countries. Its mission is to encourage the practice of medicine consistent with scientific truth and the Hippocratic oath, both of which it views as orienting medicine, as a healing art, toward the well-being and flourishing of all human life. ACOG is another membership organization of obstetricians and gynecologists. It purports to represent 58,000 physicians and partners. The Congress, ACOG's sister organization, a 501(c)(4) organization under the Internal Revenue Code, exists "to promote policy positions" of ACOG, in other words, to lobby. All members of ACOG are automatically members of The Congress regardless of the desire of the member to abstain from the Congress's pro-abortion lobbying.

In November 2007 ACOG issued Ethics Statement #385. **Exhibit One.** ACOG in this statement declares to be "unethical" any physician refusing to perform or refer for elective abortions. This statement was promptly and vigorously called into

19 S. LaSalle | Suite 603 | Chicago, IL 60603 | | P: 312.782.1680 | F: 312.782.1887
501 Scoular | 2027 Dodge | Omaha, NE 68102 | | P: 402-346-5010 | F: 402 345 8853
www.thomasmoresociety.org

"Injustice anywhere is a threat to justice everywhere." – Rev. Dr. Martin Luther King

question by AAPLOG, other medical associations, and speakers before the President's Council on Bioethics. See, e.g., **Exhibit Two** (AAPLOG Response of Feb. 6, 2008); **Exhibit Three** (Letter from Catholic Medical Association, February 28, 2008); **Exhibit Four** (Joint Letter of Protest by various medical organizations, Dec. 7, 2007); **Exhibit Five** (Letter by 16 Members of Congress, March 14, 2008). These and other objectors requested that ACOG retract the Ethics Statement #385 as being unsupported and discriminatory. At the same time, the Department of Health and Human Services ("HHS") sent a letter to the American Board of Obstetrics and Gynecology ("ABOG"), which is the certifying body for obstetricians and gynecologists in the U.S., objecting to the ACOG policy and questioning its influence on ob-gyn certification procedures. See **Exhibit Six** (March 14, 2008 Letter to [redacted], M.D., Executive Director ABOG). ABOG responded with a letter protesting its innocence. See **Exhibit Seven** (March 19, 2008 Letter of [redacted], M.D. to [redacted], Secretary HHS). ACOG itself responded to the criticism by promising its members to revisit Ethics Statement #385, see **Exhibit Eight** (Letter to [redacted] March 26, 2008), but it never changed the policy, instead reconfirming it, most recently in 2016.[1]

ABOG's letter (Exhibit Seven) as a disclaimer carries no legal weight, since it is not an affirmative policy statement of ABOG itself. It thus gives no assurance to a pro-life ob-gyn against accusation of unethical conduct under Ethics Statement #385 upon a conscience-based refusal to perform or refer for abortion. What is needed is an affirmative statement from ABOG declaring that a conscience-based refusal to perform or refer for abortion does *not* constitute an ethical violation. But that has not been forthcoming. Without it an ob-gyn remains vulnerable to the possibility that his or her conscience-based refusal to participate in abortion could be considered unethical, prompting a loss of board certification, loss of employment, and other professional and personal adverse consequences. In that respect, the threat posed by Ethics Statement #385 is neither imaginary nor inflated. Under ABOG's current rules, an accusation of unethical professional behavior can lead to rescission of board certification, loss of licensure, and loss of hospital privileges.[2] Indeed, the very existence of Ethics Statement #385 is a

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[1] See https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine (last visited, March 21, 2018).

[2] See 2018 Bulletin for the Certifying Examination in Obstetrics and Gynecology, accessible at https://www.abog.org/bulletins/2018%20Certifying%20Examination%20in%20Obstetrics%20and%20Gynecology.pdf (last visited March 21, 2018). The Bulletin states, at p.7: "If a candidate is involved in an investigation by a health care organization regarding practice

sword of Damocles hanging over Hippocratic oath physicians, and exerts a continuing chilling effect on their conscientious performance of ob-gyn services.

This ongoing state of affairs -- in which a licensed and board certified obstetrician-gynecologist can potentially be denied certification solely on the basis of refusal to perform or refer for abortions -- is also undesirable and counterproductive from the standpoint of public policy. As is well known, the United States suffers from a critical shortage of physicians, particularly in rural and other underserved areas of the country. To qualify and certify a single ob-gyn takes eight years of training, including four years of medical school and four years in an approved ob-gyn residency program. Qualified, dedicated ob-gyns provide desperately needed obstetric and gynecological services throughout the United States, including in rural and underserved areas of our country where their professional services often constitute the primary care for women of reproductive age. To deny certification to a fully trained ob-gyn solely because of ideological disagreement with a conscience-based objection to perform or refer for abortion would disserve all women who depend on such physicians, and exacerbate the already critical shortage of health care professionals in rural and other underserved communities, which desperately require such services. This makes no sense as sound public policy.

The 4,000 members of AAPLOG and countless other physicians consider ACOG Ethics Statement #385 to pose an intentional and systematic threat to the right of Hippocratic physicians in this country to follow, on the basis of conscience, time-honored Hippocratic principles of medicine. The very existence of this policy violates the conscience rights of all AAPLOG members, whom Dr. Harrison represents as Executive Director of AAPLOG, and the conscience rights of all pro-life physicians in this country.

For these reasons, AAPLOG hereby petitions the OCR for an investigation into:

1. The systematic and continued violation of conscience rights of Hippocratic physicians authorized by ACOG's adoption and continued advancement of Ethics Statement #385.

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activities or for ethical or moral issues, the individual will not be scheduled for examination, and a decision to approve or disapprove the application will be deferred until either the candidate has been cleared or until ABOG has received sufficient information to make a final decision." See also, at p. 8: "This means that each such medical license must not be restricted, suspended, on probation, revoked, nor include conditions of practice. The terms 'restricted' and 'conditions' include any and all limitations, terms or requirements imposed on a physician's license regardless of whether they deal directly with patient care."

2. The relationship between ABOG with ACOG, an abortion advocacy organization, and the use by ABOG of ACOG Ethics Statement #385 as a criteria for board certification.

3. The unlawful use by covered entities of ABOG board certification or ACOG Ethics Statement #385 to intimidate and discriminate against individuals in violation of federal laws protecting conscience rights.

We respectfully request your office, after investigating these issues, to take appropriate action to prevent -- both now and for the future -- ACOG's political views favoring abortion, and its policy statements arising from those views, from interfering with, curtailing, or punishing the rights of conscience of pro-life physicians and service providers. In this regard, we respectfully request that HHS issue regulations that: (1) Require covered entities to provide a clear statement that covered entities cannot discriminate against individuals or healthcare entities because they refuse to perform, refer for, or train to perform, elective abortions; and (2) Require covered entities to post notices informing all healthcare providers of their conscience rights as well as that government offices individuals or healthcare entities can contact to request assistance in the event their rights are violated.

AAPLOG believes that HHS should take these and other steps necessary to prevent ABOG and ACOG from the current cat-and-mouse strategy that is being used to intimidate and harass pro-life physicians and service providers in a manner wholly inconsistent with the letter and spirit of the federal laws protecting conscience.

Thank you for considering this complaint. Please contact the undersigned in the event additional information is needed to bring your investigation to conclusion.

Respectfully,

[redacted]

Counsel, Thomas More Society

[redacted]

Enclosures

EXHIBIT ONE

The Limits of Conscientious Refusal in Reproductive Medicine

ACOG COMMITTEE OPINION

Number 385, November 2007 *Reaffirmed 2016*

Committee on Ethics

PDF Format

The Limits of Conscientious Refusal in Reproductive Medicine

ABSTRACT: Health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. In resource-poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

Physicians and other providers may not always agree with the decisions patients make about their own health and health care. Such differences are expected—and, indeed, underlie the American model of informed consent and respect for patient autonomy. Occasionally, however, providers anticipate that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience. In such cases, some providers claim a right to refuse to provide certain services, refuse to refer patients to another provider for these services, or even decline to inform patients of their existing options (1).

Conscientious refusals have been particularly widespread in the arena of reproductive medicine, in which there are deep divisions regarding the moral acceptability of pregnancy termination and contraception. In Texas, for example, a pharmacist rejected a rape victim's prescription for emergency contraception, arguing that dispensing the medication was a "violation of morals" (2). In Virginia, a 42-year-old mother of two was refused a prescription for emergency contraception, became pregnant, and ultimately underwent an abortion she tried to prevent by requesting emergency contraception (3). In California, a physician refused to perform intrauterine insemination for a lesbian couple, prompted by religious beliefs and disapproval of lesbians having children (4). In Nebraska, a 19-year-old woman with a life-threatening pulmonary embolism at 10 weeks of gestation was refused a first-trimester pregnancy termination when admitted to a religiously affiliated hospital and was ultimately transferred by ambulance to another facility to undergo the procedure (5). At the heart of each of these examples of refusal is a claim of conscience—a claim that to provide certain services would compromise the moral integrity of a provider or institution.

