Nos. 20-15398, 20-15399, 20-16045 and 20-35044

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

CITY AND COUNTY OF SAN FRANCISCO, *Plaintiff-Appellee*,
v.
ALEX M. AZAR II, et al., *Defendants-Appellants*.

COUNTY OF SANTA CLARA, et al., *Plaintiffs-Appellees*,
v.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants-Appellants*.

STATE OF CALIFORNIA, *Plaintiff-Appellee*,
v.
ALEX M. AZAR, et al., *Defendants-Appellants.*

STATE OF WASHINGTON, *Plaintiff-Appellee*,
v.
ALEX M. AZAR II, et al., *Defendants-Appellants.*

On Appeal from the United States District Courts for the
Northern District of California and the Eastern District of Washington

SUPPLEMENTAL EXCERPTS OF RECORD
VOLUME III OF X

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March 27, 2018

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

By electronic submission

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

To Whom it May Concern:

I am writing on behalf of National Latina Institute for Reproductive Health (NLIRH) in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. As a reproductive justice organization, NLIRH believes a health care provider's personal beliefs should never determine the care a patient receives. NLIRH strongly opposes the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule"), which seeks to permit discrimination in all aspects of health care.[1]

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

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

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[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88) [hereinafter Rule].
[2] Racial and ethnic identity is multifaceted and in a recent study, 24 percent of U.S. Latinos identified themselves as afro-Latinos, while only 18 percent answered Black as their race. Pew Research Center. "Afro-Latino: A deeply rooted identity among U.S. Hispanics." March 1, 2016. http://www.pewresearch.org/fact-tank/2016/03/01/afro-latino-a-deeply-rooted-identity-among-u-s-hispanics.
[3] NLIRH, conscious of the importance of gender equity in the production of educational materials utilizes gender-neutral terms throughout this document. "Latinx" is a term that challenges the gender binary in the Spanish language and embraces the diversity of genders that often are actively erased from spaces. Due to the limitations of data collection, we use "Latina(s)" or "women" where research only shows findings for cisgender women, including Latinas.

HHS Conscience Rule-000160475

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

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

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

By issuing the Proposed Rule and creating a new division within the Office of Civil Rights (OCR) – the new Conscience and Religious Freedom Division – the Department seeks to inappropriately use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. <u>For these reasons NLIRH calls on the Department and OCR to withdraw the Proposed Rule in its entirety.</u>

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

The Proposed Rule attempts to expand the reach of existing harmful refusal of care laws and create new refusals of care where none were intended. This Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion and gender affirming care. Specifically, the Department and OCR are attempting to require a broad swath of entities to allow individuals to refuse "any lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[5] Read in conjunction with the rest of the Proposed Rule, it is clear this is intended to allow any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care.

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

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

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

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

a. Refusals of Care are Especially Dangerous for Latinxs Already Facing Barriers to Care

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a health care provider's or hospital's religious beliefs. This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the

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

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

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

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

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

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

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

[9] Athena Tapales et al., The Sexual and Reproductive Health of Foreign-Born Women in the United States, CONTRACEPTION 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health & Ctr. For Reproductive Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: the Fight for Women's Reproductive Health in the Rio Grande Valley* 1, 7 (2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf.
[10] Since 2010, eighty-three rural hospitals have closed. See Rural Hospital Closures: January 2010 – Present, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
[11] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. KAISER FAMILY FOUND., Women's Health Insurance Coverage 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.
[12] Athena Tapales et al., The Sexual and Reproductive Health of Foreign-Born Women in the United States, CONTRACEPTION 8 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf.
[13] *Id.* at 8, 16.
[14] Ctr. for Reprod. Rights, Nat'l Latina Inst. for Reprod. Health & Sistersong Women of Color Reprod. Justice Collective, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [*hereinafter* Reproductive Injustice]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), available at http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.
[15] Reproductive Injustice, *supra* note 14, at 16-17.
[16] Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT (2018), available at https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

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

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

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

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

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

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

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[17] Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.
[18] *Id.* at 12.
[19] *Id.* at 9.
[20] *Id.* at 14.
[21] *Id.* at 15.
[22] Michelle M. Casey et al., *Providing Health Care to Latino Immigrants: Community-Based Efforts in the Rural Midwest*, AM. J. PUB. HEALTH (2011), available at http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1709.
[23] Nat'l Latina Inst. for Reprod. Health & Ctr. for Reprod. Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight For Women's Reproductive Health In The Rio Grande Valley*, 7 (2013), available at http://www.nuestrotexas.org/pdf/NT-spread.pdf.
[24] Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA, (last visited Mar. 21, 2018).
[25] M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH (2010), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/.

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

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

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

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

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

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[26] Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations*, ECON. RESEARCH SERV. (2009), available at https://www.ers.usda.gov/publications/pub-details/?pubid=44427.
[27] Thomas A. Arcury et al., *The Effects of Geography and Spatial Behavior on Health Care Utilization Among the Residents of a Rural Region*, 40 HEALTH SERV. RESEARCH (2005) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361130/.
[28] Human Rights Watch, *All We Want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.
[29] See Rule *supra* note 1, at 180-181, 183. See also Title X Family Planning, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2018), https://www.hhs.gov/opa/title-x-family-planning/index.html; Title X an Introduction to the Nation's Family Planning Program, NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOC. (2017) (hereinafter NFPRHA), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf.
[30] National Family Planning and Reproductive Health Association, *Title X: An Introduction to the Nation's Family Planning Program*, February 2017, https://www.nationalfamilyplanning.org/file/Title-X-101-February-2017-final.pdf.

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

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

When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions with low-incomes, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[35]

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

The Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Individuals seeking reproductive health care, regardless of their reasons for needing these services, should be treated with dignity and respect. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to communities harms them and impairs their ability to make the health care decision that is right for them.

a. Contraception Access

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

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

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

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

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

In light of the pervasive and severe health inequities that Latinxs face, resources and tools, such as contraception, which help decide when and whether to become pregnant are necessary to achieve positive health outcomes. According to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care[41] and Latinas are 1.7 times more likely than white adults to have been diagnosed with diabetes.[42] Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant.[43] The ability of Latinxs to access contraception and to ensure health equity for the Latinx community is threatened by providers having the ability to deny care based on religious or moral beliefs.

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

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[37] According to the Centers for Disease Control and Prevention, during 2011 to 2012, the pregnancy-related mortality ratios were 11.8 deaths per 100,000 live births for white women, 41.1 deaths per 100,000 live births for Black women, and 15.7 deaths per 100,000 live births for women of other races. Given these statistics, the Afro-Latinx community may disproportionately face maternal mortality and the underlying factors of maternal mortality. Centers for Disease Control and Prevention. Reproductive Health. Pregnancy Mortality Surveillance System. http://www.cdc. gov/reproductivehealth/maternalinfanthealth/pmss.html (last visited October 7, 2016).
[38] Lisa L. Lindley & Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High-School Students*, 105 AMERICAN JOURNAL OF PUBLIC HEALTH 1379 (2015).
[39] Unintended Pregnancy in the United States, Guttmacher Inst. (Sept. 2016), available at https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.
[40] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in rates of unintended pregnancy in the United States*, 1994 and 2001, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90-6 (2006).
[41] Am. Diabetes Ass'n, *Standards Of Medical Care In Diabetes-2017*, 40 DIABETES CARE S115, S117 (2017), available at http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf.
[42] Office of Minority Health. *Diabetes and Hispanic Americans*. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63.
[43] *Id.*

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

b. Emergency Contraception

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

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

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

c. Abortion Care

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

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

In addition, the Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to individual's health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[48] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[49] Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

The Proposed Rule ignores the many providers with deeply held moral convictions that affirmatively motivate them to provide abortion services. Moreover, the Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[50] No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion.

[48] 42 U.S.C. § 1295dd(a)-(c) (2003).
[49] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. See, e.g., Shelton v. University of Medicine and Dentistry of New Jersey, 223 F.3d 220, 228 (3rd Cir. 2000); In In re Baby K, 16 F.3d 590, 597 (4th Cir. 1994); Nonsen v. Medical Staffing Network, Inc. 2006 WL 1529664 (W.D. Wis.); Grant v. Fairview Hosp., 2004 WL 326694, 93 Fair Empl. Prac. Cas. (BNA) 685 (D. Minn. 2006); Brownfield v. Daniel Freeman Marina Hosp., 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); Barris v. County of Los Angeles, 972 P.2d 966, 972 (Cal. 1999).
[50] See The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).

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

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

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

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

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

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

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

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

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

[56] *Id.*

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

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

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

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

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

[57] *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, GAY LESBIAN BISEXUAL & TRANSGENDER HEALTH ACCESS PROJECT, http://www.glbthealth.org/CommunityStandardsofPractice.htm (last visited Jan. 26, 2018, 12:59 PM); *Creating an LGBTQ-friendly Practice*, A.M.A., https://www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice#Meet a Standard of Practice (last visited Jan. 26, 2018).
[58] James, S. E. & Salcedo, B. (2017). *2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents*. Washington, DC and Los Angeles, CA: National Center for Transgender Equality and TransLatin@ Coalition.
[59] Grant JM et al. National Gay and Lesbian Taskforce; National Center for Transgender Equality. *Injustice at every turn: A report of the National Transgender Discrimination Survey*, 73-74, 2011, available at http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.
[60] *Id.*
[61] Ravishankar M. *The story about Robert Eads*, THE JOURNAL OF GLOBAL HEALTH, January 18, 2013, http://www.ghjournal.org/jgh-online/the-story-about-robert-eads/.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[78] National Latina Institute for Reproductive Health, *Cervical Cancer & Latinxs: The Fight for Prevention and Health Equity* January 2018, available at http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf.
[79] National Latina Institute for Reproductive Health, *Cervical Cancer & Latinxs: The Fight for Prevention and Health Equity* January 2018, available at http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf.
[80] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for American Progress, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.
[81] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 5 (2010), *available at* http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.
[82] *Id.*
[83] National Latina Institute for Reproductive Health, *Cervical Cancer & Latinxs: The Fight for Prevention and Health Equity* January 2018, available at http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf
[84] OCR's Mission and Vision, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to

language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce.[85] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health inequities. If finalized, however, the Proposed Rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities.[86] Through robust enforcement of civil rights laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities, segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[87]

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

participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").

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

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

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

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

parts of the country (the Rio Grande and areas of California) maternal death rates are higher for Latinas. According to a recent study, Hispanic women in Texas make up 31 percent of maternal deaths and account for nearly half of all births in Texas (Black women account for 30 percent). Another recent study showed that Mexican-born women in California are more likely to die from birthing related complications than their white counterparts. Further, the disparity in maternal mortality is growing rather than decreasing,[89] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resulting health disparities. For example, women's pain is routinely undertreated and often dismissed.[90]

OCR must work to address these disparities, yet the Proposed Rule seeks to prioritize the expansion of existing religious refusal laws beyond their statutory requirements and create new religious exemptions where none had previously existed rather than using already limited resources to protect patient access to health care. The Proposed Rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.[91]

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

It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on society."[92] The Proposed Rule plainly fails on both counts. Although the Proposed Rule attempts to quantify the costs of compliance, it completely fails to address the costs and burdens to patients who may be denied care and who then may incur and experience even greater social and medical costs.[93]

Moreover, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant religious exemptions and, in fact, bars granting an exemption when it would detrimentally affect any third party.[94] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[95]

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[89] See *id.*
[90] See, e.g., Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001).
[91] See *supra* note 83.
[92] Improving Regulation and Regulatory Review, Executive Order 13563 (Jan. 18, 2011), https://obamawhitehouse.archives.gov/the-press-office/2011/01/18/executive-order-13563-improving-regulation-and-regulatory-review.
[93] See Rule *supra* note 1, at 94-177
[94] U.S. Const. amend. I; Cutter v. Wilkinson. 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing Estate of Thornton v. Caldor, 472 U.S. 703, 710 (1985)); see also Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2781 n.37 (2014); Holt v. Hobbs, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[95] Respecting religious exercise may not "unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling." See Burwell v. Hobby Lobby, 134 S. Ct. at 2787. When considering

Conclusion

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

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

The Proposed Rule goes far beyond established law and will allow religious beliefs to dictate health care by unlawfully expanding already harmful refusals. The Proposed Rule is discriminatory, violates multiple federal statutes and the Constitution, ignores congressional intent, fosters confusion, and harms patients contrary to the Department's stated mission. Most importantly, this Proposed Rule puts the lives of our community at risk. For all of these reasons National Latina Institute for Reproductive Health calls on the Department to withdraw the Proposed Rule in its entirety.

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whether the birth control coverage requirement was the least restrictive means in Hobby Lobby, the Court considered that the accommodation offered by the government ensured that affected employees "have precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing coverage." See id. at 2759. In other words, the effect of the accommodation on women would be "precisely zero." Id. at 2760.

Exhibit 135

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March 27, 2018

VIA ELECTRONIC SUBMISSION

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

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

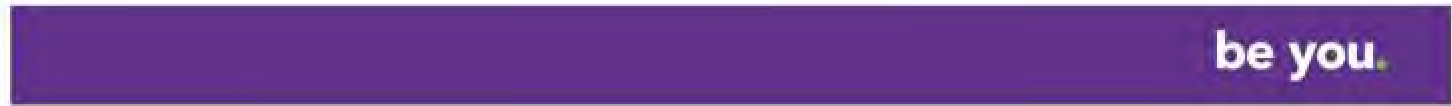
To Whom It May Concern:

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

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

The proposed rule ignores the prevalence of discrimination and the damage it causes. It will undoubtedly lead to increased discrimination and flat-out denials of care for some of the most vulnerable members of our community. We all deeply value freedom of religion, but sweeping exemptions that obstruct access to care are a fundamental distortion of that principle. We deserve better.

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



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By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the U.S. Department of Health and Human Services (Department) seeks to use the Office of Civil Rights' (OCR's) limited resources to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. For these reasons, the National LGBTQ Task Force calls on the Department and OCR to withdraw the proposed rule in its entirety.

I. Expanding religious refusals can exacerbate the barriers to care that LGBTQ, women, people of color, and those living with HIV already face.

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

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

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

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

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

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

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

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

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

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

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a. Ending a Pregnancy

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

b. Artificial Reproductive Technology (ART)

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

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

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

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

c. HIV Health

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

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

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

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

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

Sincerely,

National LGBTQ Task Force

be you.

Exhibit 139

March 27, 2018

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

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

To Whom It May Concern:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[8] Stein, Rob, *Religious hospitals' restrictions sparking conflicts, scrutiny*, The Washington Post, January 3, 2011, accessed at https://www.washingtonpost.com/health-environment-science/religious-hospitals-restrictions-sparking-conflicts-scrutiny/2011/01/03/ABVVxmD_story.html?utm_term=.ec34abebb928

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

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

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

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

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

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

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

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

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

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

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

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management she needed because the hospital objected to this care.[17] Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.[18] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital, which refused to provide him a hysterectomy.[19] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[20] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[21]

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

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[22] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[23] In rural areas there may be no other sources of health and life preserving medical care.[24] When these individuals encounter refusals of care, they may have nowhere else to go.

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

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

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

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

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

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

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

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

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

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

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

of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[27]

7. The Department is abdicating its responsibility to patients

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

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

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

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

Conclusion

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

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

Exhibit 140

March 27, 2018

Via electronic submission

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

To Whom It May Concern:

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

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

The Proposed Rule Will Harm Patients

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

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

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

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

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

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

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

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

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

The Proposed Rule Will Lead to Discrimination Against Already Vulnerable Populations

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

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

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

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

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

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

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

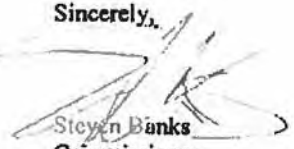
The proposed rule may impact the ability of State and local governments to enforce the full scope of their health- and insurance-related laws and policies by conditioning the receipt of federal funding on compliance with the rule. Similarly, it may leave providers caught between conflicting mandates.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

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

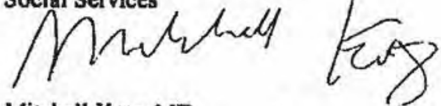
We oppose regulations that allow personal beliefs to trump science at the expense of vulnerable populations' access to health care. We oppose systems that compromise our duty to protect and improve the health of City residents. We oppose actions that sanction discrimination against patients based on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

We urge HHS to rescind the proposed rule.

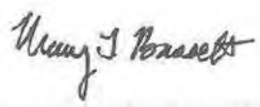
Sincerely,



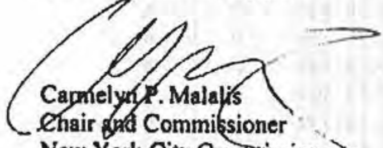
Steven Banks
Commissioner
New York City Department of Social Services



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



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



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

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

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

Exhibit 141

March 27, 2018

Submitted electronically

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

Attn: Conscience NPRM, RIN 0945-ZA03

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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A. Assist in the Performance

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

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

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

B. Referral or Refer for

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

 HHS Conscience Rule-000137578

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

C. Discriminate or Discrimination

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

D. Other Expansions of the Scope of the Refusal Statutes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Title VII

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

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

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

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

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

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

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

B. EMTALA

The Proposed Rule also puts patients at risk by ignoring the federal Emergency Medical Treatment and Labor Act ("EMTALA") and hospitals' obligations to care for patients in an emergency. As Congress has recognized, a refusal to treat patients facing an emergency puts their health and, in some cases, their lives at serious risk. Through EMTALA, Congress has required hospitals with an emergency room to provide stabilizing treatment to any individual experiencing an emergency medical condition or to provide a medically beneficial transfer. 42 U.S.C. § 1395dd(a)-(c). New York also has many protections in place to ensure medical care for patients in need, such as professional misconduct laws prohibiting abandonment of a patient in need of care,[10] and state laws requiring emergency treatment for patients at hospital emergency rooms.[11] The proposed rule casts doubt on the State's continued authority to enforce such provisions.

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

It is particularly troubling, therefore, to have the Department use attempts to require hospitals to comply with their obligations under EMTALA in its Preamble as *justification* for

[10] *See* 8 NYCRR § 29.2 (2008) (including abandoning patient in need of care in definition of professional misconduct for medical professionals).
[11] *See* New York State Emergency Medical Services Reform Act (EMSRA), N.Y. Public Health Law §2805-b; 10 NYCRR Part 800.

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

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

C. Section 1557

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

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

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

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

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

Thus, the Proposed Regulation and its treatment of state and local laws puts at risk provisions of New York State and local laws that prohibit medical facilities and providers from discriminating against anyone on the basis of certain characteristics, such as race, sex, sexual orientation, marital status or disability.[12]

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

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

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

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[12] *See e.g.* N.Y. Human Rights Law, N.Y. Executive Law Article 15, § 290 *et seq.* and N.Y.C. Human Rights Law, N.Y.C. Admin. Code Title 8, § 8-801 *et seq.*.

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

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

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

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

* * *

For all these reasons, the Department should withdraw the Proposed Rule. If it fails to do

so, it must substantially modify the Proposed Rule so as, at a minimum, not to exceed the terms of and congressional intent behind the underlying statutes.

Sincerely,

Katharine Bodde
Senior Policy Counsel

Beth Haroules
Senior Staff Attorney

Exhibit 143

March 27, 2018

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

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

To Whom It May Concern:

I am writing on behalf of the North Carolina Justice Center in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1]

The North Carolina Justice Center advocates for the social, political, economic, and healthful well-being of all North Carolinians. Our mission is to eliminate poverty by ensuring that every household has access to the resources, services and fair treatment it needs to enjoy economic security and participate equally in the opportunities available in the state. A project of the NC Justice Center, the Health Advocacy Project works to ensure that all North Carolinians, especially underserved populations, including racial and ethnic minorities and rural communities, have meaningful access to high quality, affordable, equitable, and comprehensive health care so that children, adults, and families have better health outcomes and live productive lives. In addition, each of the undersigned organizations joining to support these comments also advocates for policies that would improve access to health care for North Carolinians.

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

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

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

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

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

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

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

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

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

An expansive interpretation of "assist in the performance of" thus *could conceivably allow an ambulance driver to refuse to transport a patient to the hospital for care he/she finds objectionable*. It

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

could mean a hospital admissions clerk could refuse to check a patient in for treatment the clerk finds objectionable or a technician could refuse to prepare surgical instruments for use in a service.

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

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

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

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

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

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

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

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

[9] 42 U.S.C. § 1295dd(a)-(c) (2003).

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

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

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

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

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

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

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

Doctors are, in effect, forced to abandon their patients when they are prevented by health care institutions from providing a service they believe is medically-indicated. This was the case for a doctor in Sierra Vista, Arizona, who was prevented from ending a patient's wanted, but doomed, pregnancy after

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

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

[13] 42 U.S.C. § 2000e-2 (1964).