In this opinion, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics considers the issues raised by conscientious refusals in reproductive medicine and outlines a framework for defining the ethically appropriate limits of conscientious refusal in reproductive health contexts. The committee begins by offering a definition of conscience and describing what might constitute an authentic claim of conscience. Next, it discusses the limits of conscientious refusals, describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care. It then outlines options for public policy regarding conscientious refusals in reproductive medicine. Finally, the committee proposes a series of recommendations that maximize accommodation of an individual's religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.

Defining Conscience

In this effort to reconcile the sometimes competing demands of religious or moral freedom and reproductive rights, it is important to characterize what is meant by conscience. Conscience has been defined as the private, constant, ethically

attuned part of the human character. It operates as an internal sanction that comes into play through critical reflection about a certain action or inaction (6). An appeal to conscience would express a sentiment such as "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night." According to this definition, not to act in accordance with one's conscience is to betray oneself—to risk personal wholeness or identity. Thus, what is taken seriously and is the specific focus of this document is not simply a broad claim to provider autonomy (7), but rather the particular claim to a provider's right to protect his or her moral integrity—to uphold the "soundness, reliability, wholeness and integration of [one's] moral character" (8).

Personal conscience, so conceived, is not merely a source of potential conflict. Rather, it has a critical and useful place in the practice of medicine. In many cases, it can foster thoughtful, effective, and humane care. Ethical decision making in medicine often touches on individuals' deepest identity–conferring beliefs about the nature and meaning of creating and sustaining life (9). Yet, conscience also may conflict with professional and ethical standards and result in inefficiency, adverse outcomes, violation of patients' rights, and erosion of trust if, for example, one's conscience limits the information or care provided to a patient. Finding a balance between respect for conscience and other important values is critical to the ethical practice of medicine.

In some circumstances, respect for conscience must be weighed against respect for particular social values. Challenges to a health care professional's integrity may occur when a practitioner feels that actions required by an external authority violate the goals of medicine and his or her fiduciary obligations to the patient. Established clinical norms may come into conflict with guidelines imposed by law, regulation, or public policy. For example, policies that mandate physician reporting of undocumented patients to immigration authorities conflict with norms such as privacy and confidentiality and the primary principle of nonmaleficence that govern the provider–patient relationship (10). Such challenges to integrity can result in considerable moral distress for providers and are best met through organized advocacy on the part of professional organizations (11, 12). When threats to patient well-being and the health care professional's integrity are at issue, some individual providers find a conscience-based refusal to comply with policies and acceptance of any associated professional and personal consequences to be the only morally tenable course of action (10).

Claims of conscience are not always genuine. They may mask distaste for certain procedures, discriminatory attitudes, or other self-interested motives (13). Providers who decide not to perform abortions primarily because they find the procedure unpleasant or because they fear criticism from those in society who advocate against it do not have a genuine claim of conscience. Nor do providers who refuse to provide care for individuals because of fear of disease transmission to themselves or other patients. Positions that are merely self-protective do not constitute the basis for a genuine claim of conscience. Furthermore, the logic of conscience, as a form of self-reflection on and judgment about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say "I would have a guilty conscience if she did 'x.'" Although some have raised concerns about complicity in the context of referral to another provider for requested medical care, the logic of conscience entails that to act in accordance with conscience, the provider need not rebuke other providers or obstruct them from performing an act (8). Finally, referral to another provider need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees (14).

The authenticity of conscience can be assessed through inquiry into 1) the extent to which the underlying values asserted constitute a core component of a provider's identity, 2) the depth of the provider's reflection on the issue at hand, and 3) the likelihood that the provider will experience guilt, shame, or loss of self-respect by performing the act in question (9). It is the genuine claim of conscience that is considered next, in the context of the values that guide ethical health care.

Defining Limits for Conscientious Refusal

Even when appeals to conscience are genuine, when a provider's moral integrity is truly at stake, there are clearly limits to the degree to which appeals to conscience may justifiably guide decision making. Although respect for conscience is a value, it is only a prima facie value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance. Professional ethics requires that health be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and nondiscriminatory. By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice (15). Thus, with professional privileges come professional responsibilities to patients, which must precede a provider's personal interests (16). When conscientious refusals conflict with moral obligations that are central to the ethical practice of medicine, ethical care requires either that the physician provide care despite reservations or that there be resources in place to allow the patient to gain access to care in the presence of conscientious refusal. In the following sections, four criteria are highlighted as important in determining appropriate limits for conscientious refusal in reproductive health contexts.

1. Potential for Imposition

The first important consideration in defining limits for conscientious refusal is the degree to which a refusal constitutes an imposition on patients who do not share the objector's beliefs. One of the guiding principles in the practice of medicine is respect for patient autonomy, a principle that holds that persons should be free to choose and act without controlling constraints imposed by others. To respect a patient's autonomy is to respect her capacities and perspectives, including her right to hold certain views, make certain choices, and take certain actions based on personal values and beliefs (17). Respect involves acknowledging decision-making rights and acting in a way that enables patients to make choices for themselves. Respect for autonomy has particular importance in reproductive decision making, which involves private, personal, often pivotal decisions about sexuality and childbearing.

It is not uncommon for conscientious refusals to result in imposition of religious or moral beliefs on a patient who may not share these beliefs, which may undermine respect for patient autonomy. Women's informed requests for contraception or sterilization, for example, are an important expression of autonomous choice regarding reproductive decision making. Refusals to dispense contraception may constitute a failure to respect women's capacity to decide for themselves whether and under what circumstances to become pregnant.

Similar issues arise when patients are unable to obtain medication that has been prescribed by a physician. Although pharmacist conduct is beyond the scope of this document, refusals by other professionals can have an important impact on a physician's efforts to provide appropriate reproductive health care. Providing complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine. Providers refusing to provide such information on the grounds of moral or religious objection fail in their fundamental duty to enable patients to make decisions for themselves. When the potential for imposition and breach of autonomy is high due either to controlling constraints on medication or procedures or to the provider's withholding of information critical to reproductive decision making, conscientious refusal cannot be justified.

2. Effect on Patient Health

A second important consideration in evaluating conscientious refusal is the impact such a refusal might have on well-being as the patient perceives it—in particular, the potential for harm. For the purpose of this discussion, harm refers to significant bodily harm, such as pain, disability, or death or a patient's conception of well-being. Those who choose the profession of medicine (like those who choose the profession of law or who are trustees) are bound by special fiduciary duties, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest (16). Although conscientious refusals stem in part from the commitment to "first, do no harm," their result can be just the opposite. For example, religiously based refusals to perform tubal sterilization at the time of cesarean delivery can place a woman in harm's way—either by putting her at risk for an undesired or unsafe pregnancy or by necessitating an additional, separate sterilization procedure with its attendant and additional risks.

Some experts have argued that in the context of pregnancy, a moral obligation to promote fetal well-being also should justifiably guide care. But even though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients. Indeed, in the vast majority of cases, the interests of the pregnant woman and fetus converge. For situations in which their interests diverge, the pregnant woman's autonomous decisions should be respected (18). Furthermore, in situations "in which maternal competence for medical decision making is impaired, health care providers should act in the best interests of the woman first and her fetus second" (19).

3. Scientific Integrity

The third criterion for evaluating authentic conscientious refusal is the scientific integrity of the facts supporting the objector's claim. Core to the practice of medicine is a commitment to science and evidence-based practice. Patients rightly expect care guided by best evidence as well as information based on rigorous science. When conscientious refusals reflect a misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part, by the strength or weakness of the science on which refusals are based. In other words, claims of conscientious refusal should be considered invalid when the rationale for a refusal contradicts the body of scientific evidence.

The broad debate about refusals to dispense emergency contraception, for example, has been complicated by misinformation and a prevalent belief that emergency contraception acts primarily by preventing implantation (20). However, a large body of published evidence supports a different primary mechanism of action, namely the prevention of fertilization. A review of the literature indicates that Plan B can interfere with sperm migration and that preovulatory use of Plan B suppresses the luteinizing hormone surge, which prevents ovulation or leads to the release of ova that are resistant to fertilization. Studies do not support a major postfertilization mechanism of action (21). Although even a slight possibility of postfertilization events may be relevant to some women's decisions about whether to use contraception, provider refusals to dispense emergency contraception based on unsupported beliefs about its primary mechanism of action should not be justified.

In the context of the morally difficult and highly contentious debate about pregnancy termination, scientific integrity is one of several important considerations. For example, some have argued against providing access to abortion based on claims that induced abortion is associated with an increase in breast cancer risk; however, a 2003 U.S. National Cancer Institute panel concluded that there is well-established epidemiologic evidence that induced abortion and breast cancer are not associated (22). Refusals to provide abortion should not be justified on the basis of unsubstantiated health risks to women.

Scientific integrity is particularly important at the level of public policy, where unsound appeals to science may have masked an agenda based on religious beliefs. Delays in granting over-the-counter status for emergency contraception are one such example. Critics of the U.S. Food and Drug Administration's delay cited deep flaws in the science and evidence used to justify the delay; flaws these critics argued were indicative of unspoken and misplaced value judgments (23). Thus, the scientific integrity of a claim of refusal is an important metric in determining the acceptability of conscience-based practices or policies.

4. Potential for Discrimination

Finally, conscientious refusals should be evaluated on the basis of their potential for discrimination. Justice is a complex and important concept that requires medical professionals and policy makers to treat individuals fairly and to provide medical services in a nondiscriminatory manner. One conception of justice, sometimes referred to as the distributive paradigm, calls for fair allocation of society's benefits and burdens. Persons intending conscientious refusal should consider the degree to which they create or reinforce an unfair distribution of the benefits of reproductive technology. For instance, refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not realistically available to her. She thus may experience loss of control of her reproductive fate and quality of life for herself and her children. Refusals that unduly burden the most vulnerable of society violate the core commitment to justice in the distribution of health resources.

Another conception of justice is concerned with matters of oppression as well as distribution (24). Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well. Consider, for instance, refusals to provide infertility services to same-sex couples. It is likely that such couples would be able to obtain infertility services from another provider and would not have their health jeopardized, per se. Nevertheless, allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult, namely reinforcing the scientifically unfounded idea that fitness to parent is based on sexual orientation, and, thus, reinforcing the oppressed status of same-sex couples. The concept of oppression raises the implications of all conscientious refusals for gender justice in general. Legitimizing refusals in reproductive contexts may reinforce the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally. As the place of conscience in reproductive medicine is considered, the impact of permissive policies toward conscientious refusals on the status of women must be considered seriously as well.

Some might say that it is not the job of a physician to "fix" social inequities. However, it is the responsibility, whenever possible, of physicians as advocates for patients' needs and rights not to create or reinforce racial or socioeconomic inequalities in society. Thus, refusals that create or reinforce such inequalities should raise significant caution.

Institutional and Organizational Responsibilities

Given these limits, individual practitioners may face difficult decisions about adherence to conscience in the context of professional responsibilities. Some have offered, however, that "accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences" (1). Rather, institutions and professional organizations should work to create and maintain organizational structures that ensure nondiscriminatory access to all professional services and minimize the need for individual practitioners to act in opposition to their deeply held beliefs. This requires at the very least that systems be in place for counseling and referral, particularly in resource-poor areas where conscientious refusals have significant potential to limit patient choice, and that individuals and institutions "act affirmatively to protect patients from unexpected and disruptive denials of service" (13). Individuals and institutions should support staffing that does not place practitioners or facilities in situations in which the harms and thus conflicts from conscientious refusals are likely to arise. For example, those who feel it improper to prescribe emergency contraception should not staff sites, such as emergency rooms, in which such requests are likely to arise, and prompt disposition of emergency contraception is required and often integral to professional practice. Similarly, institutions that uphold doctrinal objections should not position themselves as primary providers of emergency care for victims of sexual assault; when such patients do present for care, they should be given prophylaxis. Institutions should work toward structures that reduce the impact on patients of professionals' refusals to provide standard reproductive services.

Recommendations

Respect for conscience is one of many values important to the ethical practice of reproductive medicine. Given this framework for analysis, the ACOG Committee on Ethics proposes the following recommendations, which it believes maximize respect for health care professionals' consciences without compromising the health and well-being of the women they serve.

1. In the provision of reproductive services, the patient's well-being must be paramount. Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled.
2. Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.
3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.
5. 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.
6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients' rights to health care services.
7. Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.

References

1. Charo RA. The celestial fire of conscience--refusing to deliver medical care. N Engl J Med 2005;352:2471–3.
2. Denial of rape victim's pills raises debate; moral, legal questions surround emergency contraception. New York (NY): Associated Press; 2004. Available at: http://www.msnbc msn.com/id/4359430. Retrieved July 10, 2007.
3. E.D. What happens when there is no plan B? Washington Post; June 4, 2006. p. B1. Available at: http://www washingtonpost.com/wp-dyn/content/article/2006/06/02/ AR2006060201405 html. Retrieved July 10, 2007.
4. Wolf E. Breeder reaction: does everyone now have a right to bear children? Mother Jones 2006;31(4):33–7. Available at: http://www motherjones.com/news/feature/2006/07/breeder_reaction.html. Retrieved July 10, 2007.

5. American Civil Liberties Union. Religious refusals and reproductive rights: ACLU Reproductive Freedom Project. New York (NY): ACLU; 2002. Available at: http://www.aclu.org/FilesPDFs/ACF911.pdf. Retrieved July 10, 2007.
6. Childress JF. Appeals to conscience. Ethics 1979;89:315–35.
7. Wicclair MR. Conscientious objection in medicine. Bioethics 2000;14:205–27.
8. Beauchamp TL, Childress JF. Principles of biomedical ethics. 5th ed. New York (NY): Oxford University Press; 2001.
9. Benjamin M. Conscience. In: Reich WT, editor. Encyclopedia of bioethics. New York (NY): Simon & Schuster Macmillan; 1995. p. 469–73.
10. Ziv TA, Lo B. Denial of care to illegal immigrants. Proposition 187 in California. N Engl J Med 1995;332:1095–8.
11. American College of Obstetricians and Gynecologists. Code of professional ethics of the American College of Obstetricians and Gynecologists. Washington, DC: ACOG; 2004. Available at: http://www.acog.org/~/media/About ACOG/acogcode.ashx Retrieved July 10, 2007.
12. American Medical Association. Principles of medical ethics. In: Code of medical ethics of the American Medical Association: current opinions with annotations, 2006–2007 ed. Chicago (IL): AMA; 2006. p. xv.
13. Dresser R. Professionals, conformity, and conscience. Hastings Cent Rep 2005;35:9–10.
14. Blustein J. Doing what the patient orders: maintaining integrity in the doctor–patient relationship. Bioethics 1993;7:290–314.
15. Brody H, Miller FG. The internal morality of medicine: explication and application to managed care. J Med Philos 1998;23:384–410.
16. Dickens BM, Cook RJ. Conflict of interest: legal and ethical aspects. Int J Gynaecol Obstet 2006;92:192–7.
17. Faden RR, Beauchamp TL. A history and theory of informed consent. New York (NY): Oxford University Press; 1986.
18. Maternal decision making, ethics, and the law. ACOG Committee Opinion No. 321. American College of Obstetricians and Gynecologists. Obstet Gynecol 2005;106:1127–37.
19. International Federation of Gynecology and Obstetrics. Ethical guidelines regarding interventions for fetal well being. In: Ethical issues in obstetrics and gynecology. London (UK): FIGO; 2006. p. 56–7. Available at: http://www.figo.org/docs/Ethics%20Guidelines.pdf. Retrieved July 10, 2007.
20. Cantor J, Baum K. The limits of conscientious objection—may pharmacists refuse to fill prescriptions for emergency contraception? N Engl J Med 2004;351:2008–12.
21. Davidoff F, Trussell J. Plan B and the politics of doubt. JAMA 2006;296:1775–8.
22. Induced abortion and breast cancer risk. ACOG Committee Opinion No. 285. American College of Obstetricians and Gynecologists. Obstet Gynecol 2003;102:433–5.
23. Grimes DA. Emergency contraception: politics trumps science at the U.S. Food and Drug Administration. Obstet Gynecol 2004;104:229–1.
24. Young IM. Justice and the politics of difference. Princeton (NJ): Princeton University Press; 1990.

The limits of conscientious refusal in reproductive medicine. ACOG Committee Opinion No. 385. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1203–8.

ISSN 1074-861X

EXHIBIT TWO

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February 6, 2008

AAPLOG RESPONSE TO THE ACOG ETHICS COMMITTEE OPINION #385, TITLED "THE LIMITS OFCONSCIENTIOUS REFUSAL IN REPRODUCTIVE MEDICINE"

The American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), one of the largest Special Interest Groups of the American College of Obstetricians and Gynecologists (ACOG), strongly objects to the November 2007 release of ACOG Committee Opinion, Number 385, titled "The Limits of Conscientious Refusal in Reproductive Medicine."

We find it unethical and unacceptable that a small committee of ACOG members would pretend to provide the moral compass for 49,000 other members on one of the most ethically controversial issues in our society and within our medical specialty—and that without ever consulting the full membership.

ACOG Committee Opinion #385 is in opposition to 2500 years of accepted Hippocratic ethical medical tradition. Legal elective abortion made a unique arrival in the late 1960s in the United States as part of a legal-societal initiative, rather than as the culmination of a scientific process in biomedicine. The acceptance of elective abortion in American medical practice was contrary to the historic ethical position of Western medicine with regard to abortion.

Therefore it is of great concern that this committee opinion repeatedly describes elective abortion, and other controversial reproductive medical procedures and services as "standard." The term "standard," as used in the document, is never defined. Ideally, a care "standard" would involve a balanced and thorough consideration of the existing medical literature for the effect on the patient's health and well being, both in the short term and in the long term. There is scant evidence regarding the outcomes of elective abortion, other than its decided effectiveness at ending a pregnancy. In general, the long term safety of abortion, and its "benefit" for women, has been either assumed, or accepted on the basis of inadequate follow-up studies.