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

[15] *See id.*

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

she suffered premature rupture of membranes. The patient had to be sent to the nearest non-objecting hospital, which was 80 miles away, far from her family and friends. The physician described the experience as "a very gut wrenching thing to put the staff through and the patient, obviously."[17]

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

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

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

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

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[24] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[25] In rural

[17] Uttley, L, et all, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.
[18] *See, e.g.*, *supra* note 2.
[19] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, Pub. Rights Private Conscience Project 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[20] *See* Julia Kaye, et al., *Health Care* Denied, Am. Civil Liberties Union 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[21] *See* Kira Shepherd, et al., *supra* note 19, at 29.
[22] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, Nat'l Women's L. Ctr. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, Wash. Post (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.
[23] *See* Kira Shepherd, et al., *supra* note 19, at 27.
[24] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. *Women's Health Insurance* Coverage, Kaiser Family Found. 1, 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.
[25] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, Contraception 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health &

areas there may be no other sources of health and life preserving medical care.[26] When these individuals encounter refusals of care, they may have nowhere else to go.

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

7. The Department is abdicating its responsibility to patients

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

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

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

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

Ctr. For Reproductive Rights, *Nuestra Voz, Nuestra Salud, Nuestra Texas: the Fight for Women's Reproductive Health in the Rio Grande Valley* 1, 7 (2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf.

[26] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Ctr for Health Servs. Res. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

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

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

[29] *See, e.g., Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, Am. Civil Liberties Union & Merger Watch (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

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

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

[32] *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, Nat'l Gay and Lesbian Task Force & Nat'l Ctr. For Transgender Equality, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

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

Conclusion

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

Thank you for this opportunity to comment. If you have any questions, please contact Brendan Riley at Brendan@ncjustice.org.

North Carolina Justice Center

Exhibit 148

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

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

To Whom It May Concern:

I am writing on behalf of the Oregon Foundation for Reproductive Health in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1] The Oregon Foundation for Reproductive Health (OFRH) is a non-profit advocacy organization located in Portland, that provides a channel for Oregon women's voices from all over the state to be heard, particularly those historically under-served. We believe that all people should have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction for themselves and their families without fear of discrimination, exclusion, or harm. We will work to break down barriers to health care so that all people have the opportunity to thrive. Our mission is to improve access to comprehensive reproductive health care, such as preventing unintended pregnancy and planning healthy families, and we are committed to advancing reproductive rights and advocating for reproductive health equity in all Oregon communities.

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

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

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

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

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

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

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

An expansive interpretation of "assist in the performance of" thus *could conceivably allow an ambulance driver to refuse to transport a patient to the hospital for care he/she finds objectionable.* It

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could mean a hospital admissions clerk could refuse to check in a patient for treatment the clerk finds objectionable or a technician could refuse to prepare surgical instruments for use in a service.

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

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

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

rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[16]

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

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

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

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

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

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another

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[16] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).
[17] Uttley, L, et all, *Miscarriage of Medicine,* MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.
[18] *See, e.g.*, *supra* note 2.
[19] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[20] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[21] *See* Kira Shepherd, et al., *supra* note 19, at 29.
[22] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.
[23] *See* Kira Shepherd, et al., *supra* note 19, at 27.

location, refusals bar access to necessary care.[24] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[25] In rural areas there may be no other sources of health and life preserving medical care.[26] When these individuals encounter refusals of care, they may have nowhere else to go.

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

7. The Department is abdicating its responsibility to patients

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

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

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

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

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

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

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

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

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

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

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

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

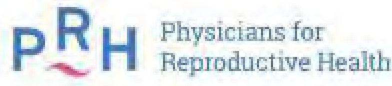
The proposed rule will have a chilling effect on the enforcement and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. Moreover, the proposed rule invites states to further expand refusals of care by making clear that this expansive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

Conclusion

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

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

Exhibit 153



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March 27, 2018

The Honorable Alex Azar

Secretary of Health and Human Services

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Washington, DC 20201

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

Dear Secretary Azar:

Physicians for Reproductive Health is committed to ensuring all individuals have access to health care, regardless of their gender identity, sexual orientation, and/or the type of services being requested, including abortion, contraception or sterilization. Physicians for Reproductive Health (Physicians) is a doctor-led national advocacy organization that uses evidence-based medicine to promote sound reproductive health policies. Physicians unites the medical community and concerned supporters. Together, we work to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients. Physicians believes a health care provider's personal beliefs should never determine the care a patient receives. By allowing patient care to be compromised by religious or personal beliefs without consideration of the best medical care for the patient, this rule stands to undermine the very foundation of the doctor-patient relationship. Indeed, one of the reasons cited for the proposed rule is a case—*Chamorro v. Dignity Health*—we filed in California against a Catholic

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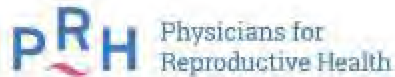

hospital network regarding their refusal to allow doctors to provide patients with the standard of care in the form of postpartum tubal ligations. That is why we strongly oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule"), which seeks to permit discrimination in all aspects of health care.[1]

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

By issuing the Proposed Rule and creating a new division within the Office of Civil Rights ("OCR") – the new "Conscience and Religious Freedom Division" – the Department seeks to inappropriately use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. For these reasons Physicians calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

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

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

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

The Proposed Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion and transition-related care. Specifically, the Department and OCR are attempting to require a broad swath of entities to allow individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."[2] Read in conjunction with

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (*to be codified at* 45 C.F.R. pt. 88) [*hereinafter* Rule].
[2] *See id.* at 12.

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the rest of the Proposed Rule, it is clear this is intended to allow any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care.

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

Already existing refusal of care laws are used across the country to deny patients the care they need.[3] The Proposed Rule attempts to expand these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions specifically related to the service or research activity to which they object.[4] But the Proposed Rule attempts to broaden this provision to allow individuals to refuse to perform aspects of their jobs based on a mere reference to a religious or moral belief regardless of whether it relates to the specific biomedical or behavioral service or research activity they are working on.[5] Such an attempted expansion goes beyond what the statute enacted by Congress allows. Furthermore, the Proposed Rule would expansively apply other provisions of the Church Amendments to, among other things, individuals working under global health programs funded by the Department, thereby allowing global health providers and entities to refuse individuals the care they need contrary to the very purpose of such programs.

Similarly, the Proposed Rule defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. For example, the definition of "assist in the performance" greatly expands the types of services that can be

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[3] *See, e.g.*, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Catherine Weiss, et al., *Religious Refusals and Reproductive* Rights, AM. CIVIL LIBERTIES UNION (2002), https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report; Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[4] The Church Amendments, 42 U.S.C. § 300a-7 (2018).
[5] *See* Rule *supra* note 1, at 185.

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refused to include merely "making arrangements for the procedure" no matter how tangential.[6] This means individuals not "assisting in the performance" of a procedure within the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, can now assert a new right to refuse. The Proposed Rule's definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information, including location or funding, that could help an individual to get the care they need.[7]

Furthermore, the Proposed Rule's new and unwarranted expanded definitions often exceed, or are not in accordance with, existing definitions contained within the statutes the Proposed Rule seeks to enforce. Specifically, under the Coats and Weldon Amendments "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.[8] The Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term.[9] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but goes directly against congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert.[10]

When these impermissibly broad definitions are combined with the expansive interpretations of the underlying statutes, they work together to further expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, one way the Weldon Amendment is expanded under the Proposed Rule is through the definition of "discrimination."[11] In particular, the Proposed Rule defines "discrimination" against a health care entity broadly to include a number of activities, including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[12] In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is nonsensical and inappropriate. Further, such a vague and

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

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inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

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

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

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[13] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[14] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[15] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[16] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[17] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in

[13] *See, e.g., supra* note 3.
[14] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[15] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[16] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 29 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[17] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.

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the following days, the hospital did not give her full information about her condition and treatment options.[18]

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

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[19] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[20] In rural areas there may be no other sources of health and life preserving medical care.[21] In developing countries where many health systems are weak, health care options and supplies are often unavailable.[22] When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen

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[18] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 27 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[19] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. *Women's Health Insurance* Coverage, KAISER FAMILY FOUND. 1, 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.
[20] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health & Ctr. For Reproductive Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: the Fight for Women's Reproductive Health in the Rio Grande Valley* 1, 7 (2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf.
[21] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
[22] *See* Nurith Aizenman, *Health Care Costs Push a Staggering Number of People into Extreme Poverty*, NPR (Dec. 14, 2017), https://www.npr.org/sections/goatsandsoda/2017/12/14/569893722/health-care-costs-push-a-staggering-number-of-people-into-extreme-poverty; *Tracking Universal Health Coverage: 2017 Global Monitoring Report*, WORLD HEALTH ORG. & THE WORLD BANK (2017), http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf.

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states, women of color are more likely than white women to give birth in Catholic hospitals.[23] These hospitals, as well as many Catholic-affiliated hospitals, must follow the Ethical and Religious Directives (ERDs) which provides guidance on a wide range of hospital matters, including reproductive health care and can keep providers from offering the standard of care.[24] Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women were delayed care or transferred to other facilities at great risk to their health.[25] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[26] In addition, in many of the countries where the Department implements global AIDS programs, many of the patients served already face numerous barriers to care, including a broad and harmful refusal provision contained within the statute governing such programs.[27]

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

By expanding refusals of care the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on society."[28] The Proposed Rule plainly fails on both counts. Although the Proposed Rule attempts to quantify the costs of compliance, it

[23] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[24] *See id.* at 10-13.
[25] Lori R. Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.
[26] *See, e.g.*, *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.
[27] *See The Mexico City Policy: An Explainer*, KAISER FAMILY FOUND. (June 1, 2017), https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/.
[28] Improving Regulation and Regulatory Review, Executive Order 13563 (Jan. 18, 2011), https://obamawhitehouse.archives.gov/the-press-office/2011/01/18/executive-order-13563-improving-regulation-and-regulatory-review.

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completely fails to address the costs and burdens to patients who may be denied care and who then may incur and experience even greater social and medical costs.[29]

Moreover, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant religious exemptions and, in fact, bars granting an exemption when it would detrimentally affect any third party.[30] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[31]

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

The Proposed Rule would seemingly allow health care entities to receive grants and contracts under HHS-funded programs or other federal health programs, such as Title X, the only domestic family planning program, while refusing to provide key services required by those programs.[32] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[33] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[34] Under the Proposed Rule, the Department would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such

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[29] *See* Rule *supra* note 1, at 94-177.
[30] U.S. Const. amend. I; *Cutter v. Wilkinson*, 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[31] Respecting religious exercise may not "unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling." *See Burwell v. Hobby Lobby*, 134 S. Ct. at 2787. When considering whether the birth control coverage requirement was the least restrictive means in Hobby Lobby, the Court considered that the accommodation offered by the government ensured that affected employees "have precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing coverage." *See id.* at 2759. In other words, the effect of the accommodation on women would be "precisely zero." *Id.* at 2760.
[32] *See* Rule *supra* note 1, at 180-181, 183. *See also Title X Family Planning*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2018), https://www.hhs.gov/opa/title-x-family-planning/index.html; *Title X an Introduction to the Nation's Family Planning Program*, NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOC. (2017) (*hereinafter* NFPRHA), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf.
[33] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[34] *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).

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funds are generally conditioned.[35] The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[36] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[37]

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

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care. Hospital systems across the country use religious beliefs to prevent their employees from treating patients regardless of the professional, ethical, or moral convictions of these providers.[38] The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions, including foreign and international organizations, to bind the hands of providers and attempt to limit the types of care they can provide.

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health providers and patients and ensure patient-centered decision-making.[39] Informed consent requires providers disclose relevant and medically accurate information about treatment choices and alternatives so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment

[35] *See, e.g.*, Rule *supra* note 1, at 180-185.
[36] *See* NFPRHA *supra* note 34.
[37] *See id.*
[38] *See* Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[39] *See* TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).

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altogether.[40] By allowing providers, including hospital and health care institutions, to refuse to provide patients with information, the Proposed Rule makes it impossible for patients to have full information regarding treatment options. While the Department claims the Proposed Rule improves communication between patients and providers, in truth it will deter open, honest conversations that are vital to ensuring that a patient can control their medical circumstances.[41]

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[42] Individuals seeking reproductive health care, regardless of their reasons for needing these services, should be treated with dignity and respect. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them.

In addition, the Proposed Rule ignores the many providers with deeply held moral convictions that affirmatively motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. Moreover, the Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[43] No health care professional should face

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[40] *See id.*
[41] *See* Rule *supra* note 1, at 150-151.
[42] For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant. AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE § 114-15, S117 (2017), available at http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf. The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics guidelines state that the risks to the woman from persistent severe pre-eclampsia are such that delivery (abortion) is usually suggested regardless of fetal age or potential for survival. AM. ACAD. OF PEDIATRICS & AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).
[43] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).

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discrimination from their employer because they treated or provided information to a patient seeking an abortion.

The Department is Abdicating its Responsibility to Patients

The Proposed Rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.[44] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce.[45] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[46] If finalized, however, the Proposed Rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities. Through robust enforcement of civil rights laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities,

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

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

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

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segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[47]

Nevertheless, there is still work to be done, and the Proposed Rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.[48] And these disparities do not occur in isolation. Black women, for example, are three to four times more likely than white women to die during or after childbirth.[49] Further, the disparity in maternal mortality is growing rather than decreasing,[50] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resulting health disparities. For example, women's pain is routinely undertreated and often dismissed.[51] And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[52] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[53] Eight percent of

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[47] *See, e.g.*, *Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html; *Protecting the Civil Rights and Health Information Privacy Rights of People Living with HIV/AIDS*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/hiv/index.html; *National Origin Discrimination*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/national-origin/index.html; *Health Disparities*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/health-disparities/index.html.
[48] *See* Skinner et al., *Mortality after Acute Myocardial Infarction in Hospitals that Disproportionately Treat African-Americans*, NAT'L INSTIT. OF HEALTH 1 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1626584/pdf/nihms13060.pdf.
[49] *See* Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.
[50] *See id.*
[51] *See, e.g.*, Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001).
[52] *See, e.g.*, Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. of the Am. Heart Ass'n 1 (2015).
[53] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf. A survey examining discrimination against LGBTQ people in health care more than half of respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care

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lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[54]

OCR must work to address these disparities, yet the Proposed Rule seeks to prioritize the expansion of existing religious refusal laws beyond their statutory requirements and create new religious exemptions where none had previously existed, rather than using already limited resources to protect patient access to health care. The Proposed Rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.[55]

The Proposed Rule Conflicts with Other Existing Federal Law

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals to care it would create. For example, the Proposed Rule makes no mention of Title VII,[56] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[57] With respect to religion, Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[58] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The Proposed Rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both. Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel filed

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

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

[55] *See supra* note 46.

[56] 42 U.S.C. § 2000e-2 (1964).

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

[58] *See id.*

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comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[59]

Furthermore, the language in the Proposed Rule would seem to put health care entities in the position of being forced to hire people who intend to refuse to perform essential elements of a position even though Title VII would not require such an "accommodation." For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling even though the employer would not be required to do so under Title VII.[60] It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

In addition, the Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[61] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[62] Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

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[59] Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.
[60] *See* Rule *supra* note 1, at 180-181.
[61] 42 U.S.C. § 1295dd(a)-(c) (2003).
[62] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); In In re Baby K, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, 93 Fair Empl. Prac. Cas. (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).

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

The Proposed Rule will have a chilling effect on the enforcement of and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. The preamble of the Proposed Rule discusses at length state laws that the Department finds objectionable, such as state laws that require anti-abortion counseling centers to provide information about where reproductive health care services can be obtained or whether facilities have licensed medical staff, as well as state laws that require health insurance plans to cover abortion.[63] Moreover, the Proposed Rule invites states to further expand refusals of care by making clear that this expansive rule is a floor, and not a ceiling, for religious exemption laws.[64]

Conclusion

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

Sincerely,
Board of Directors, Physicians for Reproductive Health

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

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Exhibit 154

Planned Parenthood
Federation of America

Planned Parenthood Action Fund

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

[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

[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

[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

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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

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[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
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Exhibit 159

March 27, 2018

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

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

To Whom it May Concern:

We are writing on behalf of Raising Women's Voices for the Health Care We Need (Raising Women's Voices) in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.[1]

Raising Women's Voices is a national initiative with 30 regional coordinator organizations in 29 states working to ensure that the health care needs of women and our families are addressed in federal and state health policies. We have a special mission of engaging women who are not often invited into health policy discussions: women of color, low-income women, immigrant women, young women, women with disabilities, and members of the LGBTQ community.

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

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

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

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

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

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

We are also concerned about potential enabling of care denials by providers based on their non-scientific personal beliefs about other types of health services. For example, certain religiously-affiliated hospitals and individual clinicians have refused to provide rape victims with emergency contraception to prevent pregnancy[5] based on the belief that it can cause an abortion, even though there is no scientific evidence that this is the case. Providers could conceivably be motivated by the proposed rule to object to administering vaccinations or refuse to prescribe or dispense Pre-exposure Profylaxis (PrEP) medication to help gay men reduce the risk of HIV transmission through unprotected sex.

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

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

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

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

On an institutional level, the right to refuse to "assist in the performance of" a service could mean *a* religiously-affiliated hospital or clinic could deny care, and *then also refuse to provide a patient with a referral or transfer to a willing provider* of the needed service. Indeed, the proposed rule's definition of "referral" goes beyond any common understanding of the term, allowing refusals to provide *any information,* including location of an alternative provider, that could help people get care they need.[6]

The proposed rule thus could be read as allowing health providers to refuse to inform patients of all potential treatment options. A 2010 publication of the National Health Law Program, "Health Care Refusals: Undermining Quality of Care for Women," noted that "refusal clauses and institutional restrictions can operate to deprive patients of the complete and accurate information necessary to give informed consent."[7]

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

There have been reported instances in which pregnant women suffering medical emergencies – including premature rupture of membranes (PPROM) and ectopic pregnancies[8] -- have gone to hospital emergency departments and been denied prompt, medically-indicated care because of institutional religious restrictions.[9] This lack of protections for patients is especially problematic in regions of the country, such as rural areas, where there may be no other nearby hospital to which a patient could easily go without assistance and careful medical monitoring enroute.[10]

The proposed rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person

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[6] *See* Rule *supra* note 1, at 183.

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

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

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

[10] For example, a 2016 study found there were 46 Catholic-affiliated hospitals that were the federally-designated "sole community providers" of hospital care for their geographic regions. Women needing reproductive health services that are prohibited by Catholic health restrictions would have no other easily accessible choice of hospital care. Uttley, L., and Khaikin, C., *Growth of Catholic Hospitals and Health Systems,* MergerWatch, 2016, accessed at www.MergerWatch.org

to another facility.[11] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[12] Because the proposed rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

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

The rule sets forth extensive requirements for health care institutions, such as hospitals, to notify employees about their refusal rights, including how to file a discrimination complaint with OCR. The rule requires posting of such notices on the employer's website and in prescribed physical locations within the employer's building. The rule also sets forth the expectation that OCR would investigate or do compliance reviews of whether health care institutions are following the posting rule.[13]

By contrast, the rule contains no requirement that patients be notified of institutional restrictions on provision of certain types of care. Such notification is essential because research has found that patients often are unaware of service restrictions at religiously-sponsored health care institutions. [14]

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

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals of care it would create. For example, the proposed rule makes no mention of Title VII,[15] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[16] 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.[17] For decades, Title VII has

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[11] 42 U.S.C. § 1295dd(a)-(c) (2003).

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

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

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

[15] 42 U.S.C. § 2000e-2 (1964).

[16] *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.

[17] *See id.*

established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The proposed rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both. Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[18]

Furthermore, the language in the proposed rule would seem to put health care entities in the position of being forced to hire people who intend to refuse to perform essential elements of a position, even though Title VII would not require such an "accommodation." For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling, even though the employer would not be required to do so under Title VII.[19] 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.

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

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care and end-of-life care. The rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[20]

Doctors are, in effect, forced to abandon their patients when they are prevented by health care institutions from providing a service they believe is medically-indicated. This was the case for a doctor in Sierra Vista, Arizona, who was prevented from ending a patient's wanted, but doomed, pregnancy after she suffered premature rupture of membranes. The patient had to be sent to the nearest non-objecting hospital, which was 80 miles away, far from her family and friends. The physician described the experience as "a very gut wrenching thing to put the staff through and the patient, obviously."[21]

7. The proposed rule carries severe consequences for patients and would exacerbate existing inequities.

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

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[18] Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.
[19] *See* Rule *supra* note 1, at 180-181.
[20] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).
[21] Uttley, L, et all, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), p. 16, https://www.aclu.org/report/miscarriage-medicine.

Across the country, refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[22] One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[23] Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.[24] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[25] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[26] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[27]

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

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[28] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[29] In rural areas there may be no other sources of health and life preserving medical care.[30] When these individuals encounter refusals of care, they may have nowhere else to go.

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[22] *See, e.g.*, *supra* note 2.
[23] *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.
[24] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[25] *See* Kira Shepherd, et al., *supra* note 23, at 29..
[26] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.
[27] *See* Kira Shepherd, et al., *supra* note 23, at 27..
[28] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. *Women's Health Insurance* Coverage, KAISER FAMILY FOUND. 1, 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.
[29] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8, 16 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf; Nat'l Latina Inst. For Reproductive Health & Ctr. For Reproductive Rights, *Nuestra Voz, Nuestra Salud, Nuestro Texas: the Fight for Women's Reproductive Health in the Rio Grande Valley* 1, 7 (2013), http://www.nuestrotexas.org/pdf/NT-spread.pdf.
[30] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that In 19 states, women of color are more likely than white women to give birth in Catholic hospitals.[31] Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provide guidance on a wide range of hospital matters, including reproductive health care, and can keep providers from offering the standard of care.[32] Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women were delayed care or transferred to other facilities at great risk to their health.[33] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[34]

We concur with the comments submitted by the National Health Law Program (NHeLP) that the regulations fail to consider the impact of refusals on persons suffering from substance use disorders. Rather than promoting the evidence-based standard of care, the rule could allow practitioners to refuse to provide, or even recommend, Medication Assisted Treatment (MAT) and other evidence-based interventions due simply to a personal objection.