On the contrary, there are poor reproductive and other health outcomes associated with elective abortion in methodologically sound scientific studies. The data from nations with extensive computer based health registries, where linkage with subsequent health outcomes is a practical reality, show that elective

abortion has significant adverse association with subsequent preterm birth,[1] depression,[2] suicide,[3] placenta previa.[4] and breast cancer.[5] ("Although it remains uncertain whether elective abortion increases subsequent breast cancer, it is clear that a decision to abort and delay pregnancy culminates in a loss of protection with the net effect being an increased risk.")[4]

While there may be conflicting data with regard to these issues, ACOG documents have summarily denied the significance of any literature demonstrating an association. We are aware of no current ACOG educational materials providing balance to this extreme position.

In this regard, we also find the Opinion statement, "Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care," to be at odds with the actual practice of informed consent in elective abortion. The College has allowed the development of a procedure (elective abortion) in its specialty area for which record keeping is inadequate and meaningful tracking of complications is virtually impossible. There is a relative absence of data collected on abortion and subsequent health status in the United States. ACOG has colluded in this state of affairs by not insisting on adequate record keeping and reporting for this procedure. Since accurate risk and complication rates are unavailable, it is vacuous to make reference to "accurate and unbiased information" for making "informed" decisions.

Further, in most instances, the abortion practitioner is not responsible to care for "complications" of his or her work, and often may not even be aware that a complication has occurred. Rather, the emergency room physician, or the obstetrician/gynecologist on call for the emergency department, inherits untoward fallout of abortion. Therefore the physician performing the procedure cannot even accurately reference his or her own experience with regard to complications in informed consent conversations. This is the only instance in American medicine where the operating physician is not the primary physician responsible for the initial oversight of complications of their surgical procedure. Perhaps the ACOG

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[1] National Academy of Science's Institute of Medicine report " Preterm Birth: Causes, Consequences, and Prevention." July 2006, Appendix, page 518-19; Calhoun, B, Rooney, B; "Induced Abortion and Risk of Later Premature Birth," Journal of American Physicians and Surgeons, Volt 8, #2, 2003.

[2] David M. Fergusson, et al; "Abortion In Young Women And Subsequent Mental Health," J. of Child Psychology and Psychiatry, Vol 47:1 2006.

[3] Gissler, M, et.al., "Pregnancy associated deaths in Finland 1987-1994, Acta Obsetricia et Gynecologica Scandinavica 76:651-657, 1997.

[4] Thorp, et al, "Long Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence," OB GYN Survey, Vol 58, No. 1, 2002.

[5] MacMahon, et al, Bull. "Age at First Birth and Breast Cancer Risk", WHO 43:209-221, 1970; Trichopolous D, Hsieh C, MacMahon B, Lin T, et al, Age at any Birth and Breast Cancer Risk, International J Cancer, 31:70l-704, 1983.

Committee on Ethics should address the strange ethics of this "prevailing standard" of reproductive health service.

Dr. Allan Sawyer, who is an AAPLOG member and current Chairman of the ACOG Committee on Coding and Nomenclature, as well as chairman of a hospital ethics committee, has stated in a prior letter to ACOG, "It is a foundational principle of ethics that autonomy must be balanced by the other principles of ethics. Any one principle of ethics cannot trump all of the others, otherwise there is distortion of truth and the dominant principle ends up skewing the analysis. The end result often is anything but ethical. ACOG's Committee Opinion #385 is an excellent example of the collapse of ethical decision-making when patient autonomy is allowed to dominate over every other principle of ethics. This is not so much an ethics committee opinion as it is a document that promotes the right-to-abortion-on-demand stance of ACOG."[6] Dr. Sawyer's comments accurately reflect AAPLOG's position on this issue.

The idea that physicians are obligated to provide or refer for elective abortion services simply on the basis of "patient request" is antithetical to the practice of modern medicine. It is to make patient autonomy rule over physician conscience. It is to make the physician the corner vendor. A more balanced approach would be to accept that where opinions vary, the patient is free to seek a second opinion, but not to impose her will on the attending physician.

The Ethics Committee directive that those who oppose elective abortion on conscience grounds should locate their practice in proximity to an abortionist for patient convenience is patently absurd. Quite apart from our conscience convictions, this is a completely unrealistic idea. Conformity with this recommendation would result in large swathes of the United States being without any obstetric or gynecologic care (the large majority of abortion clinics are located in the inner city).

The Committee Opinion informs us that conscience based refusals should be evaluated on the basis of their potential for discrimination. For years a glaring example of systematic discrimination has been implicitly accepted within the current provision of abortion services nationwide. Year after year, African-American women have their unborn children aborted at a per capita rate three times that of Caucasian women. There has never been a protest from ACOG against this extreme disproportion in the actual distribution of abortion services. What would the Ethics Committee advise to rectify this inequity? Should the abortion rate be increased for Caucasian women, or should the abortion rate be decreased for African-American women, in order to meet the standards of justice and equitable distribution of reproductive health services?

[6] Used with Dr. Sawyer's permission

Finally, it seems that the Ethics Committee does not understand the strength and depth of a conscience conviction against the elective, deliberate taking of an unborn human life. This is not a negotiable issue for those who hold this conviction. The United States Supreme Court allowed elective abortion to be a legal right. The U.S. Supreme Court is not an infallible moral guide for a person's conscience, as evidenced by a previous similar egregious ruling.[7]

For these reasons, we, the AAPLOG board of directors, find this Committee Opinion to be neither scientifically nor ethically sound. We strongly urge that Committee Opinion #385 be rescinded at the earliest opportunity.

Sincerely,

Joseph L. DeCook, MD, FACOG, Vice-President, AAPLOG, for the Executive Committee and the Board of AAPLOG

[7] We reference the infamous Dred Scott vs Sanford case of 1857, in which the Supreme Court of the United States found, by a 7-2 majority, that no person of African descent could claim U.S. Citizenship. (Africans, according to the Court, were "beings of an inferior order, and altogether unfit to associate with the white race,… so far inferior that they had no rights which the white man was bound to respect.") Since slaves had no claim to citizenship, they could not bring suit in court. We find the status of the unborn under Roe to be strikingly similar to the plight of the African slaves under Dred Scott: Both are human beings, but neither had/has basic human rights: neither had/has the legal right to appeal to the courts for justice or protection when they were/are victims of inhumane treatment or purposeful killing.

EXHIBIT THREE

[redacted] D.
Board President
American College of Obstetricians and Gynecologists
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Washington, D.C. 20090-6920
February 28, 2008

Dear [redacted]:

On November 7, 2007, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics released an Opinion, "The Limits of Conscientious Refusal in Reproductive Medicine" (the "Opinion"), which attempts to resolve the issue of ethically appropriate limits of conscientious judgments in reproductive medicine. This is an issue that demands serious attention and sustained dialogue. Unfortunately, however, the Opinion not only fails to provide helpful guidance, but is so flawed that it threatens the reputation of ACOG itself. The Catholic Medical Association urges ACOG to rescind this opinion immediately.

The Committee on Ethics' Opinion exhibits three fatal flaws: (1) it is woefully inadequate in basic ethical theory and analysis; (2) the "considerations" advanced to limit conscientious judgments are so vague and contentious that they cannot meaningfully function as ethical or professional guidelines; and (3) the solutions proposed are unjust, unworkable, and harmful to the profession of medicine. We elaborate on these points briefly below.

1. Flaws in Ethical Analysis. The Opinion contains a seriously flawed and gratuitously condescending approach to conscience. The Opinion describes conscience in limited, negative, emotional terms, emphasizing such terms as "private," "sanction," "sentiment," and emotions such as self-hatred. At best, the Opinion notes, "Personal conscience, so conceived, is not merely a source of potential conflict." In fact, however, while conscience is a personal, subjective judgment, it is not merely "private" or relativistic. Conscientious judgments provide guidance both for good actions that should be done and unethical actions that should be refused. It is true that conscientious judgments are at times accompanied by emotion, particularly in conflict cases. Still, conscience is not a matter of feeling, as the Opinion suggests, but a judgment about moral truth.

In addition to providing an inadequate description of the nature and role of conscience, the Opinion fails to do justice to the ethical issue of cooperation in evil raised by providing referrals for abortion and, indeed, dismisses concerns about complicity in gravely immoral actions.

This disregard for the harm caused by complicity in moral evil is particularly hard to understand given the painful lessons the medical profession learned from physicians' silent tolerance of, or complicity in, the crimes against humanity in Nazi Germany. Here in the United States, in the infamous Tuskegee Syphilis Study, U.S. Public Health Service physicians denied treatment to patients with syphilis so they could study the late stages of the disease. Moreover, physicians participated or acquiesced in involuntary sterilizations under color of law in more than 30 more states between 1907 and the early 1970s. All agree now that these practices were unethical and a violation of patients' rights and that physicians were wrong to cooperate, even tacitly, or to remain silent, even when they were not direct participants.

The Opinion mentions, but fails to describe, what it means by the "set of moral values – and duties – that are central to medical practice." Since the Opinion goes on to list four "criteria" that ostensibly trump physicians' ethical convictions, it appears that these are the moral values and duties the Ethics Committee has in mind. Inexplicably missing in this section of the Opinion is any mention of respect for human life, which *has* been recognized by most physicians across centuries and cultures as a fundamental value and duty that *is* central to the practice of medicine.

Finally, the Opinion attempts, in several ways, to legitimize a moral duty to provide any requested "reproductive service." The Opinion appeals to terminology such as "standard care," "standard reproductive services," and "standard practices" without ever defining who or what has established these standards. The Opinion attempts to conflate the duty to provide treatment in an emergency with a new obligation – to provide "medically indicated and requested care" where failure to do so "might" negatively affect a patient's "mental health." This so-called obligation is unnecessary and completely unfounded. Our position is that elective abortion is not healthcare, nor does it qualify as an emergency. In a true emergency, where a pregnant woman's life is in danger, physicians can and should strive to save the lives of the mother and her unborn child.

2. Considerations Limiting Conscientious Refusal. The "considerations" that the Opinion claims limit conscientious judgments are so vague and contentious that they cannot meaningfully function as ethical guidelines. For example, the Opinion cites the "degree of imposition" as a criterion for overriding the ethical and professional judgment of physicians. It is

not clear at all what kinds or degrees of "imposition" will trump ethical judgment, much less why they should. In appealing to the criterion of "effect on patient health," the Opinion unfairly assumes that all requested reproductive interventions (including abortion or egg harvesting) are in fact good for the patient's health. Moreover, it unfairly implies that physicians with ethical objections to such practices are not motivated precisely by concern for the patient's short and long term health. In appealing to the category of scientific integrity, the Opinion overstates the certainty that current science can provide about the mechanism of drugs (such as those used in Plan B). And it fails to recognize that the real "possibility of postfertilization events" inherent in the use of such drugs *is* a valid matter for a professional's clinical and ethical judgment. Finally, in appealing to "matters of oppression," the Opinion injects a dubious political criterion into the heart of medical decision-making.

3. Solutions Proposed. The Opinion proposes solutions that are unjust, unworkable, and harmful to the profession of medicine. The Opinion unfairly dictates that only physicians who oppose a specific set of medical "services" should be required to provide patients with "prior notice of their personal moral commitments." We think that *all* physicians should be ready to explain, whenever appropriate, their ethical convictions with regard to medical practice and care. To suggest that providers with pro-life ethical convictions "practice in proximity to individuals who do not share their views" is unworkable.

The solutions proposed in the Opinion are not only unjust and unworkable, but harmful to the profession of medicine. First, by negatively and narrowly defining conscience and by suggesting that judgments of conscience are best left to "organized advocacy" groups, the Opinion tacitly discourages physicians from thinking and acting in accordance with their judgment of what is ethical or unethical. The demand that physicians provide "professionally accepted characterizations of reproductive health services" shows distrust of professionals and of the quality of the medical profession as a whole. Second, in appealing to the vague criterion of past discrimination allegedly suffered by some people, the Opinion allows values and considerations extraneous to the practice and profession of medicine to dictate treatment modalities.

Third, the Opinion invites lawmakers to enforce compliance with these vague and contentious notions. This would run counter to AMA Code of Ethics Opinion E-10.05: "[I]t may be ethically permissible for physicians to decline a potential patient when . . . [a] specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs." Moreover, this expressly contradicts ACOG's own Statement of Policy on Abortion: "The intervention of legislative bodies into medical decision making is inappropriate, ill-advised and dangerous."

Such legislation could not help but undermine the freedom and integrity of the profession of medicine and invite additional litigation and legislation that have nothing to do with promoting the health of women. Indeed, ACOG should be aware that legislation attempting to enforce this Opinion would violate constitutional and statutory protections of physicians' freedom of religion and conscience rights at federal and state levels. Finally, driving out physicians who respect the value of every human life – born and unborn – from the profession of obstetrics and gynecology would harm the profession and the health of many women and children.

There is a great deal of work to be done in assisting members of ACOG to practice medicine conscientiously, and to educate patients on what this means and why it is important. We stand ready to assist in this task. However, to be valid, any effort will have to be based on sound ethical analysis, undertaken in a spirit of dialogue, with respect for diversity in beliefs. The Committee on Ethics Opinion No. 385 falls significantly short in all these respects. Therefore, it should be rescinded immediately.

Respectfully,

[redacted]
President, Catholic Medical Association

[redacted]
Executive Director, Catholic Medical Association

cc.:

[redacted]
Chair, ACOG Committee on Ethics

[redacted]
c/o ACOG Ethics Committee

[redacted]
c/o ACOG Ethics Committee

EXHIBIT FOUR

Project Logo **Protection of Conscience Project**
www.consciencelaws.org
Service, not Servitude

Joint Letter of Protest

Christian Medical Association *et al*

Reproduced with permission

December 7, 2007

American College of Obstetricians and Gynecology
Douglas W. Laube, MD, President
PO Box 96920
Washington, D.C. 20090-6920

Dear [redacted]:

The undersigned individuals and organizations urge the repudiation and withdrawal of the recently published position statement of The Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG), "The Limits of Conscientious Refusal in Reproductive Medicine."

The ACOG statement suggests a profound misunderstanding of the nature and exercise of conscience, an underlying bias against persons of faith and an apparent attempt to disenfranchise physicians who oppose ACOG's political activism on abortion.

The paper indicates that ACOG views the exercise of conscience and faith not so much as a cornerstone right in a democracy or as a historic hallmark of medicine, but rather as an inconvenient obstacle to abortion access.

A few excerpts from ACOG's paper illustrate these concerns:

> 1. "An appeal to conscience would express a sentiment such as 'If I were to do 'x,' I could not live with myself / I would hate myself, I wouldn't be able to sleep at night."

By caricaturing conscience as a pitifully self-centered, subjective feeling, ACOG denigrates the objective sources of conviction. Physicians of faith base decisions of conscience not on personal whims and feelings but on the objective teachings of Scripture--the same Scriptures that have provided the foundation for the laws of much of civilization. A physician's conscience may also be informed by time-honored ethical standards such as the Hippocratic Oath, which for centuries provided a foundation for medical ethics until abortion advocacy censored its teachings.

> 2. Physicians may not exercise their right of conscience if that might "constitute an imposition of religious or moral beliefs on patients."

is tantamount to "imposing religious or moral beliefs on patients."

> 3. "Physiciansâ€¦have the duty to refer patients in a timely manner to other providers if they do not feel they can in conscience provide the standard reproductive service that patients request."

This assertion contradicts a basic corollary of conscience. The same life-honoring, objective principles- "Thou shalt not kill," and "first, do no harm"--that persuade many conscientious physicians not to perform abortions also persuade them not to recommend someone else to do the deed.

> 4. "All healthcare providers must provide accurate and unbiased information so that patients can make informed decisions."

Normally no one would question this principle, but in this case, context is everything. Since ACOG has gone to court to fight laws requiring abortion doctors to offer informed consent information to patients on the risks and alternatives to abortion,[1] clearly ACOG intends to selectively apply this requirement only to pro-life physicians to force them to offer abortion as an option.

> 5. "Providers with moral or religious objections should â€¦ practice in proximity to individuals who do not share their viewsâ€¦"

It is incredible that ACOG would actually require a pro-life physician to relocate his or her practice to be close to an abortion facility. Besides the fact that this drastic requirement is selectively invoked only against pro-life doctors, it would also have the negative practical impact of removing desperately needed doctors from underserved areas.

ACOG's misguided and uninformed public statement on conscience limits is bound to have the effect, whether unintended or actually intended, of discouraging persons of faith from practicing or choosing obstetrics and gynecology as a profession. At a time when many communities are already suffering the loss of obstetricians and gynecologists forced out of their practices for economic reasons, it seems especially unwise to send such a message of ideological intolerance and religious discrimination.

ACOG's aggressive political advocacy for abortion has significantly impaired its ability to speak for all physicians and to judge matters of medical ethics without bias. We urge ACOG to reconsider and withdraw this statement as a step toward remedying that lamentable loss of respectability and credibility.

Sincerely,

[redacted]

[redacted]

Notes

1. American College of Obstetricians v. Thornburgh, 737 F.2d 283, 297-98 (3d Cir.1984).

cc: ACOG Executive Board Affairs
ACOG Government Relations
ACOG Clinical Practice

EXHIBIT FIVE

Congress of the United States
Washington, DC 20515

March 14, 2008

[redacted] MD, MS, President
The American College of Obstetricians and Gynecology
409 12th Street, SW
Washington, DC 20090-6920

Dear [redacted],

We are deeply concerned to learn of The American College of Obstetricians and Gynecology (ACOG) Committee Opinion #385 which could destroy the rights of conscience for pro-life obstetricians and gynecologists across our nation. Conforming to this guideline would force pro-life OB-GYNs to violate their moral and ethical beliefs regarding controversial issues like abortion. Furthermore, when paired with newly revised certification policies of the American Board of Obstetrics and Gynecology that condition board certification on compliance with ACOG ethics guidelines, we are concerned that the views represented in Opinion #385 can be used to force valuable pro-life OB-GYNs out of the practice of medicine for exercising their rights of conscience. *If used as a basis for decertifying physicians, these physicians* would most likely lose hospital privileges and effectively be put out of business, denying the physician's right to practice his or her profession. Moreover, pro-life women would lose the right to choose OB-GYNs who share their moral convictions.