Stigma associated with drug use stands in the way of saving lives.[35] America's prevailing cultural consciousness -- after decades of treating the disease of addiction as largely a criminal justice and not the public health issue it is -- generally perceives drug use as a moral failing and drug users as less deserving of care. For example, a needle exchange program designed to protect injection drug users from contracting blood borne illnesses such as HIV, Hepatitis C, and bacterial endocarditis was shut down in October 2017 by the Lawrence County, Indiana County Commission due to their moral objection to drug use, despite overwhelming evidence that these programs are effective at reducing harm and do not increase drug use.[36] One commissioner even quoted the Bible as he voted to shut it down. Use of MAT to reverse overdose has been decried as "enabling these people" to go on to overdose again.[37]

In this frame of mind, only total abstinence is seen as successful treatment for substance use disorders, usually as a result of a 12-step or faith-based program, even though evidence for 12-step

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[31] *See* Kira Shepherd, et al., *supra* note 23, at 12.
[32] *See id.* at 10-13.
[33] Lori R. Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.
[34] *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.
[35] Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL'Y 49, 56 (2010); German Lopez, *There's a highly successful treatment for opioid addiction. But stigma is holding it back.*, https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone.
[36] German Lopez, *An Indiana county just halted a lifesaving needle exchange program, citing the Bible,* VOX, Oct. 20, 2017, https://www.vox.com/policy-and-politics/2017/10/20/16507902/indiana-lawrence-county-needle-exchange.
[37] Tim Craig & Nicole Lewis, *As opioid overdoses exact a higher price, communities ponder who should be saved*, WASH. POST, Jul. 15, 2017, https://www.washingtonpost.com/world/as-opioid-overdoses-exact-a-higher-price-communities-ponder-who-should-be-saved/2017/07/15/1ea91890-67f3-11e7-8eb5-cbccc2e7bfbf_story.html?utm_term=.4184c42f806c.

programs is weak. The White House's own opioid commission found that "negative attitudes regarding MAT appeared to be related to negative judgments about drug users in general and heroin users in particular."[38]

People with substance use disorders already suffer due to stigma and have a difficult time finding appropriate care. This rule, which allows misinformation and personal feelings to get in the way of science and lifesaving treatment, would not help achieve the goals of the administration; it could instead trigger countless numbers of deaths.

By expanding refusals of care, the proposed rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this proposed rule will fall hardest on those most in need of care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on society."[39] The proposed rule plainly fails on both counts. Although the proposed rule attempts to quantify the costs of compliance, it completely fails to address the costs and burdens to patients who may be denied care and who then may incur and experience even greater social and medical costs.[40]

Moreover, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant religious exemptions and, in fact, bars granting an exemption when it would detrimentally affect any third party.[41] Because the proposed rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[42]

8. The Department is abdicating its responsibility to patients

The proposed rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.[43] Instead, the proposed rule appropriates language from civil

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[38] Report of the President's Commission on Combating Drug Addiction and the Opioid Crisis, Nov. 1, 2017, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf
[39] *Improving Regulation and Regulatory Review*, Executive Order 13563 (Jan. 18, 2011), https://obamawhitehouse.archives.gov/the-press-office/2011/01/18/executive-order-13563-improving-regulation-and-regulatory-review.
[40] *See* Rule *supra* note 1, at 94-177.
[41] U.S. Const. amend. I; *Cutter v. Wilkinson*. 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[42] Respecting religious exercise may not "unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling." *See Burwell v. Hobby Lobby*, 134 S. Ct. at 2787. When considering whether the birth control coverage requirement was the least restrictive means in Hobby Lobby, the Court considered that the accommodation offered by the government ensured that affected employees "have precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing coverage." *See id.* at 2759. In other words, the effect of the accommodation on women would be "precisely zero." *Id.* at 2760.
[43] *OCR's Mission and Vision*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS

rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the proposed rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the proposed rule seeks to enforce.[44]

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[45] If finalized, however, the proposed rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities. Through robust enforcement of civil rights laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities, segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[46]

Nevertheless, there is still work to be done, and the proposed rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.[47] Black women are three to four times more likely than white women to die during or after childbirth.[48] According to a recent report, doctors often fail to inform Black women of the full range of reproductive health options regarding labor or delivery, possibly due to stereotypes about Black women's sexuality and reproduction.[49] Young Black women said they felt they were shamed by

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programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").

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

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

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

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

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

[49] CTR. FOR REPROD. RIGHTS, NAT'L LATINA INST. FOR REPROD. HEALTH & SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), *available at*

providers when seeking sexual health information and contraceptive care, due to their age and in some instances, sexual orientation.[50]

Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[51] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[52]

As NHelP's comments note, many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously-affiliated providers. Historically, people with disabilities who rely on these services have sometimes faced discrimination, exclusion, and a loss of autonomy due to provider objections. Group homes have, for example, refused to allow residents with intellectual disabilities who were married to live together in the group home.[53] Individuals with HIV – a recognized disability under the ADA – have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. One man with HIV was refused care by six nursing homes before his family was finally forced to relocate him to a nursing home 80 miles away.[54] Given these and other experiences, the extremely broad proposed language at 45 C.F.R. § 88.3(a)(2)(vi) that would allow <u>any</u> individual or entity with an "articulable connection" to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a moral or religious objection is extremely alarming and could seriously compromise the health, autonomy and well-being of people with disabilities.

OCR must work to address these disparities, yet the proposed rule seeks to prioritize the expansion of existing religious refusal laws beyond their statutory requirements and create new religious exemptions where none had previously existed rather than using already limited resources to protect patient access to health care. The proposed rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.[55]

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

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https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter *Reproductive Injustice*]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), *available at* http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

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

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

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

[53] See *Forziano v. Independent Grp. Home Living Prog.*, No. 13-cv-00370 (E.D.N.Y. Mar. 26, 2014) (dismissing lawsuit against group homes, including a religiously affiliated group home, that refused to allow married couple with intellectual disabilities live together). Recent regulations have reinforced protections to ensure available choice of roommates and guests. 42 C.F.R. §§ 441.301(c)(4)(vi)(B) & (D).

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

[55] *See supra* note 42.

The proposed rule will have a chilling effect on the enforcement of and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. The preamble of the proposed rule discusses at length state laws that the Department finds objectionable, such as state laws that require anti-abortion counseling centers to provide information about where reproductive health care services can be obtained or whether facilities have licensed medical staff, as well as state laws that require health insurance plans to cover abortion.[56] Moreover, the proposed rule invites states to further expand refusals of care by making clear that this expansive rule is a floor, and not a ceiling, for religious exemption laws.[57]

10. The proposed rule will undermine critical federal health programs, including Title X

The proposed rule would seemingly allow health care entities to receive grants and contracts under HHS-funded programs or other federal health programs, such as Title X, the only domestic family planning program, while refusing to provide key services required by those programs.[58] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[59] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[60] Under the Proposed Rule, the Department would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such funds are generally conditioned.[61] The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the sub-recipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[62] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[63]

Conclusion

The proposed rule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The proposed rule is discriminatory, violates multiple federal statutes and the

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[56] *See, e.g.*, Rule, *Supra* note 1, at 3888-89.
[57] *See id.*
[58] *See* Rule *supra* note 1, at 180-181, 183. *See also Title X Family Planning*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2018), https://www.hhs.gov/opa/title-x-family-planning/index.html; *Title X an Introduction to the Nation's Family Planning Program*, NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOC. (2017) (*hereinafter* NFPRHA), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf.
[59] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[60] *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).
[61] *See, e.g.*, Rule *supra* note 1, at 180-185.
[62] *See* NFPRHA *supra* note 34.
[63] *See id.*

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Constitution, ignores congressional intent, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons, Raising Women's Voices calls on the Department to withdraw the proposed rule in its entirety.

If you have any questions regarding these comments, please contact Lois Uttley, co-founder of Raising Women's Voices and Women's Health Program Director for Community Catalyst, at luttley@communitycatalyst.org.

Respectfully submitted,

Raising Women's Voices for the Health Care We Need

Exhibit 162

City and County of San Francisco
Mark Farrell
Mayor

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

Secretary Alex Azar
The U.S. Department of Health & Human Services
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RE: Department of Health and Human Services Proposed Rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," Docket ID No. HHS-OCR-2018-0002 (RIN 0945-ZA03)

Dear Secretary Azar,

Thank you for the opportunity to submit comments on "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," Department of Health and Human Services (HHS) proposed rule RIN0945-ZA03, Docket ID No. HHS-OCR-2018-0002. **The San Francisco Department of Public Health (SFDPH) strongly opposes this proposed rule and requests that it be withdrawn.** In support of our position, we offer the information below based on our experience as a safety net provider of direct health services to thousands of insured and uninsured residents of San Francisco, including those most socially and medically vulnerable.

SFDPH, through the San Francisco Health Network (SFHN), provides San Francisco's only complete care system and includes primary care, dental care, emergency and trauma treatment, medical and surgical specialties, diagnostic testing, skilled nursing and rehabilitation, behavioral health services and jail health services. The mission of SFDPH is to protect and promote the health of all San Franciscans. SFDPH is dedicated to reducing health disparities and providing inclusive care to all patients. SFDPH provides this care though its top-rated programs, fifteen primary care community clinics, and hospitals, including Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG). For example, Zuckerberg San Francisco General alone delivers over one thousand babies a year, has been at the forefront of HIV/AIDS care from the beginning of the AIDS crisis, and provides gender-confirmation surgeries to transgender patients.

Zuckerberg San Francisco General cares for approximately one in eight San Franciscans a year, regardless of their ability to pay. As the City's safety net hospital, Zuckerberg San Francisco General provides the highest-quality services, including to many patients covered through Medi-Cal (California's Medicare program). It provides life-saving emergency care as the only level one trauma center in San Francisco, serving a region of more than 1.5 million people. With the busiest emergency room in San Francisco, Zuckerberg San Francisco General receives one-third of all ambulances in the City, and treats nearly four

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thousand patients with traumatic injuries, annually. Many of Zuckerberg San Francisco General's programs focus on providing life-saving care in emergency situations.

As a safety net provider, SFDPH is extremely concerned by the proposed rule. HHS recently created the Division of Conscience and Religious Freedom with the purpose of protecting health care workers who refuse to treat patients on the basis of religious and moral objections. This new division and the proposed rule threaten the health of our patients, and are likely to have a particular negative impact on low-income people, women, and the LGBTQ community.

The proposed rule compromises patient care, undermines the oaths sworn to by medical and healthcare professionals, is unnecessary, and is practically unworkable.

First, the proposed rule provides no benefits and imposes only burdens on patients. It fails to take into account the very real costs it imposes on patients' rights to access care, and to do so without being subjected to discrimination. Prioritizing religious freedom over the provision of care allows discrimination and threatens the lives of patients, including women and the LGBTQ community. The proposed rule would undermine San Francisco's long-standing efforts to advance women's health and reproductive rights, prevent domestic violence, address sexual assault and human trafficking, and promote the health and well-being of women and the LGBTQ community through access to health promotion and health care services. The proposed rule threatens patients' constitutional right to access reproductive healthcare services, including abortions. This proposed rule would also exacerbate already enormous deficiencies in health care access among transgender and gender non-conforming individuals. Nearly a quarter of transgender people already report avoiding seeking medical care for fear of being mistreated.[1] This rule could further dissuade transgender people from seeking even the most routine services. The breadth of the rule is such that it is impossible to fully predict how the rule could impact patients—even access to basic care that on its face has no discernable connection to religious observance, such as dental care, could be threatened. Further, it would disproportionately place low-income San Franciscans at risk and threaten San Francisco's ability to provide necessary healthcare services to its residents most in need. The proposed rule completely fails to take into account the very real costs it imposes on patients' rights to access care, and to do so without being subjected to discrimination.

Second, the proposed rule elevates a right of conscience above all other ethical considerations. The proposed rule is in direct violation of the Hippocratic Oath, in which doctors swear to do no harm and to treat the ill to the best of their ability. Its definition of "refer" is so broad that it could potentially prevent SFDPH from ensuring that if one health care provider were unwilling to give certain care, another provider would be able to provide it without delay. When a patient seeks care from one of SFHN's clinics or hospitals, both the patient and SFDPH need to know that the patient is receiving all medically-necessary care.

Third, existing laws and regulations ensure that patients receive the essential health services they need, while adequately protecting the rights of conscience of healthcare workers. Patients have the right to access high-quality, inclusive and comprehensive care without encountering discrimination, and current

[1] Sandy E. James et al., The Report of the U.S. Transgender Survey 98 (2016), www.ustranssurvey.org/report.

law ensures that access while also allowing accommodations for healthcare workers' religious beliefs. SFDPH is not aware of any employee request for a religious accommodation that it has been unable to provide under existing laws and regulations. Current law is perfectly adequate, and there is no need for the proposed rule.

Lastly, the proposed rule is unworkable in many other respects. In addition to ignoring the needs of patients, the proposed rule fails to account for how a health care organization could legally administer it. The proposed rule ignores competing obligations imposed on SFHN by other statutes such as the Emergency Medical Treatment and Active Labor Act and California's Unruh Civil Rights Act. It also ignores SFDPH's contractual obligations to its employees; the proposed rule could create problems with the fair administration of labor contracts between employees asserting conscience rights and those who do not.

The rule also appears to create administrative obstacles to providing employees with religious accommodations. The current draft lacks a requirement that workers seeking to assert a right of conscience inform their organization of their request, and therefore could deny the organization an opportunity to provide the worker with an accommodation. Moreover, the proposed definition of "discrimination" is so broad that even if a worker did request an accommodation, the very act of providing one could be considered discriminatory. If an employee failed to request an accommodation in advance of being presented with a patient who has an immediate need for care, the proposed rule creates a very real risk that the patient could be denied legally required or medically necessary care. Patient care is SFDPH's first and primary priority, but it is worth noting that in addition to harming a patient, such a situation could also potentially expose SFDPH to liability for violations of other laws and for malpractice.

For these reasons, we respectfully request HHS withdraw the Proposed Rule from consideration.

Sincerely,

Barbara A. Garcia

Director of Health
San Francisco Department of Public Health

Exhibit 163

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March 27, 2018

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

Introduction

On behalf of the Sargent Shriver National Center on Poverty Law (Shriver Center), we respectfully submit these comments to the federal Department of Health and Human Services ("Department") and its Office for Civil Rights ("OCR") to express our strong opposition on behalf of our clients to the proposed regulation entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."[1]

Shriver Center advocates for quality comprehensive, accessible, and affordable health care coverage and services for all populations experiencing poverty. Shriver Center advocates against racial inequity and inequality and works to reduce health care disparities for communities of color. In particular, we have a special focus and expertise in Medicaid policy as well as policy implementing the Affordable Care Act Marketplace, which provides subsidized health care coverage to Illinois residents with household income under 400% of the poverty level. We provide training and technical assistance to thousands of enrollment professionals in Illinois who assist consumers to enroll in health care programs including Medicaid and the Marketplace and to access financial assistance and health care services. We are also a co-leader of Protect Our Care Illinois, a membership coalition of healthcare advocates, providers, and consumers, joining efforts to promote and preserve access to high quality affordable healthcare for Illinois residents and families. The regulations as proposed would significantly burden our clients and restrict their access to care causing poorer health outcomes. Our specific concerns are outlined below.

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

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

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

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

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

> "[e]qual access for all individuals without discrimination is essential to achieving" the ACA's aim to expand access to health care and health coverage for all, as "discrimination in the health care context can often…exacerbate existing health disparities in underserved communities."[2]

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

The federal government argues that robust religious refusals, as implemented by this proposed rule, will facilitate open and honest conversations between patients and physicians.[3] As an outcome of this rule, the government believes that patients, particularly those who are "minorities", including those who identify as people of faith, will face fewer obstacles in accessing care.[4] The proposed rule will not achieve these outcomes. Instead, the proposed rule will increase barriers to care, harm patients by allowing health care professionals to ignore established medical guidelines, and

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[2] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,194 (Sept. 8, 2015) (codified at 45 C.F.R. pt. 2).
[3] 83 Fed. Reg. 3917.
[4] *Id.*

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undermine open communication between providers and patients. The harm caused by this proposed rule will fall hardest on those most in need of care.

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

Women, individuals living with disabilities, LGBTQ persons, people living in rural communities, and people of color face significant health care disparities, and these disparities are compounded for individuals who hold these multiple identities. For example, among adult women, 15.2 percent of those who identified as lesbian or gay reported being unable to obtain medical care in the last year due to cost, as compared to 9.6 percent of straight individuals.[5] Women of color experience health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.[6] Meanwhile, people of color in rural America are more likely to live in an area with a shortage of health professionals, with 83% of majority-Black counties and 81% of majority-Latino/a counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

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

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

Broadly-defined and widely-implemented refusal clauses undermine access to basic health services for all, but will be particularly harmful to low-income women. The burdens on low-income women can be insurmountable when women and families are uninsured,[7] underinsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services nor travel to another location. This is especially true for immigrant women. In comparison to their U.S. born

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

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

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

peers, immigrant women are more likely to be uninsured.[8] Notably, immigrant, Latina women have far higher rates of being uninsured than Latina women born in the United States (48 percent versus 21 percent, respectively).[9]

According to a recent report, doctors often fail to inform Black women of the full range of reproductive health options regarding labor or delivery possibly due to stereotypes about Black women's sexuality and reproduction.[10] Young Black women noted that they were shamed by providers when seeking sexual health information and contraceptive care in part, due to their age, and in some instances, sexual orientation.[11]

New research also shows that women of color in many states disproportionately receive their care at Catholic hospitals, subjecting them to treatment that does not comply with the standards of care.[12] In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[13] In New Jersey, for example, women of color make up 50 percent of women of reproductive age in the state, yet have twice the number of births at Catholic hospitals compared to their white counterparts.[14] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on wide range of hospital matters, including reproductive health care. In practice, the ERDs prohibit the provision of emergency contraception, sterilization, abortion, fertility services, and some treatments for ectopic pregnancies. Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals and as a result, women were delayed care or transferred to other facilities, risking their health.[15] The proposed rule will give health care providers a license, such as Catholic hospitals, to opt out of evidence-based care that the medical community endorses. If this rule were to be implemented, more women, particularly women of color, will be put in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services. For many, this choice does not exist.

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[8] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf.
[9] *Id.* at 8, 16.
[10] CTR. FOR REPROD. RIGHTS, NAT'L LATINA INST. FOR REPROD. HEALTH & SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter *Reproductive Injustice*]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), *available at* http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.
[11] *Reproductive Injustice*, *supra* note 10, at 16-17.
[12] Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT (2018), *available at* https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[13] *Id* at 12.
[14] *Id* at 9.
[15] Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.

b. The proposed rule will negatively impact rural communities

The ability to refuse care to patients will leave many individuals in rural communities with no health care options. Medically underserved areas already exist in every state,[16] with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[17] Many rural communities experience a wide array of mental health, dental health, and primary care health professional shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.[18] Among the many geographic and spatial barriers that exist, individuals in rural areas often must have a driver's license and own a private car to access care, as they must travel further distances for regular checkups, often on poorer quality roads, and have less access to reliable public transportation.[19] This scarcity of accessible services leaves survivors of intimate partner violence (IPV) in rural areas with fewer shelter beds close to their homes, with an average of just 3.3 IPV shelter beds per rural county as compared to 13.8 in urban counties.[20] Among respondents of one survey, more than 25 percent of survivors of IPV in rural areas have to travel over 40 miles to the nearest support service, compared to less than one percent of women in urban areas.[21]

Illinois has a large number of counties in rural areas of the state, many of which are designated as health care shortage areas. Patients in these rural counties already have to travel by car very long distances to find providers, hospitals and specialists who can treat them – sometimes even traveling to providers in other neighboring states including Indiana, Missouri and Iowa. Many of our clients who are low income do not have the resources to travel these distances and public transportation is basically non-existent. This proposed rule will only exacerbate an already difficult situation. Patients in rural counties in Illinois cannot afford to lose any providers or have providers refuse to treat them.

Some individuals in rural areas, such as people with disabilities, people with Hepatitis C, and people of color, have intersecting identities that further exacerbate existing barriers to care in rural areas. Racial and ethnic minority communities often live in concentrated parts of rural America, in communities experiencing rural poverty, lack of insurance, and

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[16] Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA, (last visited Mar. 21, 2018).
[17] M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH (2010), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/.
[18] Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations*, ECON. RESEARCH SERV. (2009), *available at* https://www.ers.usda.gov/publications/pub-details/?pubid=44427.
[19] Thomas A. Arcury et al., *The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region*, 40 HEALTH SERV. RESEARCH (2005) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361130/.
[20] Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources*, 20 J. OF WOMEN'S HEALTH (Nov. 2011) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216064/.
[21] *Id.*

health professional shortage areas.[22] People with disabilities experience difficulties finding competent physicians in rural areas who can provide experienced and specialized care for their specific needs, in buildings that are barrier free.[23] Individuals with Hepatitis C infection find few providers in rural areas with the specialized knowledge to manage the emerging treatment options, drug toxicities and side effects.[24] All of these barriers will worsen if providers are allowed to refuse care to particular patients.

Meanwhile, immigrant, Latina women and their families often face cultural and linguistic barriers to care, especially in rural areas.[25] These women often lack access to transportation and may have to travel great distances to get the care they need.[26] In rural areas there may simply be no other sources of health and life preserving medical care. When these women encounter health care refusals, they have nowhere else to go.

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

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

LGBTQ people continue to face discrimination in many areas of their lives, including health care, on the basis of their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[27] LGBTQ people still face discrimination in a wide variety of services affecting access to health care, including reproductive services, adoption and foster care services, child care, homeless shelters, and transportation services – as well as

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[22] Janice C. Probst et al., *Person and Place: The Compounding Effects of Race/Ethnicity and Rurality on Health*, AM. J. PUB. HEALTH (2011), *available at* http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1695.
[23] Lisa I. Iezzoni et al., *Rural Residents with Disabilities Confront Substantial Barriers to Obtaining Primary Care*, 41 HEALTH SERV. RESEARCH (2006), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1797079/.
[24] Sanjeev Arora et al., *Expanding access to hepatitis C virus treatment – Extension for Community Healthcare Outcomes (ECHO) Project: Disruptive Innovation in Specialty Care*, 52 HEPATOLOGY (2010), *available at* http://onlinelibrary.wiley.com/doi/10.1002/hep.23802/full.
[25] Michelle M. Casey et al., *Providing Health Care to Latino Immigrants: Community-Based Efforts in the Rural Midwest*, AM. J. PUB. HEALTH (2011), *available at* http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1709.
[26] NAT'L LATINA INST. FOR REPROD. HEALTH & CTR. FOR REPROD. RIGHTS, NUESTRA VOZ, NUESTRA SALUD, NUESTRO TEXAS: THE FIGHT FOR WOMEN'S REPRODUCTIVE HEALTH IN THE RIO GRANDE VALLEY, 7 (2013), *available at* http://www.nuestrotexas.org/pdf/NT-spread.pdf.
[27] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 8, 2018).

physical and mental health care services.[28] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.[29] They concluded that discrimination as well as insensitivity or disrespect on the part of health care providers were key barriers to health care access and that increasing efforts to provide culturally sensitive services would help close the gaps in health care access.[30]

i. Discrimination against the transgender community

Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.[31] Numerous federal courts have found that federal sex discrimination statutes reach these forms of gender-based discrimination.[32] In 2012, the Equal Employment Opportunity Commission (EEOC) likewise held that "intentional discrimination against a transgender individual because that person is transgender is,

[28] HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.
[29] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.
[30] *Id.*
[31] *See, e.g.*, *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018); *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (Title IX and Equal Protection Clause); Doddsv. U.S. Dep't of Educ., 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *A.H. ex rel. Handling v. Minersville Area School District*, 3:17-CV-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and Equal Protection Clause); *Stone v. Trump*, ---F.Supp.3d ---, No. 17–2459 (D. Md. Nov. 21, 2017) (Equal Protection Clause); Doe v. Trump, ---F.Supp.3d ---, 2017 WL 4873042 (D.D.C. Oct. 30, 2017) (Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, ---F.Supp.3d ---, 2017 WL 4310756 (S.D. Cal. Sept. 27, 2017) (Section 1557); *E.E.O.C. v. Rent-a-Center East, Inc.*, ---F.Supp.3d ---, 2017 WL 4021130 (C.D. Ill. Sept. 8, 2017) (Title VII); *Brown v. Dept. of Health and Hum. Serv.*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017) (Equal Protection Clause); *Smith v. Avanti*, 249 F.Supp.3d 1194 (D. Colo. 2017) (Fair Housing Act); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); *Mickens v. Gen. Elec. Co.* No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hosp. of Cent. Conn.*, 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016) (Section 1557); *Doe v. State of Ariz.*, No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016) (Title VII); *Dawson v. H&H Elec., Inc.*, No. 4:14CV00583 SWW, 2015 WL 5437101 (E.D. Ark. Sept. 15, 2015) (Title VII); *U.S. v. S.E. Okla. State Univ.*, No. CIV–15–324–C, 2015 WL 4606079 (W.D. Okla. 2015) (Title VII); *Rumble v. Fairview Health Serv.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557); *Finkle v. Howard Cty.*, 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Lopez v. River Oaks Imaging & Diagnostic Grp.*, Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); *Mitchell v. Axcan Scandipharm*, Inc., No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); *Tronettiv. Healthnet Lakeshore Hosp.*, No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII).
[32] *See, e.g.*, *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). *See also* Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

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by definition, discrimination based on sex and such discrimination therefore violates Title VII."[33]

Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity and 29 percent experienced unwanted physical contact from a health care provider.[34] Additionally, the 2015 U.S. Transgender Survey found that 23 percent respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[35] Data obtained by Center for American Progress (CAP) under a FOIA request indicates the Department's enforcement was effective in resolving issues of anti-LGBTQ discrimination. CAP received information on closed complaints of discrimination based on sexual orientation, sexual orientation-related sex stereotyping, and gender identity that were filed with the Department under Section 1557 of the ACA from 2012 through 2016.

- "In approximately 30% of these claims, patients alleged denial of care or insurance coverage simply because of their gender identity – not related to gender transition."
- "Approximately 20% of the claims were for misgendering or other derogatory language."
- "Patients denied care due to their gender identity or transgender status included a transgender woman denied a mammogram and a transgender man refused a screening for a urinary tract infection."[36]

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

ii. Discrimination Based Upon Sexual Orientation

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[33] *Macy v. Holder*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).
[34] 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.
[35] NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf [hereinafter *2015 U.S. Transgender Survey*].
[36] Sharita Gruberg & Frank J. Bewkes, Center for American Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (March 7, 2018), *available at* https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.

Many LGBTQ people lack insurance and providers are not competent in health care issues and obstacles that the LGBTQ community experiences.[37] LGBTQ people still face discrimination. According to one survey, 8 percent of lesbian, gay, bisexual, and queer individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and 7 percent experienced unwanted physical contact and violence from a health care provider.[38]

Fear of discrimination causes many LGB people to avoid seeking health care, and, when they do seek care, LGB people are frequently not treated with the respect that all patients deserve. The study "When Health Care Isn't Caring" found that 56 percent of LGB people reported experiencing discrimination from health care providers – including refusals of care, harsh language, or even physical abuse – because of their sexual orientation.[39] Almost ten percent of LGB respondents reported that they had been denied necessary health care expressly because of their sexual orientation.[40] Delay and avoidance of care due to fear of discrimination compound the significant health disparities that affect the lesbian, gay, and bisexual population. These disparities include:

- LGB individuals are more likely than heterosexuals to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities.[41]
- Lesbian and bisexual women report poorer overall physical health than heterosexual women.[42]
- Gay and bisexual men report more cancer diagnoses and lower survival rates, higher rates of cardiovascular disease and risk factors, as well as higher total numbers of acute and chronic health conditions.[43]
- Gay and bisexual men and other men who have sex with men (MSM) accounted for more than half (56 percent) of all people living with HIV in the United States, and more than two-thirds (70 percent) of new HIV infections.[44]

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[37] Medical schools often do not provide instruction about LGBTQ health concerns that are not related to HIV/AIDS. Jen Kates et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S*, KAISER FAMILY FOUND.12 (2017), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US.
[38] Mirza, *supra* note 34.
[39] LAMBDA LEGAL, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 5 (2010), *available at* .http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.
[40] *Id.*
[41] David J. Lick, Laura E. Durso & Kerri L. Johnson, *Minority Stress and Physical Health Among Sexual Minorities*, 8 PERS. ON PSYCHOL. SCI. 521 (2013), *available at* http://williamsinstitute.law.ucla.edu/research/health-and-hiv-aids/minority-stress-and-physical-health-among-sexual-minorities/.
[42] *Id.*
[43] *Id.*
[44] CTRS FOR DISEASE CONTROL & PREVENTION, *CDC Fact Sheet: HIV Among Gay and Bisexual Men* 1(Feb. 2017), https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf.

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- Bisexual people face significant health disparities, including increased risk of mental health issues and some types of cancer.[45]

This discrimination affects not only the mental health and physical health of LGBTQ people, but that of their families as well. One pediatrician in Alabama reported that "we often see kids who haven't seen a pediatrician in 5, 6, 7 years, because of fear of being judged, on the part of either their immediate family or them [identifying as LGBTQ]".[46] It is therefore crucial that LGBTQ individuals who have found unbiased and affirming providers, be allowed to remain with them. If turned away by a health care provider, 17 percent of all LGBTQ people, and 31 percent of LGBTQ people living outside of a metropolitan area, reported that it would be "very difficult" or "not possible" to find the same quality of service at a different community health center or clinic.[47]

The proposed rule allowing providers to deny needed care would reverse recent gains in combatting discrimination and health care disparities for LGBT persons. Refusals also implicate standards of care that are vital to LGBTQ health. Medical professionals are expected to provide LGBTQ individuals with the same quality of care as they would anyone else. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and competency with LGBTQ issues as they pertain to any health services provided.[48] The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.[49] The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.[50] LGBTQ individuals already experience significant health disparities, and denying medically necessary care on the basis of sexual orientation or gender identity exacerbates these disparities.

In addition, LGBTQ individuals face disparities in medical conditions that may implicate the need for reproductive health services. For example, lesbian and bisexual women report heightened risk for and diagnosis of some cancers and higher rates of

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[45] HUMAN RIGHTS CAMPAIGN ET AL., *Health Disparities Among Bisexual People* (2015) *available at* http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/HRC-BiHealthBrief.pdf.
[46] HUMAN RIGHTS WATCH, *supra* note 28.
[47] Mirza, *supra* note 34.
[48] *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, GAY LESBIAN BISEXUAL & TRANSGENDER HEALTH ACCESS PROJECT, http://www.glbthealth.org/CommunityStandardsofPractice.htm (last visited Jan. 26, 2018, 12:59 PM); *Creating an LGBTQ-friendly Practice*, A.M.A., https://www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice#Meet a Standard of Practice (last visited Jan. 26, 2018, 12:56 PM).
[49] *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, WORLD PROF. ASS'N FOR TRANSGENDER HEALTH (2011), https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf.
[50] *Committee Opinion 512: Health Care for Transgender Individuals*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Dec. 2011), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals.

cardiovascular disease.[51] The LGBTQ community is significantly at risk for sexual violence.[52] Eighteen percent of lesbian, gay, bisexual students have reported being forced to have sex.[53] Transgender women, particularly women of color, face high rates of HIV.[54]

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

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

d. The proposed rule will hurt people living with disabilities

Many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously-affiliated providers. Historically, people with disabilities who rely on these services have sometimes faced discrimination, exclusion, and a loss of autonomy due to provider objections. Group homes have, for example, refused to allow residents with intellectual disabilities who were married to live together in the group home.[55] Individuals with HIV – a recognized disability under the ADA – have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. One man with HIV was refused care by six nursing homes before his family was finally forced to relocate him to a nursing home 80 miles away.[56] Given these and other experiences, the extremely broad proposed language at 45 C.F.R. § 88.3(a)(2)(vi) that would allow <u>any</u> individual or entity with an "articulable connection" to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a

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[51] Kates, *supra* note 37, at 4.
[52] Forty-six percent of bisexual women have been raped and 47 percent of transgender people are sexually assaulted at some point in their lifetime. This rate is particularly higher for transgender people of color. Kates, *supra* note 37, at 8.; *2015 U.S. Transgender Survey*, *supra* note 35, at 5.
[53] *Health Risks Among Sexual Minority Youth*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/healthyyouth/disparities/smy.htm (last updated May 24, 2017).
[54] More than 1 in 4 transgender women are HIV positive. Kates, *supra* note 37, at 6.
[55] See *Forziano v. Independent Grp. Home Living Prog.*, No. 13-cv-00370 (E.D.N.Y. Mar. 26, 2014) (dismissing lawsuit against group homes, including a religiously affiliated group home, that refused to allow married couple with intellectual disabilities live together). Recent regulations have reinforced protections to ensure available choice of roommates and guests. 42 C.F.R. §§ 441.301(c)(4)(vi)(B) & (D).
[56] NAT'L WOMEN'S LAW CTR., *Fact Sheet: Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS*, (May 2014), *available at* https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf.

moral or religious objection is extremely alarming and could seriously compromise the health, autonomy, and well-being of people with disabilities.

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

Finally, due to limited provider networks in some areas and to the important role that case managers and personal care attendants play in coordinating care, it may be more difficult for people with disabilities and older adults to find an alternate providers who can help them. For example, home care agencies and home-based hospice agencies in rural areas are facing significant financial difficulties staying open. Seven percent of all zip codes in the United States to not have any hospice services available to them.[57] Finding providers competent to treat people with certain disabilities can increase the challenge. Add in the possibility of a case manager or personal care attendant who objects to helping and the barrier to accessing these services can be insurmountable. Moreover, people with disabilities who identify as LGBTQ or who belong to a historically disadvantaged racial or ethnic group may be both more likely to encounter service refusals and also face greater challenges to receive (or even know about) accommodations.

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

The proposed rule threatens informed consent, a necessary principle of patient-centered decision-making. Informed consent relies on disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[58] This right relies on two factors: access to relevant and medically-accurate information about treatment choices and alternatives, and provider guidance based on generally accepted standards

[57] Julie A. Nelson & Barbara Stover Gingerich, *Rural Health: Access to Care and Services*, 22 HOME HEALTH CARE MGMT. PRAC. (2010), *available at* http://globalag.igc.org/ruralaging/us/2010/access.pdf.
[58] TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).

of practice. Both factors make trust between patients and health care professionals a critical component of quality of care.

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

In recent decades, the U.S. medical community has primarily looked to informed consent as key to assuring patient autonomy in making decisions.[59] Informed consent is intended to help balance the unequal balance of power between health providers and patients and ensure patient-centered decision-making. Moreover, consent is not a yes or no question but rather is dependent upon the patient's understanding of the procedure that is to be conducted and the full range of treatment options for a patient's medical condition. Without informed consent, patients will be unable to make medical decisions that are grounded in agency, their beliefs and preferences, and that meet their personal needs. This is particularly problematic as many communities, including women of color and women living with disabilities, have disproportionately experienced abuse and trauma at the hands of providers and institutions.[60] In order to ensure that patient decisions are based on free will, informed consent must be upheld in the patient-provider relationship. The proposed rule threatens this principle and may very well force individuals into harmful medical circumstances.

According to the American Medical Association: "The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."[61]The American Nursing Association similarly requires that patient autonomy and self-determination are core ethical tenets of nursing. "Patients have the moral and

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[59] BEAUCHAMP & CHILDRESS, *supra* note 58; Robert Zussman, *Sociological perspectives on medical ethics and decision-making*, 23 ANN. REV. SOC. 171-89 (1997).
[60] Gutierrez, E. R. *Fertile Matters: The Politics of Mexican Origin Women's* Reproduction, 35-54 (2008) (discussing coercive sterilization of Mexican-origin women in Los Angeles); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 411-12 (2000) (referencing one 1974 study indicating that Indian Health Services would have coercively sterilized approximately 25,000 Native American Women by 1975); Alexandra Minna Stern, *Sterilized in the Name of Public Health*, 95 AM. J. PUB. H. 1128, 1134 (July 2005) (discussing African-American women forced to choose between sterilization and medical care or welfare benefits and Mexican women forcibly sterilized). *See also Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding state statute permitting compulsory sterilization of "feeble-minded" persons); Vanessa Volz, *A Matter of Choice: Women With Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 WOMEN RTS. L. REP. 203 (2006) (discussing sterilization reform statutes that permit sterilization with judicial authorization).
[61] *The AMA Code of Medical Ethics' Opinions on Informing Patients: Opinion 9.09 – Informed Consent*, 14 AM. MED. J. ETHICS 555-56 (2012), http://journalofethics.ama-assn.org/2012/07/coet1-1207.html.

legal right to determine what will be done with their own persons; to be given accurate, complete and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens and available options in their treatment."[62] Similarly, pharmacists are called to respect the autonomy and dignity of each patient.[63]

Various state and federal laws require that health care professionals inform and counsel patients on specific issues such as preventing the spread of HIV/AIDS, non-directional information on family planning and abortion options, and emergency contraception to prevent pregnancy from rape.[64] In *Brownfield v. Daniel Freeman Marina Hospital*, a California court addressed the importance of patients' access to information in regard to emergency contraception. The court found that:

> "The duty to disclose such information arises from the fact that an adult of sound mind has 'the right, in the exercise of control over [her] own body, to determine whether or not to submit to lawful medical treatment.' [citation omitted] Meaningful exercise of this right is possible only to the extent that patients are provided with adequate information upon which to base an intelligent decision with regard to the option available."[65]

In addition, the proposed rule does not provide any protections for health care professionals who want to provide, counsel, or refer for health care services that are implicated in this rule, for example, reproductive health or gender affirming care. Due to the rule's aggressive enforcement mechanisms and its vague and confusing language, providers may fear to give care or information. The inability of providers to give comprehensive, medically accurate information and options that will help patients make the best health decisions violates established medical principles. In particular, the principle of beneficence "requires that treatment and care do more good than harm; that the benefits outweigh the risks, and that the greater good for the patient is upheld."[66] In addition, the proposed rule undermines principles of quality care. Health care should be safe, effective, patient-centered, timely, efficient, and equitable.[67] Specifically, the provision of the care should not vary due to the personal characteristics of patients and should ensure that patient values guide all clinical decisions.[68] The expansion of

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

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

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

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

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

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

[68] *Id.*

religious refusals as envisioned in the proposed rule may compel providers to furnish care and information that harms the health, well-being, and goals of patients.

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

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

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

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

The clear, evidence-based treatment standard for opioid use disorder (OUD) is medication-assisted treatment (MAT).[71] Buprenorphine, methadone, and naltrexone are the three FDA-approved drugs for treating patients with opioid use disorder. MAT is so valuable to treatment of addiction that the World Health Organization considers buprenorphine and methadone "Essential Medications."[72] Buprenorphine and

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[69] Holly Hedegaard M.D., et al. *Drug Overdose Deaths in the United States, 1999-2016*, NAT'L CTR. FOR HEALTH STATISTICS1-8 (2017).
[70] *Vital Signs*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/vitalsigns/opioid-overdoses/.
[71] U.S. DEP'T HEALTH & HUM. SERV., PUB NO. (SMA)12-4214, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS (2012), https://store.samhsa.gov/shin/content/SMA12-4214/SMA12-4214.pdf; National Institute on Drug Abuse, *Effective Treatments for Opioid Addiction*, https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction.
[72] World Health Organization, 19th WHO Model List of Essential Medicines (April 2015), http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf

methadone are, in fact, opioids. However, while they operate on the same receptors in the brain as other opioids, they do not produce the euphoric effect of other opioids but simply keep the user from experiencing withdrawal symptoms. They also keep patients from seeking opioids on the black market, where risk of death from accidental overdose increases. Patients on MAT are less likely to engage in dangerous or risky behaviors because their physical cravings are met by the medication, increasing their safety and the safety of their communities.[73] Naloxone is another medication key to saving the lives of people experiencing an opioid overdose. This medication reverses the effects of an opioid and can completely stop an overdose in its tracks.[74] Information about and access to these medications are crucial factors in keeping patients suffering from SUD from losing their jobs, losing their families, and losing their lives.

However, stigma associated with drug use stands in the way of saving lives.[75] America's prevailing cultural consciousness, after decades of treating the disease of addiction as largely a criminal justice and not a public health issue, generally perceives drug use as a moral failing and drug users as less deserving of care. For example, a needle exchange program designed to protect injection drug users from contracting blood borne illnesses such as HIV, Hepatitis C, and bacterial endocarditis was shut down in October 2017 by the Lawrence County, Indiana County Commission due to their moral objection to drug use, despite overwhelming evidence that these programs are effective at reducing harm and do not increase drug use.[76] One commissioner even quoted the Bible as he voted to shut it down. Use of naloxone to reverse overdose has been decried as "enabling these people" to go on to overdose again.[77]

In this frame of mind, only total abstinence is seen as successful treatment for SUD, usually as a result of a 12-step or faith-based program. MAT is considered by many to be simply "substituting one drug for another drug."[78] This belief is so common that even the former Secretary of the Department is on the record as opposing MAT because he didn't believe it would "move the dial," since people on medication would be not

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[73] OPEN SOC'Y INST., BARRIERS TO ACCESS: MEDICATION-ASSISTED TREATMENT AND INJECTION-DRIVEN HIV EPIDEMICS 1 (2009), https://www.opensocietyfoundations.org [https://perma.cc/YF94-88AP].

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

[75] Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL'Y 49, 56 (2010); German Lopez, *There's a highly successful treatment for opioid addiction. But stigma is holding it back.*, VOX, Nov. 15, 2017, https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone.

[76] German Lopez, *An Indiana county just halted a lifesaving needle exchange program, citing the Bible,* VOX, Oct. 20, 2017, https://www.vox.com/policy-and-politics/2017/10/20/16507902/indiana-lawrence-county-needle-exchange.