As you know, Opinion #385 entitled "The Limits of Conscientious Refusal in Reproductive Medicine," contains seven recommendations that we believe jeopardize the rights of conscience of OB/GYNs. This report calls on OB-GYNs to disregard their moral, ethical or religious objections to abortion and instructs them to perform or refer for abortion. Opinion #385 also obligates the protection of the liberty interests of the pregnant women over the life and health of the unborn child, regardless of what the provider believes is in the best interests of both patients. This is a worrisome departure from professional standards set by state legislatures and other professional medical organizations such as the American Medical Association (AMA). The AMA House of Delegates policy on abortion states: "Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles." Currently, nearly all states recognize the right of physicians to refuse to provide abortions.

We are aware that member physicians and civil rights organizations have requested for clarification on Opinion #385. We, as Members of the House of Representative are asking the same and want assurance that OB-GYNs will not face severe consequences, including decertification, for refusing to perform or refer for an abortion on grounds of conscience. In light of these concerns, we request a clear explanation of whether Opinion #385 represents the official position of ACOG and what outcomes were intended by those who crafted Opinion #385. Furthermore, as the largest American association of OBGYNs, we ask that you provide further clarification by

explaining the general intent, import and force of ACOG Ethics Opinions as applied under ABOG's 2008 MOC Bulletin. Finally, please clarify the impact of ACOG Ethics Committee reports on board certification and ACOG membership. We request the courtesy of your response to these concerns by March 29th, 2008.

Sincerely,

Phil Gingrey, M.D. (GA-11)

Trent Franks (AZ-2)

Dave Weldon, M.D. (FL-15)

Ron Paul, M.D. (TX-14)

Paul Broun, M.D. (GA-10)

Tom Price, M.D. (GA-6)

James L. Oberstar (MN-8)

Joseph R. Pitts (PA-16)

Christopher H. Smith (NJ-4)

W. Todd Akin (MO-2)

Mike Ferguson (NJ-7)

Scott Garrett (NJ-5)

J. Gresham Barrett (SC-3)

Barbara Cubin (WY)

Jeff Fortenberry (NE-1)

Jean Schmidt (OH-2)

Cc: Anne D. Lyerly, MD, Chair of Ethics Committee
The American College of Obstetricians and Gynecology

Lucia DiVenere, Director of the Department of Government Affairs
American College of Obstetricians and Gynecologists

EXHIBIT SIX

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 14 2008

[redacted]
Executive Director
The American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204

Dear [redacted]:

I am writing to express my strong concern over recent actions that undermine the conscience and other individual rights of health care providers. Specifically, I bring to your attention the potential interaction of the American Board of Obstetrics and Gynecology's (ABOG) Bulletin for 2008 Maintenance of Certification (Bulletin) with a recent report (Opinion Number 385) issued by the American College of Obstetricians and Gynecologists (ACOG) Ethics Committee on November 7, 2007 entitled "The Limits of Conscience Refusal in Reproductive Medicine".

The ACOG Ethics Committee report recommends that in the context of providing abortions, "Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive service that patients request." It appears that the interaction of the ABOG Bulletin with the ACOG ethics report would force physicians to violate their conscience by referring patients for abortions or taking other objectionable actions, or risk losing their board certification.

As you know, Congress has protected the rights of physicians and other health care professionals by passing two non-discrimination laws and annually renewing an appropriations rider that protect the rights, including conscience rights, of health care professionals in programs or facilities conducted or supported by federal funds. (See 42 U.S.C. § 238n, 42 U.S.C. § 300a-7, and the Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, 121 Stat. 1844, § 508). Additionally, threats to withhold or revoke board certification can cause serious economic harm to good practitioners.

I am concerned that the actions taken by ACOG and ABOG could result in the denial or revocation of Board certification of a physician who -- but for his or her refusal, for example, to refer a patient for an abortion -- would be certified. These actions, in turn, could result in certain HHS-funded State and local governments, institutions, or other entities that require Board certification taking action against the physician based just on the Board's denial or revocation of certification. In particular, I am concerned that such actions by these entities would violate federal laws against discrimination.

In the hope that compliance of entities with the obligations that accompany certain federal funds will not be jeopardized, it would be helpful if you could clarify that ABOG will not rely on the ACOG Ethics Committee Report, "The Limits of Conscience Refusal in Reproductive Medicine" when making determinations of whether to grant or revoke board certifications.

Thank you very much for your assistance in this matter.

Sincerely,

Michael O. Leavitt

cc:

[redacted]

The American College of Obstetricians and Gynecologists

EXHIBIT SEVEN

ABO+G

American Board of Obstetrics + Gynecology

First in Women's Health

March 19, 2008

Michael O. Leavitt
Secretary
The US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Norman F. Gant, M.D.
Executive Director

Alvin L. Brekken, M.D.
Assistant to the Executive Director

Larry C. Gilstrap, III, M.D.
Director of Evaluation

The Vineyard Centre
2915 Vine Street
Dallas, TX 75204
Phone (214) 871-1619
Fax (214) 871-1943

Dear Secretary Leavitt:

I am responding to your letter addressed to me asking about the American Board of Obstetrics and Gynecology's stand with respect to a physician's choice "to violate their conscience by referring patients for abortions or taking other objectionable actions, or risk losing their board certification." I can only say that I do not know where you came up with any suggestion, much less documentation, that the American Board of Obstetrics and Gynecology has ever asked anyone to violate their own ethical or moral standards.

Please be assured that the American Board of Obstetrics and Gynecology has taken no stand, pro or con, against individual physicians who choose to or choose not to perform abortions or to refer patients to abortion providers. Moreover, such an issue is not a consideration in the applications or in the examinations administered by the American Board of Obstetrics and Gynecology in any of its certification or in its Maintenance of Certification requirements or examinations.

Best Wishes,

[redacted]

Executive Director

NFG/kd

EXHIBIT EIGHT

March 26, 2008

Dear Fellows:

Thank you for your comments on Committee Opinion #385, "The Limits of Conscientious Refusal in Reproductive Medicine." The Committee on Ethics is grateful for the thoughtful and considered input of Fellows regarding this document. We received many letters reflecting the importance of this issue to Fellows, as well as a breadth of opinion regarding the role of conscience in professional life.

The Committee on Ethics met on March 17-18, 2008, and discussed the correspondence received since the Opinion's publication. The letters and a summary of the concerns raised were carefully reviewed. Also the Executive Committee of ACOG's Executive Board met and discussed the Opinion and the response to the Opinion on March 24, 2008.

We want to be clear the Opinion does not compel any Fellow to perform any procedure which he or she finds to be in conflict with his or her conscience and affirms the importance of conscience in shaping ethical professional conduct. For example, while this is not a document focused on abortion, ACOG recognizes that support for or opposition to abortion is a matter of profound moral conviction, and ACOG respects the need and responsibility of its members to determine their individual positions on this issue based on their personal values and beliefs. We want to assure members with a diversity of views on this issue that they have a place in our organization.

Ethics Committee Opinions provide guidance regarding ethical issues. This Committee Opinion is not part of the "Code of Professional Ethics of the American College of Obstetricians and Gynecologists." This Committee Opinion was not intended to be used as a rule of ethical conduct which could be used to affect an individual's initial or continuing Fellowship in ACOG. Similarly, it is not cited in the American Board of Obstetrics and Gynecology's "Bulletin for 2008" and "Bulletin for 2008 Maintenance of Certification," and an obstetrician-gynecologist's board certification is not determined or jeopardized by his or her adherence to this Opinion.

Conscience has an important role in the ethical practice of medicine. While this Opinion attempted to provide guidance for balancing the critical role of conscience with a woman's right to access reproductive medicine, the Executive Committee has noted the uncertain and mixed interpretation of this Opinion. Thus, the Executive Committee has instructed the Committee on Ethics to hold a special meeting as soon as possible to reevaluate ACOG Committee Opinion #385.

Thank you again for your thoughtful comments.

Sincerely yours,

President

Exhibit 130

ACLJ
American Center for Law & Justice

May 9, 2018

RECEIVED
MAY 11 2018
HHS/OCR HQ

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Attn: Conscience and Religious Freedom Division

Re: Complaint for Discrimination in Violation of 42 U.S.C. § 300a-7(c)(1) ("Church Amendment")

Contact attorney for complainant:

Francis J. Manion, Esq.
Geoffrey R. Surtees, Esq.
American Center for Law and Justice
6375 New Hope Rd.
P.O. Box 60
New Hope, KY 40052
502-549-7020
fmanion@aclj.org

Complaint filed on behalf of:

[redacted]

Person/Agency/Organization committing discrimination:

The University of Vermont Medical Center
111 Colchester Avenue
Burlington, Vermont 05401
802-847-0000

Date and nature of discriminatory acts:

In 2017, the complainant, [redacted] RN, was coerced by her employer, University of Vermont Medical Center, Inc. ("UVMMC") into participating in an abortion. Ms [redacted] a Catholic, had previously informed her employer that she

6375 New Hope Road
New Hope, Kentucky 40052
(502) 549-7020
(502) 549-5252 (Facsimile)

could not participate in such procedures as a matter of religious belief. Her employer deliberately misled [redacted] about the nature of the procedure, and then, after [redacted] confirmed that she was, in fact, being assigned to an abortion, refused her request that other equally qualified and available personnel take her place. Fearing a charge of patient abandonment which could bring with it loss of employment and revocation of her nursing license, [redacted] participated in the procedure under duress. She suffered immediate emotional distress, attempted to suppress the event psychologically, and has been haunted by nightmares ever since. In addition, her employer has created a hostile environment targeting [redacted] and other employees who conscientiously object to participating in abortion procedures.