[77] Tim Craig & Nicole Lewis, *As opioid overdoses exact a higher price, communities ponder who should be saved*, WASH. POST, Jul. 15, 2017, https://www.washingtonpost.com/world/as-opioid-overdoses-exact-a-higher-price-communities-ponder-who-should-be-saved/2017/07/15/1ea91890-67f3-11e7-8eb5-cbccc2e7bfbf_story.html?utm_term=.4184c42f806c.

[78] Lopez, *supra* note 75.

"completely cured."[79] The scientific consensus is that SUD is a chronic disease, and yet many recoil from the idea of treating SUD with medication like any other illness such as diabetes or heart disease.[80] The White House's own opioid commission found that "negative attitudes regarding MAT appeared to be related to negative judgments about drug users in general and heroin users in particular."[81]

People with SUD already suffer due to stigma and have a difficult time finding appropriate care. For example, it can be difficult to find access to local methadone clinics in rural areas.[82] Other roadblocks, such as artificial caps on the number of patients to whom doctors can prescribe buprenorphine, further prevent people with SUD from receiving appropriate care.[83] Only one-third of treatment programs across the country provide MAT, even though treatment with MAT can cut overdose mortality rates in half and is considered the gold standard of care. [84] The current Secretary of the Department has noted that expanding access to MAT is necessary to save lives and that it will be "impossible" to quell the opioid epidemic without increasing the number of providers offering the evidence-based standard of care.[85] This rule, which allows misinformation and personal feelings to get in the way of science and lifesaving treatment, will not help achieve the goals of the administration; it will instead trigger countless numbers of deaths.

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

Medical practice guidelines and standards of care establish the boundaries of medical care that patients can expect to receive and that providers should be expected to deliver. The health services impacted by refusals are often related to reproductive and sexual health, which are implicated in a wide range of common health treatment and prevention strategies. Information, counseling, referral and provisions of contraceptive and abortion services are part of the standard of care for a range of common medical

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

conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer. Many of these conditions disproportionately affect women of color.[86] The expansion of these refusals as outlined in the proposed rule will put women, particularly women of color, who experience these medical conditions at greater risk for harm.

Moreover, a 2007 survey of physicians working at religiously-affiliated hospitals found that nearly one in five (19 percent) experienced a clinical conflict with the religiously-based policies of the hospital.[87] While some of these physicians might refer their patients to another provider who could provide the necessary care, one 2007 survey found that as many as one-third of patients (nearly 100 million people) may be receiving care from physicians who do not believe they have any obligations to refer their patients to other providers.[88] Meanwhile, the number of Catholic hospitals in the United States has increased by 22 percent since 2001, and now own one in six hospital beds across the country.[89] The increase of Catholic hospitals poses a danger for women seeking reliable access to medical services, many of whom do not understand the full range of services that may be denied them. One public opinion survey found that, among the less than one-third of women who understood that a Catholic hospital might limit care, only 43 percent expected limited access to contraception, and a mere 6 percent expected limited access to the morning-after pill.[90]

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

[87] Debra B. Stulberg M.D. M.A., et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, J. GEN. INTERN. MED. 725-30 (2010) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881970/.

[88] Farr A. Curlin M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, NEW ENG. J. MED. 593–600 (2007) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2867473/.

[89] Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, AM. CIVIL LIBERTIES UNION 22 (2017), *available at* https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[90] Nadia Sawicki, *Mandating Disclosure Of Conscience-Based Limitations On Medical Practice*, 42 AM. J. OF LAW & MED. 85-128 (2016) *available at* http://journals.sagepub.com/doi/pdf/10.1177/0098858816644717.

a. Pregnancy prevention

The importance of the ability of women to make decisions for themselves to prevent or postpone pregnancy is well-established within the medical guidelines across a range of practice areas. Millions of women live with chronic conditions such as cardiovascular disease, diabetes, lupus, and epilepsy, which if not properly controlled, can lead to health risks to the pregnant woman or even death during pregnancy. Denying these women access to contraceptive information and services violates medical standards that recommend pregnancy prevention for these medical conditions. For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care.[91] Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant.[92]

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

b. Sexually transmitted infections (STIs)

Religious refusals also impact access to sexual health care more broadly. Contraceptives and access to preventative treatment for sexually transmitted infections are a critical aspect of health care. The CDC estimates that 20 million new sexually transmitted infections occur each year. Chlamydia remains the most commonly reported infectious disease in the U.S., while HIV/AIDS remains the most life threatening. Women, especially young women, and Black women, are hit hardest by Chlamydia—with rates of Chlamydia 5.6 times higher for Black than for white Americans.[96]

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[91] AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE S115, S117 (2017), available at: http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf
[92] *Id.* at S114.
[93] *Unintended Pregnancy in the United States*, Guttmacher Inst. (Sept. 2016), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.
[94] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in rates of unintended pregnancy in the United States, 1994 and 2001*, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90-6 (2006).
[95] INSTITUTE OF MEDICINE COMMITTEE ON UNINTENDED PREGNANCY, THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES (Sarah S. Brown & Leon Eisenberg eds.,1995).
[96] *Sexually Transmitted Disease Surveillance 2016*, CTR. FOR DISEASE CONTROL & PREVENTION (Sept. 2017), https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf.

Consistent use of condoms results in an 80 percent reduction of HIV transmission, and the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the World Health Organization all recommend the condom use be promoted by providers.[97]

c. Ending a Pregnancy

While there are numerous reasons for why a person would seek to end a pregnancy, there are many medical conditions in which ending a pregnancy is recommended as treatment. These conditions include: preeclampsia and eclampsia, certain forms of cardiovascular disease, and complications for chronic conditions. Significant racial disparities exist in rates of and complications associated with preeclampsia.[98] For example, the rate of preeclampsia is 61% higher for Black women than for white women, and 50% higher than women overall.[99] The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics guidelines state that the risks to the woman from persistent severe pre-eclampsia are such that delivery (abortion) is usually suggested regardless of fetal age or potential for survival.[100] ACOG and American Heart Association recommend that a pregnancy be avoided or ended for certain conditions such as severe pulmonary hypertension.[101] Many medications can cause significant fetal impairments, and therefore the Federal Food and Drug Administration and professional medical associations recommend that women use contraceptives to ensure that they do not become pregnant while taking these

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

medications.[102] In addition, some medical guidelines counsel patients to end a pregnancy if they are taking certain medications for thyroid disease.[103]

d. Emergency contraception

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

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

e. Artificial Reproductive Technology (ART)

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

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[102] ELEANOR BIMLA SCHWARZ M.D. M.S., et al., *Documentation of Contraception and Pregnancy When Prescribing Potentially Teratogenic Medications for Reproductive-Age Women*, 147 Annals of Internal Medicine. (Sept. 18, 2007).
[103] For example, the American College of Obstetricians and Gynecologists specifically recommends that if a woman taking Iodine 131 becomes pregnant, her physician should caution her to consider the serious risks to the fetus, and consider termination. American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 37: Thyroid disease in pregnancy* 100 OBSTETRICS & GYNECOLOGY 387-96 (2002).
[104] Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 ANNALS EMERGENCY MED. 105-10 (Aug. 2005), http://www.annemergmed.com/article/S0196-0644(05)00083-1/pdf
[105] *Id.* at 105.
[106] *Committee Opinion 592: Sexual Assault*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Apr. 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co592.pdf?dmc=1&ts=20170213T2116487879; *Management of the Patient with the Complaint of Sexual Assault*, AM. COLL. EMERGENCY MED. (Apr. 2014), https://www.acep.org/Clinical---Practice-Management/Management-of-the-Patient-with-the-Complaint-of-Sexual-Assault/#sm.00000bexmo6ofmepmultb97nfbh3r.
[107] *Access to Emergency Contraception H-75.985*, AMA (2014), https://policysearch.ama-assn.org/policyfinder/detail/emergency%20contraception%20sexual%20assault?uri=%2FAMADoc%2FHOD.xml-0-5214.xml.

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

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

f. HIV Health

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

VI. The proposed rule violates the Establishment Clause

The Establishment Clause of the First Amendment bars the government from granting religious and moral exemptions that would harm any third party.[110] It requires the

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[108] Alison W. Loren et al., *Fertility Preservation for Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500-10 (July 1, 2013); Ethics Committee of the American Society for Reproductive Medicine, *Fertility preservation and reproduction in patients facing gonadotoxic therapies: a committee opinion*, 100 AM. SOC'Y REPROD. MED. 1224-31 (Nov. 2013), http://www.allianceforfertilitypreservation.org/_assets/pdf/ASRMGuidelines2014.pdf; Joanne Frankel Kelvin, *Fertility Preservation Before Cancer Treatment: Options, Strategies, and Resources*, 20 CLINICAL J. ONCOLOGY NURSING 44-51 (Feb. 2016).
[109] ACOG *Committee Opinion 595: Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (May 2014), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Preexposure-Prophylaxis-for-the-Prevention-of-Human-Immunodeficiency-Virus.
[110] E.g., *Burwell v. Hobby Lobby Stores, Inc*., 134 S. Ct. 2751, 2781 n.37 (2014); *Cutter v. Wilkinson*, 544 U.S.709, 720, 726 (2005*); Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 18 n.8 (1989).

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Department to "take adequate account of the burdens" that an exemption "may impose on non-beneficiaries" and must ensure that any exemption is "measured so that it does not override other significant interests."[111]

The Supreme Court acknowledged the limitations imposed by the Establishment Clause in *Burwell v. Hobby Lobby Stores, Inc.*, declaring the effect on employees of an accommodation provided to employers under the Religious Freedom Restoration Act (RFRA) "would be precisely zero."[112] Justice Kennedy emphasized that an accommodation must not "unduly restrict other persons, such as employees, in protecting their own interests."[113] The proposed exemptions clearly impose burdens on and harm others and thus, violate the clear mandate of the Establishment Clause.

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

The regulations dangerously expand the application of the underlying statutes by offering an extremely broad definition who can refuse and what they can refuse to do. Under the proposed rule, any one engaged in the health care system could refuse services or care. The proposed rule defines workforce to include "volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity."[114] Under this definition, could any member of the health care workforce refuse to serve a patient in any way – could a nurse assistant refuse to serve lunch to a transgender patient, could a billing specialist refuse to help a patient who had sought contraceptive counseling?

a. *Discrimination*

The failure to define the term "discrimination" will cause confusion for providers, and as employers, expose them to liability. Title VII already requires that employers accommodate employees' religious beliefs to the extent there is no undue hardship on the employer.[115] The regulations make no reference to Title VII or current EEOC guidance, which prohibits discrimination against an employee based on that employee's race, color, religion, sex, and national origin.[116] The proposed rule should be read to ensure that the long-standing balance set in Title VII between the right of individuals to enjoy reasonable accommodation of their religious beliefs and the right of employers to conduct their businesses without undue interference is to be maintained.

If this balance is not maintained, the language in the proposed rule could force health care providers to hire people who intend to refuse to perform essential elements of a

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[111] *Cutter*, 544 U.S. at 720, 722; see also *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709-10 (1985).
[112] *Hobby Lobby*, 134 S. Ct. 2751, 2760 (2014).
[113] *Id.* at 2786-87 (Kennedy, J., concurring).
[114] 83 Fed. Reg. 3894.
[115] 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.
[116] *Id.*

position. For example, the proposed rule lacks clarity about whether a Title X-funded health center's decision not to hire a counselor or clinician who objected to provide non-directive options counseling as an essential job function of their position would be deemed discrimination under the rule. Furthermore, the proposed rule does not provide guidance on whether it is impermissible "discrimination" for a Title X-funded state or local health department to transfer such a counselor or clinician to a unit where pregnancy counseling is not done.

By failing to define "discrimination," supervisors in health care settings will be unable to proceed in the orderly delivery of health care services, putting women's health at risk. The proposed rule impermissibly muddies the interpretation of Title VII and current EEOC guidance. If implemented, health care entities may be forced to choose between complying with a fundamentally misguided proposed rule and long-standing interpretation of Title VII.

Finally, the proposed rule's lack of clarity regarding what constitutes discrimination, may undermine non-discrimination laws. Because of the potential harm to individuals if religious refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.[117] Instead, courts have held that the government has a compelling interest in ending discrimination and that anti-discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race," and are narrowly tailored to meet that "critical goal."[118] The uncertainty regarding how the proposed rule will interact with non-discrimination laws is extremely concerning.

b. Assist in the performance

The definition of "assist in the performance" greatly expands the types of services that can be refused beyond any reasonable stretch of the imagination. The proposed rule defines "assistance" to include participation "in any activity with an *articulable connection* to a procedure, health service or health service program, or research activity."[119] In addition, the Department includes activities such as "making

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[117] 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).
[118] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, slip op. at 46 (2014).
[119] 83 Fed. Reg. 3892.

arrangements for the procedure."[120] If workers in very tangential positions, such as schedulers, are able to refuse to do their jobs based on personal beliefs, the ability of any health system or entity to plan, to properly staff, and to deliver quality care will be undermined. Employers and medical staff may be stymied in their ability to establish protocols, policies and procedures under these vague and broad definitions. The proposed rule creates the potential for a wide range of workers to interfere with and interrupt the delivery of health care in accordance with the standard of care.

The regulations also leave unclear whether a worker can assert his or her moral belief in refusing to treat patients on the basis of their identity or deny care for reasons outside of religious or moral beliefs. Even though women living with disabilities report engaging in sexual activities at the same rate as women who do not live with disabilities, they often do not receive the reproductive health care they need for multiple reasons, including lack of accessible provider offices and misconceptions about their reproductive health needs.[121] Biased counseling can contribute to unwanted health outcomes and exacerbate health disparities.[122] The proposed rule is especially alarming as it does not articulate a definition of moral beliefs. The prejudices of a health care professional could easily inform their beliefs and consequently, serve as the basis of denying care to an individual based on characteristics alone. The proposed rule will foster discriminatory health care settings and interactions between patients and providers that are informed by bias instead of medically accurate, evidence-based, patient-centered care.

Moreover, in the preamble, the proposed rule states that the exemptions that Weldon provides is not limited to refusals of abortion care on the basis of religious or moral beliefs.[123] Due to this, health care professionals may think they can deny abortion care and other health services just because they do not want to provide the service. The preamble uses language such as "those who choose not to provide" or "Would rather not" as justification for a refusal. This is more concerning because the proposed rule contains no mechanism to ensure that patients receive the care they need if their provider refuses to furnish a service. The onus will be on the patient to question whether her hospital, medical doctor, or health care professional has religious, moral, or other beliefs that would lead them to deny services or if services were denied, the basis for refusal. This is likely to occur as the proposed rule does not have any provisions that

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[120] *Id.*
[121] RM Haynes et al., *Contraceptive Use at Last Intercourse Among Reproductive-Aged Women with Disabilities: An Analysis of Population-Based Data from Seven States*, CONTRACEPTION (2017), https://www.ncbi.nlm.nih.gov/pubmed/29253580; *See generally* Alex Zielinski, *Why Reproductive Health Can Be A Special Struggle for Women with Disabilities*, THINKPROGRESS, Oct. 1, 2015, https://thinkprogress.org/why-reproductive-health-can-be-a-special-struggle-for-women-with-disabilities-73ececea23c4/.
[122] In one study in Massachusetts, women living with intellectual and developmental disabilities, including those who were Black and Latina, faced increased risks of preterm delivery and very low and low birth weight babies. M. Mitra et al., *Pregnancy Outcomes Among Women with Intellectual and Developmental Disabilities*, AM. J. PREV. MED. (2015), https://www.ncbi.nlm.nih.gov/pubmed/25547927.
[123] 83 Fed. Reg. 3890-91.

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

c. Referral

The definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information based on which an individual could get the care they need. Any information distributed by any method, including online or print, regarding any service, procedure, or activity could be refused by an entity if the information given would lead to a service, activity, or procedure that the entity or health care entity objects. Under this definition, could a medical doctor refuse to provide a website describing the medical conditions which contraception treats? Or could an entity refuse to provide a list of LGBTQ-friendly providers? In addition, the Department states that the underlying statutes of the proposed rule permits entities to deny help to anyone who is likely to make a referral for an abortion or for other services.[124] The breadth and vagueness of this definition will possibly lead providers to refrain from providing information vital to patients out of anxiety and confusion of what the proposed rule permits them to do.

d. Health Care Entity

The proposed rule's definition of "health care entity" conflicts with Federal religious refusal laws such as the Coats and Weldon Amendments, thus fostering confusion regarding which entities are required to comply with the proposed rule and existing Federal religious refusals. Specifically, under the Coats and Weldon Amendments a "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in health care delivery. Under the proposed rule, a plan sponsor "not primarily engaged in the business of health care" would be deemed a "health care entity."[125] This definition would mean that an employer acting as a third party administrator or sponsor could count as a "health care entity" and deny coverage. In 2016, OCR found that religiously affiliated employers were not health care entities under the Weldon amendment.[126]

Moreover, the Department states that their definition of "health care entity" is "not an exhaustive list" for concern that the Department would "inadvertently omit[ting] certain types of health care professionals or health care personnel."[127] Additionally, the proposed rule incorporates entities as defined in 1 USC 1 which includes corporations, firms, societies, etc.[128] States and public agencies and institutions are also deemed to be entities.[129] The Department's inclusion of entities who are primarily not engaged in the health care delivery system highlights the true purpose of the proposed rule, to

[124] *Id.* at 3895.
[125] *Id.* at 3893.
[126] Office for Civil Rights, Decision Re: OCR Transaction Numbers: 14-193604, 15-193782 & 15-195665, 4 (Jun. 21, 2016) (letter on file with NHeLP-DC office).
[127] 83 Fed. Reg. 3893.
[128] *Id.*
[129] *Id.*

permit a greater number of entities to interfere in the provider-patient relationship and deter a patient from making the best decision based on their circumstances, preferences, and beliefs.

Conclusion

For the reasons listed above, Shriver Center opposes the proposed rule as it expands religious refusals to the detriment of our clients' health and well-being. We are concerned that these regulations, if implemented, will interfere in the patient-provider relationship by undermining informed consent. The proposed rule will allow anyone in a health care setting to refuse health care that is evidence-based and informed by the highest standards of medical care. The outcome of this regulation will cause further harm to the communities that we represent who already lack equal access to care and endure discrimination resulting in healthcare disparities.

Thank you for your attention to our comments. If you have questions, please contact Stephanie Altman, stephaniealtman@povertylaw.org.

Exhibit 177

March 27, 2018

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

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

To Whom it May Concern:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[4] In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. KAISER FAMILY FOUND., *Women's Health Insurance Coverage* 3 (Oct. 31, 2017), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.
[5] Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8 (2018), http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf.
[6] *Id*. at 8, 16.
[7] Casey Leins, *Latinos, Millennials Among Groups Least Likely to Have Insurance*, U.S. News and World Report (May 4, 2017), *available at* https://www.usnews.com/news/best-states/articles/2017-05-04/latinos-millennials-among-groups-least-likely-to-have-health-insurance.
[8] Id.
[9] CTR. FOR REPROD. RIGHTS, NAT'L LATINA INST. FOR REPROD. HEALTH & SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter *Reproductive Injustice*]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), *available at* http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.
[10] *Reproductive Injustice*, *supra* note 10, at 16-17.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. Conclusion

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

[30] *See id.*

Exhibit 178

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

March 26, 2018

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

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

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

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

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

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

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

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

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

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

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

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

The proposed rule conflicts with existing requirements in HHS programs.

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

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

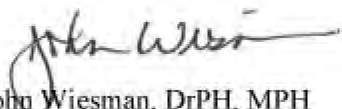
- The Title X family planning projects are designed to "consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children" (42 CFR 59.1). The Title X statute specifically requires that "all pregnancy counseling shall be nondirective" (Public Law 112-74, p. 1066-1067), and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination (42 CFR 59.5(a)(5)).

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

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

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

Sincerely,



John Wiesman, DrPH, MPH
Secretary of Health

HHS Conscience Rule-000067175

Exhibit 179

BEFORE THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

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

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

Interest of Whitman-Walker Health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Refusal to provide assistance to a same-sex couple with a sick child because of an objection to same-sex parenting?

- Refusal to even provide information to an individual questioning their gender identity on their possible options, or places where they might get the information or support they need?

- Refusal to provide help to a sick woman or man who is, or is thought to be Muslim because of a health care worker's aversion to Islam?

- Refusal to provide assistance to an individual struggling with an opioid addiction because of a conviction that the addiction is the result of sin or the patient's moral failings?

- Refusal to help an individual diagnosed with HIV or Hepatitis C because of moral or religious disapproval of the way that the individual acquired (or is assumed to have acquired) the infection – namely, sex or injection drug use?

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

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

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

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

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

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

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

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

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

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

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Conclusion

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

Respectfully Submitted,

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March 27, 2018

Exhibit 180

March 27, 2018

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

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

To Whom It May Concern:

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

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

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

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

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

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

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

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

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

[2] 42 U.S.C. § 238n(a)(1).

[3] *Id.* §§ 238n(a)(2), (a)(3), (b).

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

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

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

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

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

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

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[6] 42 U.S.C. § 300a-7(b)(1).

[7] *Id.* § 300a-7(b)(2)-(c)

[8] *Id.* § 300a-7(d).

[9] *Id.* § 300a-7.

[10] 42 U.S.C. § 1395dd.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[19] U.S. CONST. amend. I; *Cutter v. Wilkinson*. 554 U.S. 709, 714, 720 (2005) ("At some point, accommodation may devolve into an unlawful fostering of religion. . . . [Therefore, courts] must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries." (internal quotation marks and citations omitted)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).

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

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

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

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

- to the patient's physical and mental health when necessary medical services to treat particular medical conditions are denied;
- to the patient's health and well-being because refusals of service, independent of the underlying medical condition, result in dignitary harm to the individual; and
- to the community of which the patient is a member and the ability and willingness of others in that community to seek medical care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[30] *Id.*

[31] *Id.*

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

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

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

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

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

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

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

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

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

[37] *Id.*

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

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

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

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

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

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

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

[40] *Id.*

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

[42] OCR Complaint No. 10–109676.

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

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

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

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

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

IV. Conclusion

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

Respectfully Submitted,

[Signatures on next page.]

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[45] *See id.*

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

[47] *Id.* at 7.

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

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

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No. 16-111

In The Supreme Court of the United States

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

Petitioners,

v.

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

Respondents.

ON WRIT OF CERTIORARI TO THE
COLORADO COURT OF APPEALS

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

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HHS Conscience Rule-000161230

I. INTEREST OF AMICI CURIAE[1]

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

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

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

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

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

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

HHS Conscience Rule-000161232

II. SUMMARY OF ARGUMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. ARGUMENT

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

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

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

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

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

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

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

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

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

1. LGB people have long endured discrimination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[27] *Id.*

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

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

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

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

the family scrambling to find alternative funeral services).

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

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

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

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

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

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

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[29] *Id.*

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

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

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

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

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

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

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

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

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

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

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

[34] *Id.* at 813.

[35] *Id.* at 814.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[67] *Id.*

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

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

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

The Regnerus Brief suggests that the issue at stake here is a minor experience that could be "waved off by the plaintiffs as 'Oh well, we realize some people aren't on board with same-sex marriage.'" (Br. 10). The Regnerus Brief misconstrues minority stress writings to claim that this experience does not represent minority stress because the actions of Petitioners were not chronic or acute. In fact, minority stress is chronic not because each stressful event is chronic, but because LGB people repeatedly encounter such events. As we have explained here, the issue at stake is greater than the one-time interaction of the parties to this case. If this Court

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pages/victims_final; *see also* Park & Mykhyalyshyn, *L.G.B.T. People Are More Likely Targets of Hate Crimes Than Any Other Minority Group*, N.Y. Times, June 16, 2016, https://www.nytimes.com/interactive /2016/06/16/us/hate-crimes-against-lgbt.html?_r=0.

[69] Meyer, *The Elusive Promise of LGBT Equality*, 106:8 Am. J. Pub. Health 1356 (2016).

accepts Petitioners' arguments and allows for exemptions to antidiscrimination laws, it would change the social environment of LGB people for the worse, leading to repeated and acute experiences of being rejected from businesses and to expectations of such rejection and discrimination in LGB people's daily interactions within the public marketplace.

Finally, we are compelled to address the Regnerus Brief's false claim that "politics have crowded out sound scientific methodology" in research on minority stress. (Br. 21.). The studies we rely on herein—and many others in this body of research that we do not have room to cite—meet established standards for scientific rigor, as evidenced by their publication in demanding peer-reviewed journals. Furthermore, the Regnerus Brief's assertion about politics is incredible given that a federal court has already found that Mark Regnerus himself conducted results-oriented research in order to "oblige" a politically-driven funder. *DeBoer v. Snyder,* 973 F. Supp. 2d 757, 766 (E.D. Mich.), *rev'd*, 772 F.3d 388 (6th Cir. 2014), *rev'd sub nom.*, *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015).[70]

In the end, the Regnerus Brief does not successfully dispute that a stigmatizing social

[70] Indeed, the court concluded that Regnerus's testimony was "entirely unbelievable and not worthy of serious consideration." *DeBoer*, 973 F. Supp. 2d at 766. The court also concluded that Regnerus had "fringe viewpoints," *id.* at 768, which is underscored by the fact that Regnerus's own academic colleagues at his university took the extraordinary step of publicly distancing themselves from his findings. *Id.* at 766; UT Austin College of Liberal Arts, *Statement Regarding Sociology Professor Mark Regnerus* (2014), https://liberalarts.utexas.edu/public-affairs/news/7531.

environment damages the health of LGB people by bringing about life events and other conditions that are stressful. It is an environment that demands vigilance of its LGB citizens as they watch to protect themselves from potential discrimination and violence. It is an environment where, in an attempt to protect themselves from the stress of anti-LGB stigma, LGB people are moved to conceal their sexual identity. And it is an environment where stigma and stereotypes are internalized by both heterosexual and LGB people. Each of these stressors causes serious injury in the form of psychological distress, physical and mental health problems, suicide, and lowered sense of well-being. These stressors also negatively impact same-sex couples' relationship quality and stability.

IV. CONCLUSION

The minority stress literature converges on one conclusion: that when a place of public accommodation refuses to serve, or provides lesser services to, LGB people because of their sexual orientation, that experience can have powerful tangible and symbolic effects on LGB people, which adversely impact their health and well-being. Because of the power of law, if this Court countenances such discrimination, our Constitution will be a source of stigma rather than dignity for LGB people. For the foregoing reasons, the Court should affirm.

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APPENDIX

APPENDIX:
LIST OF *AMICI* SCHOLARS

1. **Ilan H. Meyer**, Ph.D., is Distinguished Senior Scholar for Public Policy at the Williams Institute, UCLA School of Law, and Professor Emeritus of Sociomedical Sciences at Columbia University. Dr. Meyer studies public health issues related to minority health, including stress and illness in minority populations, in particular, the relationship of minority status, minority identity, prejudice and discrimination and health outcomes in sexual minorities and the intersection of minority stressors related to sexual orientation, race/ethnicity, and gender. In several highly cited papers, Dr. Meyer has developed a model of minority stress that describes the relationship of social stressors and adverse health outcomes and helps to explain LGBT health disparities. The model has guided his and other investigators' population research on lesbian, gay, bisexual, and transgender health disparities by identifying the mechanisms by which social stressors impact health and by describing the harm to LGBT people from prejudice and stigma. For this work, Dr. Meyer received the Outstanding Achievement Award from the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns of the American Psychological Association (APA) and Distinguished Scientific Contribution award from the APA's Division 44. Dr. Meyer has served as an expert in several court cases and hearings, including *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921 (N.D. Cal. 2010); United States Commission on Civil Rights briefing on peer-to-peer violence and bullying in K-12 public schools (2011); *Garden State Equality v. Doe* (N.J. Sup. Ct. 2013);

Bayev v. Russia (European Court of Human Rights 2014); and *Sexual Minorities Uganda v. Scott Lively* (D. Mass. 2016). Dr. Meyer has been a principal investigator for over 20 research projects and is currently the principal investigator of two important National Institutes of Health funded studies, the *Generations Study*, a study of stress, identity, health, and health care utilization across three cohorts of lesbians, gay men, and bisexuals; and the TransPoP study, the first national probability sample of transgender individuals, both in the United States.

2. **M. V. Lee Badgett**, Ph.D., is a Professor of Economics at the University of Massachusetts Amherst and a Williams Distinguished Scholar at the Williams Institute, UCLA School of Law. Her current research focuses on poverty in the LGBT community, employment discrimination against LGBT people in the U.S., and the cost of homophobia and transphobia in global economies. Dr. Badgett's latest book is *The Public Professor: How to Use Your Research to Change the World*. Her book, *When Gay People Get Married: What Happens When Societies Legalize Same-Sex Marriage*, analyzes the positive U.S. and European experiences with marriage equality for gay couples. Her first book, *Money, Myths, and Change: The Economic Lives of Lesbians and Gay Men*, presented her groundbreaking work debunking the myth of gay affluence. Dr. Badgett's work includes testifying as an expert witness in legislative matters and litigation (including as an expert witness in California's Prop 8 case), consulting with development agencies (World Bank and UNDP), analyzing public policies, consulting with regulatory

bodies, briefing policymakers, writing op-ed pieces, speaking with journalists, and advising businesses.

3. **Juan Battle**, Ph.D., is a Professor of Sociology, Public Health, & Urban Education and the Coordinator of the Africana Studies Certificate Program at the Graduate Center of the City University of New York (CUNY). His research focuses on race, sexuality, and social justice. Dr. Battle has over 75 grants and publications, including books, book chapters, academic articles, and encyclopedia entries. In addition to having delivered lectures at a multitude of academic institutions, community-based organizations, and funding agencies throughout the world, Dr. Battle's scholarship has included work throughout North America, South America, Africa, Asia, and Europe. Among his current projects, he is heading the Social Justice Sexuality initiative—a project exploring the lived experiences of Black, Latina/o, and Asian lesbian, gay, bisexual, and transgender (LGBT) people in the United States and Puerto Rico. He is also heading a project examining LGBT poverty in New York City. Dr. Battle is a Fulbright Senior Specialist and was the Fulbright Distinguished Chair of Gender Studies at the University of Klagenfurt, Austria and was an Affiliate Faculty of the Institute for Gender and Development Studies (IGDS), The University of the West Indies, St. Augustine, Trinidad and Tobago.

4. **Stuart Biegel**, J.D., has been a longtime member of the faculty at both the UCLA School of Law and the UCLA Graduate School of Education and Information Studies. He has served as Director of Teacher Education at UCLA, Special Counsel for the California Department of Education, and the Consent

Decree Monitor for the federal court in the San Francisco school desegregation case. Professor Biegel is the original author of the West casebook *Education and the Law* (4th ed. 2016), which focuses on both K-12 and higher education communities, and also includes major coverage of technology issues, privacy law issues, and disability rights. Among many other publications, his scholarship includes *The Right to Be Out: Sexual Orientation and Gender Identity in America's Public Schools* (University of Minnesota Press, 2d ed. forthcoming 2018) and *Unfinished Business: The Employment Non-Discrimination Act (ENDA) and the K-12 Education Community,* 14 *NYU Journal of Legislation & Public Policy* 357 (2011). He has also consulted with the National Education Association and the U.S. Commission on Civil Rights on issues relating to marginalized and disenfranchised youth.

5. **Susan D. Cochran**, Ph.D, M.S., is a Professor of Epidemiology at the UCLA Fielding School of Public Health and a Professor of Statistics, UCLA. Her research focuses on the mechanisms by which social adversity affects health. She has received numerous awards for her research and professional activities including the prestigious 2001 Award for Distinguished Contributions to Research in Public Policy from the American Psychological Association. In 2010, she was a member of the APA Presidential Task Force on "Reducing and preventing discrimination against and enhancing benefits of inclusion of people whose social identities are marginalized in society." Using funding from the National Institute on Drug Abuse, she conducted three large-scale population-based studies of mental

health and substance use concerns among lesbian, gay, and bisexual individuals in California. She is also a member of the World Health Organization ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health. She has served as *Amicus curiae* (*Baehr v. Lewin*, Circuit Court, State of Hawaii, October, 1996; *Baehr v. Lewin*, Appeals Court, State of Hawaii, July, 1997) and provided expert testimony (*Howard v. Arkansas Department of Human Services*, 2004; *Doe v. Doe, Miami-Dade County*, 2008; and *Cole v. Arkansas*, 2010) for LGB-related matters.

6. **Kerith Conron**, Sc.D., M.P.H., is the Blachford-Cooper Distinguished Scholar and Research Director at the Williams Institute, UCLA School of Law. Dr. Conron earned her doctorate from the Harvard School of Public Health and MPH from the Boston University School of Public Health. She is a social and psychiatric epidemiologist whose work focuses on documenting and reducing health inequities that impact sexual and gender minority populations. Dr. Conron is committed to altering the landscape of adversity and opportunity for the most marginalized lesbian, gay, bisexual, and transgender (LGBT) communities through collaborative activities that impact the social determinants of health. She has been supported by the National Institutes of Health to conduct community-based participatory research with LGBT youth of color and to train scholars in LGBT population health research. Dr. Conron has been active in LGBT health for over 15 years, serving on the first Steering Committee of the National Coalition for LGBT Health and as the first coordinator of the Office of LGBT Health for the City

of Boston. Her current research focuses on socioeconomic status and strategies to reduce poverty and to promote health. Her publications appear in the American Journal of Public Health, Archives of Pediatrics and Adolescent Medicine, and Psychological Medicine. Her expertise and commentary have been featured by major media outlets including the New York Times, the Associated Press, and National Public Radio.

7. **Brian de Vries**, Ph.D., is a (retired) professor of Gerontology at San Francisco State University, with adjunct appointments at both Simon Fraser University (in Vancouver) and the University of Alberta (in Edmonton). Dr. de Vries has been instrumental in guiding his professional associations through his role as fellow of the Gerontological Society of America (GSA), past Board member of the American Society on Aging (ASA), and former co-Chair of the LGBT Aging Issues Network constituent group. Similarly, Dr. de Vries was appointed to the Institute of Medicine's Board on the Health of Select Populations Committee which authored the influential book: *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*. Dr. de Vries has co-edited several professional journals and acclaimed academic books as well as authored or co-authored approximately 100 journal articles and book chapters, and has given over 150 presentations to local, national, and international professional audiences on the social and psychological well-being of midlife and older LGBT persons, among other topics.

8. **Brian Dodge**, Ph.D., is an Associate Professor in the Department of Applied Health Science and Associate Director of the Center for Sexual Health Promotion at the Indiana University School of Public Health-Bloomington. A nationally recognized expert on bisexual health, he is a co-director of the Bisexual Research Collaborative on Health (BiRCH), a partnership of Indiana University, University of Illinois at Chicago, and The Fenway Institute. His research focuses on understanding social and behavioral aspects of sexual health and other aspects of well-being among a variety of understudied and underserved sexual minority communities, with a specific emphasis on the impact of stigma and minority stress on health among bisexual individuals. His work includes some of the first National Institutes of Health-funded studies on health among bisexual men and women, relative to their exclusively heterosexual and homosexual counterparts. He also collaborates on assessments of health among probability samples of sexual minority individuals in the U.S., including as a co-investigator of the ongoing nationally representative National Survey of Sexual Health & Behavior. Dr. Dodge has provided expert legal consultation on bisexuality-related cases for the Maricopa County, Phoenix, Arizona Public Defenders' Office and the U.S. Military.

9. **Jessica N. Fish**, Ph.D., is a Postdoctoral Research Fellow at the University of Texas at Austin Population Research Center and Visiting Assistant Professor in the Department of Family Science at the University of Maryland School of Public Health. Dr. Fish studies the sociocultural factors that shape the

development and health of sexual minorities. Her area of research, in particular, focuses on how prejudice and discrimination influence the prevalence and developmental patterns of substance use and mental health among sexual minority youth and adults. Among other findings, her research demonstrates the deleterious effects of discrimination on sexual minority health across the life course.

10. **Andrew R. Flores**, Ph.D., is Assistant Professor of Political Science in the Public Policy & Political Science Department at the Lorry I. Lokey Graduate School of Business and Public Policy at Mills College and a Visiting Scholar at the Williams Institute, UCLA School of Law. Dr. Flores studies attitude formation and change about marginalized groups, particularly lesbian, gay, bisexual, and transgender people (LGBT); the political behavior of LGBT people with a central focus on the role of linked fate in LGBTQ politics, and research on the demography of LGBT people; and the experiences of LGBT people while incarcerated. Dr. Flores has also analyzed the effects of social attitudes about LGBT populations on the physical and mental health of LGBT populations. Dr. Flores's research has appeared in or are forthcoming in the *American Journal of Public Health*, *Political Psychology*, *Public Opinion Quarterly*; the *Journal of Social Issues*, *Political Research Quarterly*; *Politics, Groups, and Identities*; the *Journal of Youth and Adolescence*; *Aggression and Violent Behavior*; the *International Journal of Public Opinion Research*; *Research and Politics*, *Transgender Studies Quarterly;* and the *Indiana Journal of Law and Social Equality*.

11. **David M. Frost**, Ph.D., is a Senior Lecturer (Associate Professor) in Social Psychology in the Department of Social Science at University College London. His research focuses on close relationships, stress, stigma, and health. His primary line of research examines on how stigma, prejudice, and discrimination constitute minority stress and, as a result, affect the health and well-being of marginalized individuals. He also studies how couples psychologically experience intimacy within long-term romantic relationships and how their experience of intimacy affects their health. These two lines of research combine within recent projects examining same-sex couples' experiences of stigmatization and its resulting impact on their relational, sexual, and mental health. His research has been published in several top tier social science, public health, and policy journals and has been recognized by grants and awards from the U.S. National Institutes of Health, the Society for the Psychological Study of Social Issues, and the New York Academy of Sciences.

12. **Nanette Gartrell**, M.D., is a Visiting Distinguished Scholar at the Williams Institute, UCLA School of Law. She has a Guest Appointment at the University of Amsterdam, and she was formerly on the faculties of Harvard Medical School and UCSF. Dr. Gartrell is a psychiatrist, researcher, and writer whose 48 years of scientific investigations have focused primarily on sexual minority parent families. Dr. Gartrell is the principal investigator of the U.S. National Longitudinal Lesbian Family Study, now in its 31st year. Her research has been cited internationally in litigation and legislation

concerning equality in marriage, foster care, and adoption, and it contributed to the American Academy of Pediatrics' 2013 endorsement of marriage equality. "The U.S. National Longitudinal Lesbian Family Study: Psychological Adjustment of the 17-year-old Adolescents," published in *Pediatrics,* was cited by *Discover Magazine* as one of the top 100 science stories of 2010.

13. **Jeremy Goldbach**, Ph.D., is an Assistant Professor at the University of Southern California Suzanne Dworak-Peck School of Social Work. Dr. Goldbach joined the faculty in 2012 after completing both his master's and doctoral degrees in social work at the University of Texas at Austin. His research is broadly focused on the relationship between social stigma, minority stress, and health among lesbian, gay, bisexual and transgender (LGBT) youth and adults. He has conducted studies in psychometric measurement development and is currently leading one of the first studies to examine how discrimination during adolescence may impact healthy development.

14. **Abbie E. Goldberg**, Ph.D., is an Associate Professor in the Department of Psychology at Clark University in Worcester, Massachusetts. She received her Ph.D. in clinical psychology from the University of Massachusetts Amherst. Her research examines diverse families, including lesbian- and gay-parent families and adoptive-parent families. A particular focus of her research is key life transitions (e.g., the transition to parenthood, the transition to kindergarten, and the transition to divorce) for same-sex couples. She has also studied the experiences of transgender college students, families formed through reproductive technologies, and bisexual

mothers partnered with men. She is the author of over 90 peer-reviewed articles and two books: Gay Dads (NYU Press) and Lesbian- and Gay-Parent Families (APA). She is the co-editor of LGBT-Parent Families: Innovations in Research and Implications for Practice (Springer) and the editor of the Encyclopedia of LGBTQ Studies (Sage). She has received research funding from the American Psychological Association, the Alfred P. Sloan Foundation, the Williams Institute, the Gay and Lesbian Medical Association, the Society for the Psychological Study of Social Issues, the National Institutes of Health, and the Spencer Foundation.

15. **Suzanne B. Goldberg**, J.D., is the Herbert and Doris Wechsler Clinical Professor of Law and founding director of the Sexuality and Gender Law Clinic at Columbia Law School. She also co-directs the Law School's Center for Gender & Sexuality Law. Professor Goldberg has written extensively about discrimination against lesbians, gay men, bisexuals and transgender people and has worked for nearly three decades on efforts to redress this discrimination.

16. **Gary J. Gates**, Ph.D., is a recognized expert on the geography and demography of the lesbian, gay, bisexual, and transgender (LGBT) population. Justice Anthony Kennedy cited his friend-of-the-court brief in his majority opinion in *Obergefell v. Hodges* (2015), holding that same-sex couples have a constitutional right to marriage. Dr. Gates holds a PhD in Public Policy and Management from the Heinz College, Carnegie Mellon University, a Master of Divinity degree from St. Vincent Seminary, and a Bachelor of Science degree in

Computer Science from the University of Pittsburgh at Johnstown. He is co-author of *The Gay and Lesbian Atlas* and publishes extensively on the demographic and economic characteristics of the LGBT population. National and international media outlets regularly feature his work. Dr. Gates is retired as a Distinguished Scholar and Research Director at the Williams Institute, UCLA School of Law. He has also held positions as a Senior Researcher at Gallup, a Research Associate at the Urban Institute in Washington, DC and Director of the AIDS Intervention Project in Altoona, PA.

17. **John C. Gonsiorek**, Ph.D., holds a Diplomate in Clinical Psychology from the American Board of Professional Psychology. He is past president of American Psychological Association Division 44, and has published widely on sexual orientation and identity. He is a fellow of APA Divisions 9, 12, 29, 36, and 44. Until August 2012, he was Professor in the PsyD Program at Argosy University/Twin Cities; and has taught at a number of other institutions. For over 25 years, he had an independent practice of clinical and forensic psychology in Minneapolis, and provided expert witness evaluation and testimony on a number of areas, including sexual orientation. Expert witness testimony regarding sexual orientation has included helping prepare *amicus curiae* briefs for the American Psychological Association; testimony in major cases includes: *Evans et al, v. Romer et al.*, *Equality Foundation et al. v. Cincinnati*, and *Nabozny v. Podlezny et al.* He has been a consulting editor for *Professional Psychology: Research & Practice,* and currently serves as Founding Editor for

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Psychology of Sexual Orientation and Gender Diversity. His major publications include: Homosexuality: Research implications for public policy, and Homosexuality and psychotherapy: A practitioner's handbook of affirmative models.