The coerced-participation event described above appears to have been related to a change in UVMMC policy regarding the hospital's performance of abortions. Under the leadership, since 2013, of a hospital board President with decades-long experience in senior leadership of Planned Parenthood facilities in Vermont, Portland, Oregon, and New York City, UVMMC reversed a longstanding policy which limited abortions in its facilities to those considered "medically necessary." While the policy appears to have been changed *sub silentio* at some point even before 2017, hospital staff, including [redacted] and other nurses, were only formally informed of the change in October of 2017. Thus, it is highly possible that other staff and, perhaps, [redacted] herself, have been deceived into participating in other abortion procedures which were misleadingly labeled as "miscarriages" or "medically necessary" but which were, in fact, purely elective abortions.

In addition, following public controversy which arose after the formal disclosure to staff of the hospital's new policy in the Fall of 2017, UVMMC, in February 2018, adopted a revised "Conflict of Care" policy. (Copy attached hereto). This policy is sharply inconsistent with existing federal conscience laws and inappropriately continues to leave the conscience rights of hospital employees to the virtually unbridled discretion of supervisors who, as [redacted] and others will attest, have a history of demeaning, belittling, and failing to respect the views of conscientious objectors.

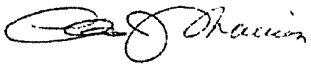
The Church Amendment protects the conscience rights of individuals and entities that object to performing or assisting in the performance of abortion or sterilization procedures if doing so would be contrary to the provider's religious beliefs or moral convictions, and prohibits discrimination in employment of "any physician or other health care personnel . . . because of his religious beliefs or moral convictions respecting sterilization procedures or abortions." 42 U.S.C. §300a-7 *et seq.*

It is clear that [redacted] (and perhaps others employed at UVMMC) has suffered and continues to suffer discrimination and violations of her conscience rights under federal law. We urge your office to immediately initiate an

investigation of these charges and order appropriate remedial and corrective actions as soon as possible.

Our investigation has disclosed identities and contact information of individuals in addition to our client who have information pertinent to this matter. That information, to the extent said individuals have already spoken publicly about it or authorize us to disclose it, will be provided upon request.

Respectfully submitted,



Francis J. Manion
Senior Counsel
American Center for Law & Justice

Date: May 9, 2018

Documents Status: **Approved**

IDENT	HR-F-09
Type of Document	Policy
Applicability Type	Corporate
Title of Owner	Dir Human Resources
Title of Approving Official	VP Human Resources
Date Effective	2/5/2018
Date of Next Review	2/5/2021

THE University of Vermont MEDICAL CENTER

TITLE: Conflict of Care: Staff Conscientious Objection

PURPOSE: UVM Medical Center respects workforce diversity and the cultural values, ethics and religious beliefs of our staff. In situations where a conflict may exist between the employee's cultural values, ethics, and religious beliefs and their participation in any aspect of patient care, UVMMC supports a process by which an employee may request to be excused from performing specific duties.

Patients and their families' perspectives and choices are valued and honored in all phases of care. Accordingly, all patients are entitled to comprehensive, quality care, without regard to their diagnosis, race, color, sex, sexual orientation, gender identity or expression, ancestry, place of birth, HIV status, national origin, religion, marital status, age, language, socioeconomic status, physical or mental disability, protected veteran status.

UVMMC encourages open dialogue between the employee and their leader.

POLICY STATEMENT: Employees may request to be excused from participating in a type of care/treatment in situations where that care/treatment conflicts with the employee's cultural values, ethics, or religious beliefs. Procedures/treatments which may present conflict may include but are ***not limited*** to the following:

- Blood and blood component administration
- Elective termination of pregnancy
- Initiation and cessation of life support
- DNR/Life support issues for critically ill/terminally ill populations
- Assisting with the harvesting of human organs
- Sterilization procedures
- Reproductive technologies

Alternative staffing arrangements will be considered, and if appropriate, arranged. At no time will staff be allowed to act in a manner that negatively impacts the patient's care or treatment.

PROCEDURE:

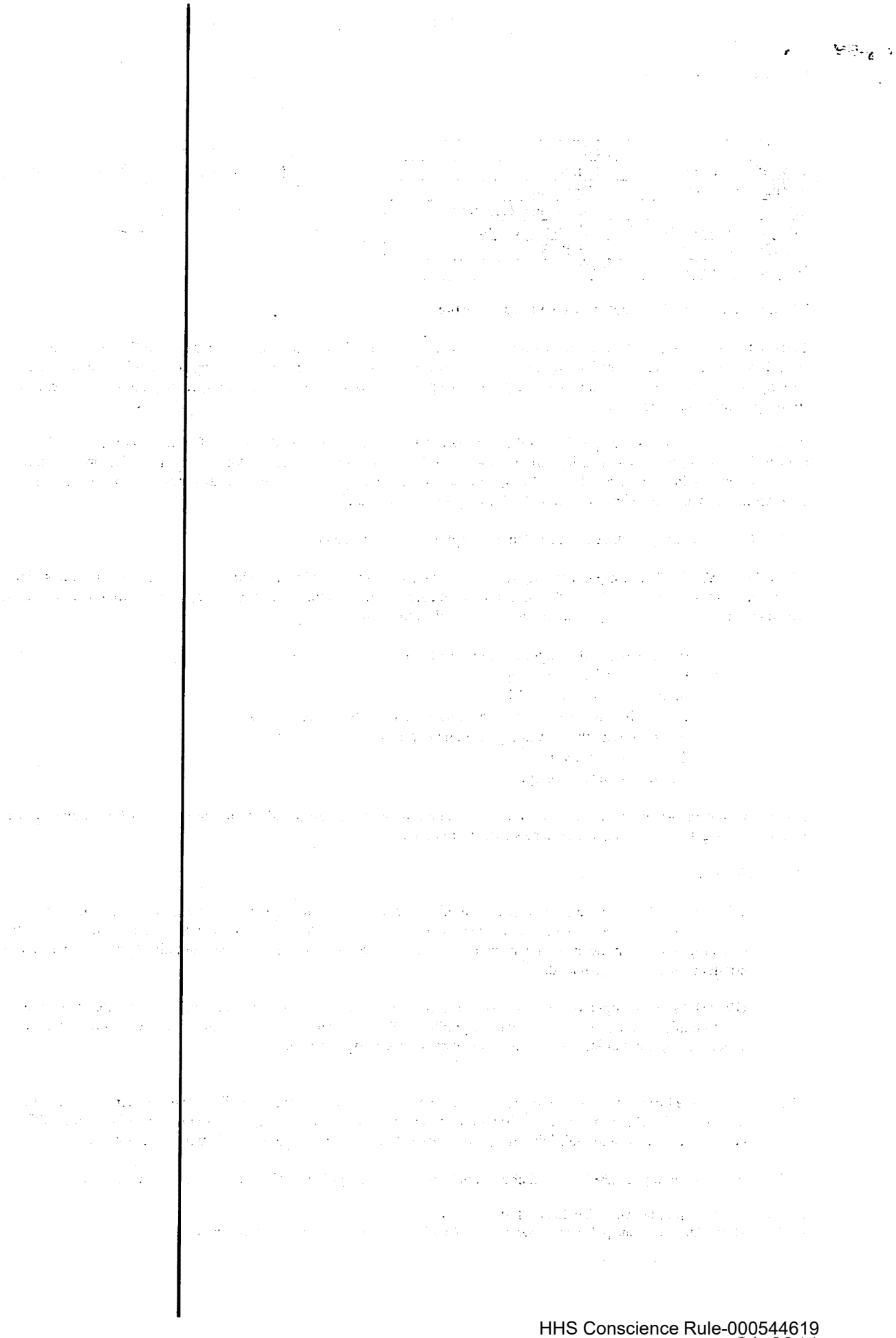
I. When the need to provide care or treatment of a patient is in conflict with an employee's cultural values, ethics or religious beliefs, the employee may request to be reassigned to other duties and not participate in the specific type of care or treatment. In the event a conflict of care arises, care of the patient will be maintained until alternate staffing arrangements can be provided.

II. UVMMC supports open dialogue between the employee and their leader when a conflict exists for the employee. We recognize that not all conflicts can be predicted. When possible we encourage employees to proactively raise concerns about potential conflicts in order to minimize impact to patient care.

III. During the hiring process, the hiring manager shall discuss the typical scope of practice and service within the department in which the candidate has applied to work. Employees are expected to perform all the duties of their positions as set forth in their job descriptions, given to them at the time of hire or whenever revised.

IV. All new employees are informed about this Conflict of Care policy during new employee orientation.

Printed on: 4/12/2018 11:00 AM By: [redacted]
DISCLAIMER: Only the online policy is considered official. Please compare with on-line document for accuracy.