18. **Perry N. Halkitis**, Ph.D., M.S., M.P.H., is dean of the Rutgers School of Public Health at Rutgers University–New Brunswick. Previously, he was professor of global public health, applied psychology, and medicine at NYU, where he has focused a significant amount of his research on HIV/AIDS, drug abuse, and mental health disease and how they are impacted by psychiatric and psychosocial factors. Dr. Halkitis also served as senior associate dean of the New York University (NYU) College of Global Public Health; director of NYU's Center for Health, Identity, and Behavior and Prevention Studies; and interim chair of the Department of Biostatistics at the College of Global Public Health. As senior associate dean for academic and faculty affairs at the NYU College of Global Public Health, Dr. Halkitis managed the academic portfolio of the college and administers the curriculum; directed faculty appointments and hiring; and participated in the college's and university's fund-raising efforts. He was NYU's inaugural associate dean for research and doctoral studies from 2005 to 2013 and earlier chaired the NYU Department of Applied Psychology.

19. **Gary W. Harper**, Ph.D., M.P.H., is a Professor of Health Behavior and Health Education, Professor of Global Public Health, and Director of the Office of Undergraduate Education at the School of Public Health at the University of Michigan. Dr.

Harper has conducted extensive research for more than 20 years with sexual minority youth/young adults, and has authored more than 130 publications in peer-reviewed academic journals. His research and community work have focused on the health and well-being of sexual minority youth and young adults, especially gay/bisexual male youth of color. This work includes the development of evidence-based interventions aimed at improving the health and well-being of sexual minority youth and young adults who experience discrimination, prejudice, and stigma. Dr. Harper's health promotion interventions for sexual minority youth are being utilized by community organizations and health centers in various states across the U.S., as well as in Kenya. Dr. Harper has testified as an expert witness in the City and County of San Francisco, California, and was appointed by the 2008 U.S. Secretary of Health and Human Services (under the George W. Bush administration) to serve on the Department of Health and Human Service's Office on AIDS Research Advisory Council.

20. **Amira Hasenbush**, J.D., M.P.H., is the Jim Kepner Law and Policy Fellow at the Williams Institute, UCLA School of Law. She researches discrimination based on sexual orientation and gender identity, family law issues for LGBT parents and children, and the legal needs of people living with HIV. She has completed empirical research on the existence and impact of public accommodations laws at the state and local level.

21. **Mark L. Hatzenbuehler**, Ph.D., is Associate Professor of Sociomedical Sciences and Sociology at Columbia University's Mailman School

of Public Health. Dr. Hatzenbuehler's research examines how structural forms of stigma—including social policies and community-level norms—increase risk for adverse health outcomes among members of stigmatized populations, with a particular focus on lesbian, gay, and bisexual individuals. He also developed a widely cited theoretical model that identifies psychosocial mechanisms linking stigma-related stressors to the development of psychopathology. Dr. Hatzenbuehler has published over 100 peer-reviewed articles and book chapters, and his work has been published in several leading journals, including *American Psychologist, Psychological Bulletin, American Journal of Public Health,* and *JAMA Pediatrics*. In recognition of this work on stigma and health inequalities, Dr. Hatzenbuehler received the 2015 Louise Kidder Early Career Award from the Society for the Psychological Study of Social Issues, the 2016 Early Career Award for Distinguished Contributions to Psychology in the Public Interest from the American Psychological Association, and the 2016 Janet Taylor Spence Award for Transformational Early Career Contributions from the Association for Psychological Science.

22. **Jody L. Herman**, Ph.D., is Scholar of Public Policy at the Williams Institute, UCLA School of Law. Dr. Herman has worked on issues of poverty, women's rights, and anti-discrimination policy development with non-profit research, advocacy, and direct-service organizations in the United States and Mexico. Before joining the Williams Institute, she worked as a research consultant on issues of voting rights in low-income minority communities and gender identity discrimination. She served as a co-

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author on the groundbreaking report Injustice at Every Turn, based on the National Transgender Discrimination Survey conducted by the National Gay and Lesbian Task Force and the National Center for Transgender Equality. At the Williams Institute, her work has included research on the fiscal and economic impact of marriage for same-sex couples, the fiscal impact of employment discrimination against people who are transgender, and the development of trans-inclusive questions for population-based surveys. Her main research interests are the impact of gender identity-based discrimination and issues related to gender regulation in public space and the built environment.

23. **Ning Hsieh**, Ph.D., is an assistant professor of sociology at Michigan State University. Dr. Hsieh studies disparities in health outcomes and health care access by sexual orientation. Her research focuses on how sexual minorities' experiences of marginalization, prejudice, and discrimination contribute to their lower access to social, economic, and other coping resources, which eventually leads to poorer mental and physical health. Her recent publications reveal the heterogeneity in health risks among sexual minorities, suggesting that sexual minorities of color and bisexual individuals are particularly disadvantaged in health and healthcare experience.

24. **Laura T. Kessler**, J.D., J.S.D., is a Professor of Law at the University of Utah, S.J. Quinney School of Law. Dr. Kessler studies discrimination and families. Her expertise includes the harms of discrimination with regard to marriage, parentage, child custody, and family leave for LGB

individuals. Professor Kessler has developed a theory of equal citizenship for LGB individuals rooted in their intimate relationships. Her papers document the long and continuing history of disapproval of LGB relationships; how this denial serves to disrespect and subordinate gays and lesbians; and the consequent emotional, political, and expressive significance for LGB individuals of legal recognition of their intimate relationships. Her research is widely cited and recognized as providing rigorous, comprehensive, interdisciplinary analyses of the stubborn problem of discrimination against minority families, including LGB families. She was co-author of Brief of Amici Curiae Family Law Professors in Support of Plaintiffs-Appellees and Affirmance, filed in *Kitchen v. Herbert*, 755 F.3d 1193 (10th Cir. 2014), addressing, among other issues, the harm of the state of Utah's marriage ban to the well-being of different-sex couples and their children.

25. **Suzanne A. Kim**, J.D., is Professor of Law at Rutgers Law School at Rutgers University in Newark. Her research interests include the socio-legal regulation of intimacy; discrimination; intersections of family law with gender, sexuality, culture, and race; critical legal theory; law and social science; and vulnerability and resilience, including as concerning minority stress. Professor Kim has served as Associate Dean for Faculty Development at Rutgers Law. A recipient of the Dream Professor Award from the Association of Black Law Students at Rutgers Law, Professor Kim has been a visiting scholar at Emory University's interdisciplinary Vulnerability and the Human Condition Initiative and Columbia Law School's Center for Gender and

Sexuality Law and has also taught at Fordham Law School. Professor Kim also serves on the Executive Committee of the Institute for Research on Women at Rutgers University.

26. **Nancy J. Knauer**, J.D., is a Professor of Law and Director of the Law & Public Policy Program at Temple University, Beasley School of Law. For the past twenty-five years, Professor Knauer has explored the impact of federal policies on the lives of LGBT people. She is the author of Gay and Lesbian Elders: History, Law and Identity Politics in the US and more than forty academic articles, books, and book chapters. Her most recent scholarship focuses on the challenges faced by LGBT older adults, including health disparities and issues related to minority stress. Professor Knauer has received a Dukeminier Award and the Stu Walter Prize from the Williams Institute for her scholarship on LGBT aging issues. She is the co-founder of the Aging, Law & Society Collaborative Research Network of the Law & Society Association and served on the Executive Committee of the Family Law Institute of the National LGBT Bar Association. Professor Knauer was selected as one of 26 law professors from across the nation to be featured in the book What the Best Law Teachers Do, published by Harvard University Press in 2013.

27. **David J. Lick**, Ph.D., is User Experience Researcher at Facebook. Dr. Lick received his doctorate in Psychology from the University of California, Los Angeles. His research examines a number of issues related to sexual orientation, ranging from the psychological factors that contribute to prejudice against LGBT people to the downstream

health consequences of such prejudice. He recently collaborated on a scientific review that synthesized the growing body of research linking sexual minorities' experiences with prejudice to physical health disparities. He and his colleagues outlined the psychological, physiological, and behavioral pathways through which prejudice could hinder overall health for LGBT people. Dr. Lick has received numerous honors and awards for his work, including funding from the National Science Foundation, American Psychological Association, American Psychological Foundation, and Society for the Psychological Study of Social Issues.

28. **Marguerita Lightfoot**, Ph.D., is Professor of Medicine at the University of California, San Francisco School of Medicine. She is Chief for the Division of Prevention Science, Director of the Center for AIDS Prevention Studies (CAPS), Director of the UCSF Prevention Research Center and she holds the Walter Gray Endowed Chair. As a counseling psychologist, her research focus has been on improving the health and well-being of adolescents and young adults as well as the development of efficacious interventions to reduce health disparities among those populations disproportionately burdened by HIV and poorer mental and physical health outcomes. Her domestic and international research has included developing culturally appropriate interventions for runaway/homeless youth, juvenile justice involved adolescents, youth in medical clinics and settings, youth with a parent living with HIV, youth living with HIV, and LGBT youth, among others. She also studies the factors and approaches that strengthen resilience and mitigate the societal

impacts of stressors among these vulnerable populations of youth.

29. **Christy Mallory**, J.D., is the Director of State & Local Policy at the Williams Institute, UCLA School of Law. She studies the prevalence and impact of discrimination against LGBT people and same-sex couples in areas such as employment, housing, public accommodations, and education. Her work has been published in various journals and books, including *When Mandates Work* (UC Press, 2013), the *Loyola of Los Angeles Law Review*, the *LGBTQ Policy Journal at the Harvard Kennedy School*, and the *Albany Government Law Review*.

30. **Michael P. Marshal**, Ph.D., is an Associate Professor of Psychiatry at the University of Pittsburgh, and a Licensed Clinical Psychologist. Dr. Marshal is also a Standing Member of the "Health Disparities and Equity Promotion" Study Section within the Center for Scientific Review, at the National Institutes of Health (NIH). His expertise includes the investigation of mental health disparities among lesbian, gay, and bisexual (LGB) adolescents, particularly adolescents under the age of 18 years old. Dr. Marshal's program of research has been supported by multiple NIH-funded grants. His peer-reviewed publications have provided strong scientific evidence for the following: (1) On average, compared with heterosexual adolescents, LGB adolescents report higher rates of substance use, depressive symptoms, suicidality, and violent victimization experiences; (2) Mental health disparities among LGBT adolescents persist as they transition into young adulthood; and (3) Consistent with Dr. Ilan Meyer's Minority Stress Model, gay-

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related victimization experiences are strongly associated with these disparities.

31. **Miguel Muñoz-Laboy**, Dr.P.H., is an Associate Professor of Social Work at Temple University's College of Public Health. Dr. Muñoz-Laboy conducts studies on: 1) social and cultural factors that impact access to HIV/sexually transmitted infections, mental health, and/or substance abuse treatments in Latino communities in the United States; 2) the roles of acculturative stress and minority stress in the health and well-being for bisexual populations; and 3) linkage and retention in HIV among Latinos(as) with severe opioids use disorder. Drawing on Dr. Ilan Meyer's minority stress model, Muñoz-Laboy published research has documented how sexual minority stress increased the severity of anxiety and depressive symptoms among Latino bisexual men. To support his research program, he has received nine grants by the U.S. National Institutes of Health and private foundations as the Principal Investigator (PI) or co-Principal Investigator (co-PI) and has served as co-Investigator in 11 additional grants. Dr. Muñoz-Laboy has published over 70 articles in peer-reviewed journals, authored 10 chapters in edited books, and co-edited two books.

32. **John Pachankis**, Ph.D., is an Associate Professor of Public Health at Yale University. Dr. Pachankis studies the mental health of sexual and gender minority individuals. He developed a highly-cited model of stigma concealment, which has been used to understand the reasons that people conceal stigmatized identities and the psychological costs of doing so. He also studies the psychological impact of

stigma and discrimination on sexual and gender minority mental health over the lifespan. Drawing on his background as a clinical psychologist, he has translated this research into some of the first evidence-based mental health treatments for LGBT individuals. He has tested the delivery of these treatments via novel technologies (e.g., smartphones), in diverse settings (e.g., Eastern Europe), and with diverse segments of the LGBT community (e.g., rural youth). He is the recipient of the 2017 Distinguished Contributions to Knowledge award of the American Psychological Association's Division 44.

33. **Charlotte J. Patterson**, Ph.D., is a professor of Psychology at the University of Virginia. She is best known for her research on the role of sexual orientation in human development and family lives—specifically for her work on child development in lesbian- and gay-parented families. Patterson's research has been published in the field's top journals and she has co-edited four books on the psychology of sexual orientation. Patterson is a Fellow of the American Psychological Association (APA) and of the Association for Psychological Science (APS) and a past president of the Society for Psychological Study of Lesbian, Gay, and Bisexual Issues. She has won a number of awards, including APA's Distinguished Contributions to Research in Public Policy Award. She also served as a member of the United States Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues, whose 2011 report on LGBT health disparities was instrumental in leading the National Institutes of Health to reorganize research and increase funding for studies in this area.

34. **John L. Peterson**, Ph.D., is emeritus professor of psychology at Georgia State University. Prior to his faculty position at Georgia State, he was on the faculty at the University of California, San Francisco, in the Department of Medicine. Dr. Peterson studies the effects of sexual prejudice and violence toward sexual minorities and psychological issues related to the HIV/AIDS prevention among nonwhite gay and bisexual men. His work has been well cited regarding the interactive effects of sexual prejudice, masculine ideology, and violence toward sexual minorities and the sociocultural and psychological factors associated with HIV risk behavior and the social determinants of racial disparity in HIV infection. Dr. Peterson served on the Institute of Medicine (IOM) Committee on Lesbian, Gay, Bisexual & Transgender Health Issues and Research Gaps at the National Academies.

35. **Nancy Polikoff**, J.D., is Professor of Law at American University Washington College of Law where she teaches Family Law and a seminar on Children of LGBT Parents. She was previously the Visiting McDonald/Wright Chair of Law at UCLA School of Law and Faculty Chair of the Williams Institute. For more than 40 years, she has been writing about, teaching about, and working on litigation and legislation about LGBT families. Among her many publications is the book *Beyond (Straight and Gay) Marriage: Valuing All Families under the Law* (2008). Professor Polikoff was instrumental in the development of the legal theories that support second-parent adoption and custody and visitation rights for legally unrecognized parents. She was successful counsel in *In re M.M.D.*, which

established joint adoption for lesbian, gay, and unmarried couples in DC, and *Boswell v. Boswell*, a Maryland case that overturned restrictions on a gay noncustodial father's visitation rights. From 2007-2009, she played a primary role in the drafting and passage of groundbreaking parentage legislation in DC. She is a former chair of the Association of American Law Schools Section on Sexual Orientation and Gender Identity Issues. In 2011, Professor Polikoff received the Dan Bradley award from the National LGBT Bar Association, the organization's highest honor.

36. **Ellen D.B. Riggle**, Ph.D., is Professor of Political Science and Gender and Women's Studies at the University of Kentucky. Dr. Riggle studies the impact of stigma and identity strengths on the health and well-being of LGBT people and same-sex couples. Her areas of research include the effects of minority stress on LGBT individuals and same-sex couples, how laws and policies affect LGBT individuals' reports of distress and well-being, and the role of positive LGBT identity factors in well-being and resilience. Dr. Riggle is the co-author of A Positive View of LGBTQ: Embracing Identity and Cultivating Well-Being, winner of the 2012 American Psychological Association Division 44 Distinguished Book Award, and Happy Together: Thriving as a Same-Sex Couple in Your Family, Workplace, and Community (published by the American Psychological Association LifeTools series).

37. **Sharon Scales Rostosky**, Ph.D., is Professor and Director of Training in the Counseling Psychology program at the University of Kentucky. She is also a licensed psychologist. Dr. Rostosky uses

qualitative and quantitative methodologies to document the negative psychosocial impacts of prejudice and discrimination against LGB individuals and same-sex relationships that is sourced at all levels of the ecological system (intrapersonal, interpersonal, and socio-cultural). Her research on same-sex couple relationships was first funded by the American Psychological Foundation in 2000 and most recently by NIH in 2017. In addition to over 70 peer-reviewed articles, Dr. Rostosky has co-authored two books based on her research findings: *A Positive View of LGBTQ: Embracing Identity and Cultivating Well-Being* (Riggle & Rostosky, 2012, Rowman & Littlefield; American Psychological Association Division 44 Distinguished Book Award for 2012.), and *Happy Together: Thriving as a Same-Sex Couple in Your Family, Workplace, and Community* (Rostosky & Riggle, 2015, American Psychological Association).

38. **Esther D. Rothblum**, Ph.D., is Professor of Women's Studies at San Diego State University and Visiting Distinguished Scholar at the Williams Institute at UCLA School of Law. She is editor of the Journal of Lesbian Studies, a former president of Division 44 (Society for the Psychological Study of LGBT Issues) of the American Psychological Association, and a Fellow of seven divisions of APA. Her research and writing have focused on LGBT relationships and mental health, focusing on using heterosexual and cisgender siblings as a comparison group. Since 2001 Dr. Rothblum has compared same-sex couples in legal relationships with their heterosexual married siblings. She has edited 27 books and has over 130 publications in academic journals and books.

39. **Jocelyn Samuels**, J.D., is the Executive Director of the Williams Institute with close to three decades of experience in interpretation and enforcement of federal civil rights laws. She has served in numerous roles in the federal government, including as Acting Assistant Attorney General for the Civil Rights Division at the U.S. Department of Justice, and Director of the Office of Civil Rights at the U.S. Department of Health and Human Services. She has deep expertise in issues related to LGBT law and policy, including with respect to barriers that continue to limit access for the LGBT community to services and benefits and the application of existing laws to discrimination based on sexual orientation and gender identity.

40. **R. Bradley Sears**, J.D., is the David Sanders Distinguished Scholar of Law and Policy at the Williams Institute and Associate Dean of Public Interest Law at UCLA School of Law. Over the past two decades, Sears has published a number of research studies and articles, primarily on discrimination against LGBT people in the workplace in the private and public sectors, HIV discrimination by health care providers, the economic and fiscal impact of discrimination against same-sex couples, and the economic and fiscal impact of LGBT health disparities at the state-level.

41. **Ari Ezra Waldman**, J.D., Ph.D., is an Associate Professor of Law at New York Law School. He is the Director of the Innovation Center for Law and Technology and the Founder and Director of the Institute for CyberSafety, a full service academic and direct outreach program that includes, among other things, the first and, to-date, only law school clinic

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representing LGBTQ victims of online harassment. Professor Waldman's research focuses, in relevant part, on the frequency and effects of bullying and cyberbullying on marginalized populations; the impact face-to-face and online harassment have on queer youth and adolescent success and health; and how federal, state, and local laws and policies can reduce cybervictimization and improve the lives of members of the LGBTQ community. His work has been published in leading law reviews and his forthcoming work explores nonconsensual image sharing among gay men and the effect of mobile apps on queer social life. He is an internationally sought-after speaker and commentator on privacy and cyberharassment.

42. **Bianca D.M. Wilson**, Ph.D., is a Senior Scholar of Public Policy at the Williams Institute, UCLA School of Law, and affiliated faculty with the UCLA California Center for Population Research. She earned a Ph.D. in Psychology from the Community and Prevention Research program at the University of Illinois at Chicago (UIC) with a minor in Statistics, Methods, and Measurement, and received postdoctoral training at the UCSF Institute for Health Policy Studies and the UCSF Lesbian Health and Research Center through an Agency for Health Research and Quality (AHRQ) postdoctoral fellowship. Her research focuses on the relationships between culture, oppression, and health, with an emphasis on racial and sexual and gender minorities. Her most current work focuses on LGBT economic instabilities and population research among foster youth, homeless youth, and youth in juvenile custody,

with a focus on sampling, data collection, and assessing disproportionality in these systems.

43. **Richard G. Wight**, Ph.D., M.P.H., is a retired Researcher from the Department of Community Health Sciences at the UCLA School of Public Health. For more than two decades, he conducted interdisciplinary research on stress and health experiences of individuals vis-à-vis the people and places around them, and his work has been widely published in the U.S. and internationally. His early publications were among the first to address public health and health policy issues relating to informal AIDS caregiving in the United States and he is an expert on the neighborhood context of health. Wight has developed life course studies that examine aging, minority stress, and health processes among the growing population of midlife and older lesbians and gay men, with a particular focus on the health effects of same-sex legal marriage. His recent work examines minority stress and health experiences of the parents of sexual minorities.

Institutional affiliations for identification purposes only

Exhibit 181

HHS-OCR-2018-0002-0001

The Wisconsin Alliance for Women's Health (WAWH) believes a health care provider's personal beliefs should never determine the care a patient receives. WAWH has an interest in ensuring patients have access to health care in Wisconsin, and that widely accepted standards of medical care, not religious beliefs, dictate patient access to care. That is why we strongly oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule"), which seeks to permit discrimination in all aspects of health care.[1]

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

By issuing the Proposed Rule and creating a new division within the Office of Civil Rights ("OCR") – the new "Conscience and Religious Freedom Division" – the Department seeks to inappropriately use OCR's limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need. For these reasons, WAWH calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

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

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

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

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

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

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (*to be codified at* 45 C.F.R. pt. 88) [*hereinafter* Rule].
[2] *See id.* at 12.

Already existing refusal of care laws are used across the country to deny patients the care they need, including existing Wisconsin state law.[3] The Proposed Rule attempts to expand these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions specifically related to the service or research activity to which they object.[4] But the Proposed Rule attempts to broaden this provision to allow individuals to refuse to perform aspects of their jobs based on a mere reference to a religious or moral belief regardless of whether it relates to the specific biomedical or behavioral service or research activity they are working on.[5] Such an attempted expansion goes beyond what the statute enacted by Congress allows. Furthermore, the Proposed Rule would expansively apply other provisions of the Church Amendments to, among other things, individuals working under global health programs funded by the Department thereby allowing global health providers and entities to refuse individuals the care they need contrary to the very purpose of such programs.

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

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

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[3] *See, e.g.*, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Catherine Weiss, et al., *Religious Refusals and Reproductive* Rights, AM. CIVIL LIBERTIES UNION (2002), https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report; Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[4] The Church Amendments, 42 U.S.C. § 300a-7 (2018).
[5] *See* Rule *supra* note 1, at 185.
[6] *Id.* at 180.
[7] *Id.* at 183.
[8] The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018).
[9] *See* Rule *supra* note 1, at 182.

against congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert.[10]

When these impermissibly broad definitions are combined with the expansive interpretations of the underlying statutes, they work together to further expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, one way the Weldon Amendment is expanded under the Proposed Rule is through the definition of "discrimination."[11] In particular, the Proposed Rule defines "discrimination" against a health care entity broadly to include a number of activities, including denying a grant or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[12] In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is nonsensical and inappropriate. Further such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

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

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

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.[13] In Milwaukee, Wisconsin, a woman who was 18 weeks pregnant went into premature labor and taken to a Catholic hospital.[14] Her medical condition became dangerous, as she was hemorrhaging and was febrile. As her condition worsened, the patient and her family asked her health care providers to speed up the process of terminating her pregnancy, but her providers were unable to do so because the hospital, because of Catholic health dictates, did not stock mifepristone or perform a dilation and evacuation procedures, which is fastest and safest method for terminating a second trimester pregnancy. Because she was denied access to best medical practices, the patient was forced to labor painfully for more than 24 hours and required a blood transfusion, only to deliver a fetus that had no hope of survival.

Similar incidents have occurred in other states. One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[15] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside

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[10] The doctrine of expression unius est exclusion alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[11] *See* Rule *supra* note 1, at 180.
[12] *Id.*
[13] *See, e.g.*, *supra* note 3.
[14] *See* Amy Littlefield, *Catholic Rules Forced This Doctor to Watch Her Patient Sicken—Now, She's Speaking Out*, Rewire (September 7, 2017), https://rewire.news/article/2017/09/07/catholic-rules-forced-doctor-watch-patient-sicken-now-shes-speaking/

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

Chicago, Illinois.[16] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[17] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[18] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[19]

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

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.[20] This is especially true for immigrant patients who often lack access to transportation and may have to travel great distances to get the care they need.[21] In rural areas there may be no other sources of health and life preserving medical care.[22] In developing countries where many health systems are weak, health care options and supplies are often unavailable.[23] When these individuals encounter refusals of care, they may have nowhere else to go.

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

[17] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 29 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

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

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

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

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

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

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

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, including Wisconsin, women of color are more likely than white women to give birth in Catholic hospitals.[24] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on a wide range of hospital matters, including reproductive health care and can keep providers from offering the standard of care.[25] Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women were delayed care or transferred to other facilities at great risk to their health.[26] The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.[27]

In addition, in many of the countries where the Department implements global AIDS programs, many of the patients served already face numerous barriers to care, including a broad and harmful refusal provision contained within the statute governing such programs.[28]

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

By expanding refusals of care the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored "to impose the least burden on society."[29] The Proposed Rule plainly fails on both counts. Although the Proposed Rule attempts to quantify the costs of compliance, it completely fails to address the costs and burdens to patients who may be denied care and who then may incur and experience even greater social and medical costs.[30]

Moreover, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant religious exemptions and,

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[24] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[25] *See id.* at 10-13.
[26] Lori R. Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.
[27] *See, e.g.*, *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.
[28] *See The Mexico City Policy: An Explainer*, KAISER FAMILY FOUND. (June 1, 2017), https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/.
[29] Improving Regulation and Regulatory Review, Executive Order 13563 (Jan. 18, 2011), https://obamawhitehouse.archives.gov/the-press-office/2011/01/18/executive-order-13563-improving-regulation-and-regulatory-review.
[30] *See* Rule *supra* note 1, at 94-177.

in fact, bars granting an exemption when it would detrimentally affect any third party.[31] Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.[32]

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

The Proposed Rule would seemingly allow health care entities to receive grants and contracts under HHS-funded programs or other federal health programs, such as Title X, the only domestic family planning program, while refusing to provide key services required by those programs.[33] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling[34] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[35] Under the Proposed Rule, the Department would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such funds are generally conditioned.[36] The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.[37] When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.[38]

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

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards,

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[31] U.S. Const. amend. I; *Cutter v. Wilkinson*, 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[32] Respecting religious exercise may not "unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling." *See Burwell v. Hobby Lobby*, 134 S. Ct. at 2787. When considering whether the birth control coverage requirement was the least restrictive means in Hobby Lobby, the Court considered that the accommodation offered by the government ensured that affected employees "have precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing coverage." *See id.* at 2759. In other words, the effect of the accommodation on women would be "precisely zero." *Id.* at 2760.
[33] *See* Rule *supra* note 1, at 180-181, 183. *See also Title X Family Planning*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2018), https://www.hhs.gov/opa/title-x-family-planning/index.html; *Title X an Introduction to the Nation's Family Planning Program*, NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOC. (2017) (*hereinafter* NFPRHA), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf.
[34] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).
[35] *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).
[36] *See, e.g.*, Rule *supra* note 1, at 180-185.
[37] *See* NFPRHA *supra* note 34.
[38] *See id.*

and ignore the reality that many providers want to provide comprehensive care. Hospital systems across the country use religious beliefs to prevent their employees from treating patients regardless of the professional, ethical, or moral convictions of these providers.[39] The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions, including foreign and international organizations, to bind the hands of providers and attempt to limit the types of care they can provide.

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health providers and patients and ensure patient-centered decision-making.[40] Informed consent requires providers disclose relevant and medically accurate information about treatment choices and alternatives so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[41] By allowing providers, including hospital and health care institutions, to refuse to provide patients with information, the Proposed Rule makes it impossible for patients to have full information regarding treatment options. While the Department claims the Proposed Rule improves communication between patients and providers, in truth it will deter open, honest conversations that are vital to ensuring that a patient can control their medical circumstances.[42]

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[43] Individuals seeking reproductive health care, regardless of their reasons for needing these services, should be treated with dignity and respect. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them.

In addition, the Proposed Rule ignores the many providers with deeply held moral convictions that affirmatively motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. Moreover, the Proposed Rule fails to acknowledge the Church Amendments'

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[39] *See* Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[40] *See* TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).
[41] *See id.*
[42] *See* Rule *supra* note 1, at 150-151.
[43] For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant. AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE § 114-15, S117 (2017), available at http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf. The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics guidelines state that the risks to the woman from persistent severe pre-eclampsia are such that delivery (abortion) is usually suggested regardless of fetal age or potential for survival. AM. ACAD. OF PEDIATRICS & AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).

protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.[44] No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion.

The Department is Abdicating its Responsibility to Patients

The Proposed Rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.[45] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce.[46] They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[47] If finalized, however, the Proposed Rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities. Through robust enforcement of civil rights laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities, segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[48]

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[44] *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).
[45] *OCR's Mission and Vision*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").
[46] *See* Rule *supra* note 1, at 203-214.
[47] As one of its first official acts in 1967, the Office of Equal Health Opportunity undertook the massive effort of inspecting 3,000 hospitals to ensure they were complying with Title VI's prohibition against discrimination on the basis of race, color, or national origin. 42. U.S.C. § 2000d (1964). After this auspicious start, the Office of Equal Health Opportunity which would eventually become OCR would go on to ensure that health programs and activities it regulated complied with key anti-discrimination laws including Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1973), Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 (1972), the Age Discrimination Act of 1976, 42 U.S.C. § 6101 (1976), and Section 1557 of the Affordable Care Act, 42 U.S.C. §18116 (2010), among others. Through robust enforcement of these laws, OCR has worked to reduce discrimination in health care.
[48] *See, e.g., Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html; *Protecting the Civil Rights and Health Information Privacy Rights of People Living with HIV/AIDS*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/hiv/index.html; *National Origin Discrimination*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/national-origin/index.html; *Health Disparities*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/health-disparities/index.html.

Nevertheless, there is still work to be done, and the Proposed Rule seeks to divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.[49] And these disparities do not occur in isolation. Black women, for example, are three to four times more likely than white women to die during or after childbirth.[50] Further, the disparity in maternal mortality is growing rather than decreasing,[51] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resulting health disparities. For example, women's pain is routinely undertreated and often dismissed.[52] And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[53] Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.[54] Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.[55]

OCR must work to address these disparities, yet the Proposed Rule seeks to prioritize the expansion of existing religious refusal laws beyond their statutory requirements and create new religious exemptions where none had previously existed rather than using already limited resources to protect patient access to health care. The Proposed Rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.[56]

The Proposed Rule Conflicts with Other Existing Federal Law

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

For example, the Proposed Rule makes no mention of Title VII,[57] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance

[49] *See* Skinner et al., *Mortality after Acute Myocardial Infarction in Hospitals that Disproportionately Treat African-Americans*, NAT'L INSTIT. OF HEALTH 1 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1626584/pdf/nihms13060.pdf.
[50] *See* Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.
[51] *See id.*
[52] *See, e.g.*, Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001).
[53] *See, e.g.*, Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. of the Am. Heart Ass'n 1 (2015).
[54] *See, e.g.*, *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf. A survey examining discrimination against LGBTQ people in health care more than half of respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health care status; or health care professionals being physically rough or abusive.
[55] *See* Jaime M. Grant et al., *Injustice at Every Turn: a Report of the National Transgender Discrimination Survey*, NAT'L GAY AND LESBIAN TASK FORCE & NAT'L CTR. FOR TRANSGENDER EQUALITY, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.
[56] *See supra* note 46.
[57] 42 U.S.C. § 2000e-2 (1964).

on Title VII.[58] With respect to religion, Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[59] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The Proposed Rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both. Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[60]

Furthermore, the language in the Proposed Rule would seem to put health care entities in the position of being forced to hire people who intend to refuse to perform essential elements of a position even though Title VII would not require such an "accommodation." For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling even though the employer would not be required to do so under Title VII.[61] It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

In addition, the Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[62] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[63] Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

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

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[58] *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.
[59] *See id.*
[60] Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.
[61] *See* Rule *supra* note 1, at 180-181.
[62] 42 U.S.C. § 1295dd(a)-(c) (2003).
[63] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); In In re Baby K, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, 93 Fair Empl. Prac. Cas. (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).

WAWH is committed to ensuring that all patients in Wisconsin have access to medical care according to the standard of care. The Proposed Rule will have a chilling effect on the enforcement of and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. The preamble of the Proposed Rule discusses at length state laws that the Department finds objectionable, such as state laws that require anti-abortion counseling centers to provide information about where reproductive health care services can be obtained or whether facilities have licensed medical staff, as well as state laws that require health insurance plans to cover abortion.[64] Moreover, the Proposed Rule invites states to further expand refusals of care by making clear that this expansive rule is a floor, and not a ceiling, for religious exemption laws.[65]

Conclusion

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

Sincerely,

Sara Finger
Executive Director

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

Exhibit 182

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WISCONSIN HOSPITAL ASSOCIATION, INC.

March 26, 2018

Alex Azar
Secretary, Department of Health & Human Services
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

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

Dear Mr. Azar:

The Wisconsin Hospital Association ("WHA") is a statewide nonprofit association with a membership of more than 140 Wisconsin hospital and integrated health systems that includes not only critical access hospitals providing crucial services to their rural communities, but also major academic medical centers providing critical care, research, and training. On behalf of our members, WHA appreciates the opportunity to comment on RIN 0945-ZA03, a proposed rule regarding protection of statutory conscience rights in health care issued by the Department of Health and Human Services ("HHS"), Office for Civil Rights ("OCR").

As is explained in more detail below, WHA offers three primary recommendations with respect to this proposed rule:

- As HHS proceeds with this rulemaking to create a more robust enforcement structure for important statutory protections for health care provider decisions based on religious belief or moral conviction, WHA encourages HHS to do so in such a way that aligns with HHS's and WHA's mutual commitment to combatting patient discrimination and expanding health care access for all patients.
- WHA urges HHS not to finalize the proposal to require health care organizations to report the existence of all filed complaints and of all OCR investigations and compliance because, as written, the proposal (1) unfairly would apply even to organizations that have not violated the law and (2) is inconsistent with the Administration's and WHA's shared interest in reducing regulatory burden.
- WHA urges HHS to establish notice, hearing, and appeal procedures that HHS must follow before it can take remedial action (including termination of Medicare and Medicaid funding) against any health care organization found to have violated a federal health care provider conscience protection law.

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I. WHA encourages HHS to align its rulemaking with HHS's and WHA's mutual commitment to expanding health care access for all patients, regardless of race, color, national origin, disability, age, or sex.

WHA and its hospital and health system members are strongly committed to expanding access to high-quality health care for all Wisconsin communities, regardless of any patient's race, color, national origin, disability, age, or sex. At the same time, Wisconsin hospitals and health systems likewise are committed to respecting the personal religious beliefs and moral convictions of their employees and other personnel and to fostering respectful and diverse workplaces.

This goal of a health care system free from discrimination obviously is shared by HHS and OCR, which is the federal agency responsible for enforcing federal statutes that prohibit health care organizations that receive certain federal funds from engaging in discrimination. Specifically, OCR is responsible for enforcing statutes that prohibit discrimination against patients in the delivery of health care. *See, e.g.*, Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq.*, 45 C.F.R. pt. 80; § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 701 *et seq.*, 45 C.F.R. pt. 84; Age Discrimination Act of 1975, 42 U.S.C. § 6101 *et seq.*, 45 C.F.R. pts. 90 & 91; Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116, 45 C.F.R. pts. 92. In addition, OCR is responsible for enforcing what it calls at 45 C.F.R. § 88.1 "federal health care provider conscience protection statutes," *i.e.*, statutes that prohibit discrimination against health care personnel who refuse to perform or assist in performing certain procedures (*e.g.*, abortions, sterilizations, or assisted suicides) due to religious beliefs or moral convictions. *See, e.g.*, Church Amendments, 42 U.S.C. § 300a-7; Coats-Snowe Amendment, 42 U.S.C. § 238n; Section 1553 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18113.

While OCR already has the regulatory authority to enforce and handle complaints filed under these federal health care provider conscience protection statutes, *see* 45 C.F.R. pt. 88, in its proposed rule OCR intends to restate these federal statutes, expand and make more explicit certain regulatory authorities, and place specific regulatory requirements on health care organizations covered under the federal statutes. As HHS proceeds with this rulemaking to create a more robust enforcement structure for important statutory protections for health care provider decisions based on religious belief or moral conviction, WHA encourages HHS to do so in such a way that aligns with HHS's and WHA's mutual commitment to combatting patient discrimination and expanding health care access for all patients.

II. In order to advance the Administration's and WHA's mutual commitment to reducing regulatory burden, WHA urges HHS not to finalize the proposal to require health care organizations to report the existence of all filed complaints and of all OCR investigations and compliance reviews.

The Trump Administration often has expressed its support for reducing the burden associated with regulatory compliance. For example, on January 30, 2017, the President issued an Executive Order, "Reducing Regulation & Controlling Regulatory Costs," that stated that "it is essential to manage the costs associated with the governmental imposition of private expenditures required to comply with Federal regulations" and that "it is important that for every one new regulation issued, at least two prior regulations be identified for elimination." Exec. Order No. 13,771, 82 Fed. Reg. 9,339 (Feb. 3, 2017). In addition, on March 5, 2018, in remarks to the Federation of American Hospitals, the HHS Secretary himself identified the following as a "key engine for transformation" of health care: "addressing any government burdens that may be getting in the way of integrated, collaborative, and holistic care for the patient, and of structures that may create new value more generally." Azar, Alex, *Remarks on Value-Based Transformation to the Federation of American Hospitals* (March 5, 2018), https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html.

WHA and its hospital and health system members support the Administration's policy on reducing regulatory burden. Just last fall, WHA submitted comments to the U.S. House of Representatives' Ways & Means Committee in response to the Committee's request for provider feedback on ways to reduce statutory and regulatory burden within Medicare. *See* Wis. Hosp. Ass'n, *Submission to U.S. House, Committee on Ways and Means, Subcommittee on Health* (Aug. 24, 2017), www.wha.org/data/sites/1/pdf/8-24-2017WHAsubmissionWMMedicareRedTapeReview.pdf. WHA's comments identified laws across the health care delivery continuum that Congress and the Administration could address to reduce Medicare's burden on Wisconsin hospitals and health systems.

The proposed rule would impose several additional regulatory requirements on covered hospitals and health systems, including the following:

- Organizations must report the existence of all filed complaints alleging violation of a federal health care provider conscience protection law and of all OCR investigations and compliance reviews, including reviews conducted in the absence of a filed complaint. 83 Fed. Reg. 3,880, 3,930. For reports of filed complaints, the organization must make the report for a duration of *five years* from the date of the complaint. *Id.*
- Organizations must submit written assurances and certifications of compliance with the federal health care provider conscience protection laws as a condition of receiving funding from HHS. *Id.* at 3,928.

- Organizations must post notices to advise persons about their rights and about such organizations' obligations under the federal health care provider conscience protection laws. *Id.* at 3,929.
- Organizations must maintain records evidencing compliance with the federal health care provider conscience protection laws and afford OCR reasonable access to such records. *Id.*
- Organizations must cooperate with OCR investigations and compliance reviews, which cooperation includes producing documents, participating in interviews, responding to data requests, and submitting to on-site inspections. *Id.* at 3,929-30.

WHA urges HHS not to finalize the proposal to require health care organizations to report the existence of all filed complaints and of all OCR investigations and compliance reviews. First, as written, this proposed regulatory requirement would not apply narrowly to organizations that in fact have violated a federal health care provider conscience protection law, but also would apply unfairly to any organization that OCR determines, after investigation, not to have violated such laws. This proposal, therefore, would have the effect of punishing organizations that have complied with all applicable laws. It is especially important not to finalize this proposal because elsewhere the proposed rule allows OCR to conduct a compliance review against organizations *even in the absence of a filed complaint* and allows *any* person to file a complaint, even if the complaint turns out not to have been based on any evidence of an actual legal violation. *See id.* at 3,930.

Second, the proposal as written is inefficient and does not advance the Administration's stated policy of reducing regulatory burden on private organizations. An alternative policy that would create more efficiencies and better align with the Administration's and WHA's commitment to regulatory burden reduction would be for OCR itself to track which organizations OCR has determined to be noncompliant and then report such information directly to HHS. This alternative policy would be more efficient because OCR itself would already have such information in a centralized, internal location and could easily convey such information to HHS for HHS to use in making funding decisions with respect to noncompliant organizations.

III. WHA urges HHS to establish notice, hearing, and appeal procedures for any remedial action that HHS may take against a noncompliant health care organization, including termination of HHS funds.

The proposed rule provides that "[i]f there appears to be a failure or threatened failure" of a health care organization to have complied with the federal health care provider conscience protection laws, HHS may terminate all HHS funding, including Medicare and Medicaid. 83 Fed. Reg. 3,880, 3,931. There are no "due process" provisions contained in the proposed rule that establish a specific procedure that HHS must follow before terminating an organization's Medicare and Medicaid funding or that provide the organization an opportunity to have a hearing before or to file an appeal after HHS decides to terminate the organization's funding.

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HHS specifically seeks comment on "what administrative procedures or opportunities for due process the Department should, as a matter of policy, or must, as a matter of law, provide," before HHS terminates an organization's HHS funding or otherwise takes remedial action against such organization. *Id.* at 3,898. WHA urges HHS to establish notice, hearing, and appeal procedures for any remedial action, including termination of HHS funds, that HHS may take against a health care organization for noncompliance (or "threatened" noncompliance) with the federal health care provider conscience protection laws. As an analogue for what such procedures might look like, HHS is advised to consult its own regulations implementing Title VI of the Civil Rights Act of 1964, *see* 45 C.F.R. §§ 80.8-80.10, or the Conditions of Participation for Medicare and Medicaid, *see* 42 C.F.R. § 489.53 & pt. 498.

Thank you again for the opportunity to comment. If you have any questions, please contact Andrew Brenton at (608) 274-1820 or abrenton@wha.org, or Jon Hoelter at (608) 274-1820 or jhoelter@wha.org.

Sincerely,

Eric Borgerding

President