Documents Status: **Approved**

V. The direct Supervisor/designee shall be responsible for administering and monitoring a process to accommodate an employee's cultural values, ethics, and religious beliefs regarding treatment of patients.

a) An employee who desires to be reassigned from a specific type of care or treatment shall submit the request in writing to the Supervisor/designee. Written request may be received on the form provided in this policy OR via an email addressed to the Supervisor/designee containing the details as requested/outlined on the form.

b) The written request will be acknowledged by the Supervisor/designee and maintained in the appropriate unit resource binder for scheduling purposes within the unit. The Supervisor/designee will assign staff as necessary for appropriate patient coverage. The written request will be placed in the employee's electronic personnel file by the Supervisor/designee.

c) Any conflict which may occur in an emergent situation for which staff may not have previously submitted a written request, may be brought to the Supervisor/designee. Alternative coverage may be sought at the discretion of the Supervisor/designee. The written request shall be submitted by the employee directly following the event and the request will be placed in the employee's electronic personnel file by the Supervisor/designee.

d) Any employee who is excused from an aspect of care will be re-assigned to other responsibilities.

e) In any scenario where circumstances prevent arrangements for alternate coverage, the staff member will be expected to provide the assigned care to ensure patient care is not negatively impacted.

f) Refusal to perform assigned job functions will be addressed in accordance with established corrective action procedures by the supervisor, in consultation with leadership and/or Human Resources.

VI. All employees have access to the Ethics Consultation through UVMMC's Director of Clinical Ethics and can request input on ethical issues by contacting Provider Access Services (847-2700), ask who the ethics consultant on call is and should then contact that consultant by phone or in person.

VII. An employee experiencing ongoing conflict of care issues should seek a transfer to a department or position where conflict of care issues are less likely to occur.

MONITORING PLAN: N/A

DEFINITIONS: N/A

RELATED POLICIES: Code of Conduct B1N; Clinical Ethics Consultations ETH15; Compliance & Privacy Plan B31

REFERENCES: 2017, Hospital Accreditation Standards, The Joint Commission LD.04.02

REVIEWERS: [redacted]

OWNER: [redacted], Dir Human Resources

APPROVING OFFICIAL: [redacted] Human Resources

Printed on: 4/12/2018 11:00 AM By: [redacted]
DISCLAIMER: Only the online policy is considered official. Please compare with on-line document for accuracy.

Documents Status: **Approved**

Conflict of Care Disclosure Form

To be completed by the employee making the request: *Make a copy of this form for your records and then give this form to your leader.*

Your Name: _____ (Please Print)

Your Signature: _____ Date: _____

Please identify the clinical circumstances where you experience personal conflict. Please provide specific details regarding which procedure/treatment you are requesting to be excused from.

Please briefly provide your reasons for requesting removal from the patient's care team.

Received by:_____ (Please Print)

Leader Signature _____ Date Received _____

Printed on: 4/12/2018 11:00 AM By: [redacted]
DISCLAIMER: Only the online policy is considered official. Please compare with on-line document for accuracy.

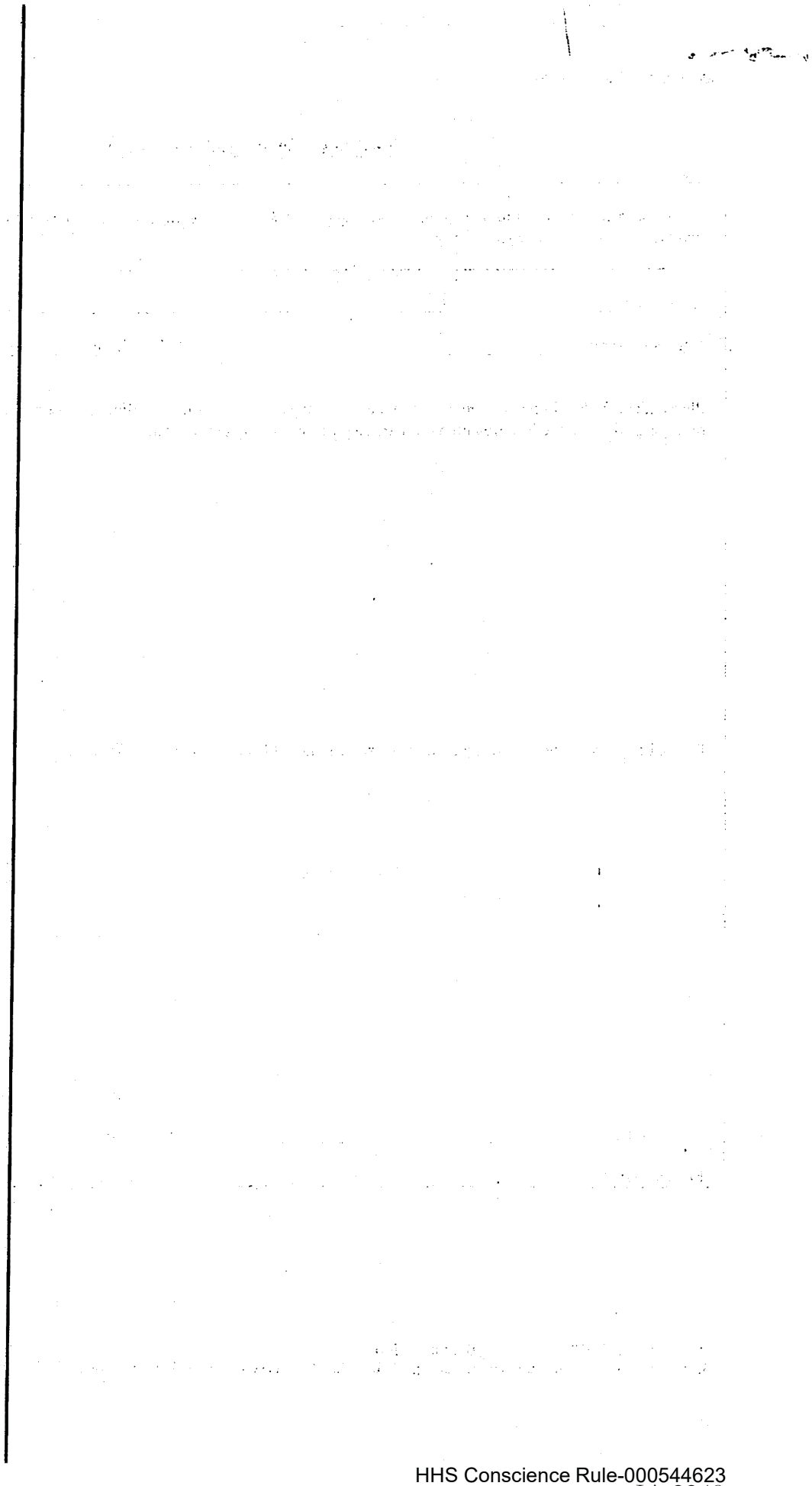


Exhibit 131

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME | YOUR LAST NAME

H[redacted]LL PHONE (Please include area code) | W[redacted]NE (Please include area code)

S[redacted] | CITY

S[redacted] | ZIP | E-MAIL ADDRESS (If availa[redacted]

Are you filing this complaint for someone else? ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME | LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

Ecumenical Ministries of Oregon

STREET ADDRESS | CITY

245 SW Bancroft Street Suite B | Portland

STATE | ZIP | PHONE (Please include area code)

Oregon | 97239 | (503) 221-1054 x204

When do you believe that the discrimination occurred?

LIST DATE(S)

09/12/2018

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

I was suspended from EMO HIV Day Center because I contacted their board of directors. They say I am being suspended for refusing to meet with them about my two grievances. I told them that I prefer handle everything related to my grievances, in writing. Also there is no written policy stating that I am obligated to meet with them to discuss my grievance. EMO HIV Day Center is a Ryan White funded agency.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE | DATE *(mm/dd/yyyy)*

[redacted] | 09/13/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement
Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 09/13/2018

**Please sign and date if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted] (H)

NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

I was suspended from EMO HIV Day Center because I contacted their board of directors. They say I am being suspended for refusing to meet with them about my two grievances. I told them that I prefer handle everything related to my grievances, in writing. Also there is no written policy stating that I am obligated to meet with them to discuss my grievance. EMO HIV Day Center is a Ryan White funded agency.

[redacted],

We are suspending you from any further involvement with the HIV Day Center until we are able to meet with you to resolve your grievances. Please notify [redacted] that you are willing to meet and then work with him on a time that is convenient for each of us to meet.

Sincerely,

[redacted]
Ecumenical Ministries of Oregon
0245 SW Bancroft St., Suite B, Portland, OR 97239
Phone: [redacted]
Fax: [redacted]

The reason, [redacted], is that your various grievances are unresolvable until we meet to discuss them. You continue to communicate with our staff and board about concerns you have. Until we can meet to resolve these, we are unable to serve you further.

I trust this explanation helps.

Sincerely,
[redacted]

CERTIFICATE OF SERVICE

I hereby certify that on April 27, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Leif Overvold
Leif Overvold