NCLR NATIONAL CENTER FOR LESBIAN RIGHTS

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March 26, 2018

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

RE: Protecting Statutory Conscience Rights in Health Care (RIN 0945-ZA03)

The National Center for Lesbian Rights (NCLR) writes to urge that the above-referenced Proposed Rule be withdrawn in its entirety, as it would endanger patient health and encourage widespread discrimination in health care delivery.

NCLR is a non-profit, public interest law firm that litigates precedent-setting cases at the trial and appellate court levels, advocates for equitable public policies affecting the lesbian, gay, bisexual, and transgender (LGBT) community, provides free legal assistance to LGBT people and their advocates, and conducts community education on LGBT issues. NCLR has been advancing the civil and human rights of LGBT people and their families across the United States through litigation, legislation, policy, and public education since its founding in 1977. We also seek to empower individuals and communities to assert their own legal rights and to increase public support for LGBT equality through community and public education. NCLR recognizes the critical importance of access to affordable health care for all people, and is concerned about the increasing use of religious exemptions to undercut civil rights protections and access to services for our community.

Our overarching objections to this Proposed Rule are twofold. First, it strays far from the primary mission of the Department of Health & Human Services. Our nation's premier public health agency should always maintain a focus on protecting the health of all, rather than seeking to empower health care providers to withhold care, in contravention of the core principles of informed consent and adherence to accepted standard of care. Second, it exceeds the agency's authority and was promulgated in violation of the Administrative Procedure Act. We provide further detail below.

I. The Proposed Rule disregards HHS's core mission

The Proposed Rule disregards the health care needs of patients and the core mission of the Department of Health & Human Services (HHS). The purpose of our nation's health care delivery system is to deliver health care to the people of this country. As the nation's largest public health agency, and one that is charged with furthering the health of all Americans, HHS is primarily charged with assisting patients in accessing care and health care providers in

delivering high-quality, culturally-competent care to everyone. Access to care, rather than denials of care, should be the goal. This Proposed Rule, in addition to being on questionable legal ground, focuses exclusively on purported rights of health care providers to turn patients away, with virtually no mention of the impact on patient health and well-being or on how access to care will be ensured. The priorities reflected in the Rule represent a sharp departure from the missions of HHS and its Office for Civil Rights (OCR) and should be withdrawn.

A. HHS should be trying to broaden access, not encourage denials of care

The HHS web site states: "It is the mission of the U.S. Department of Health & Human Services (HHS) to enhance and protect the health and well-being of all Americans. We fulfill that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services" (emphasis added).[1] The Proposed Rule departs significantly from that vision as well as the Office for Civil Rights (OCR's) mission to address health disparities and discrimination that harm patients.[2] 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, proposing a regulatory scheme that would be affirmatively harmful to many patients seeking care.

HHS, through 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.[3] If finalized, however, the Proposed Rule will undermine HHS's mission of combating discrimination, protecting patient access to care, and eliminating health disparities. Through enforcement of civil rights laws, OCR has in the past worked to reduce discrimination in health care by ending discriminatory practices such as segregation in health care facilities based on race or disability, 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.[4]

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[1] *See* https://www.hhs.gov/about/index.html.

[2] *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.").

[3] 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 in the past worked to reduce discrimination in health care.

[4] *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*

Despite this past progress, there is still much work to be done, and the Proposed Rule would 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.[5] Black women are three to four times more likely than are white women to die during or after childbirth.[6] And the disparity in maternal mortality is growing rather than decreasing,[7] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resultant health disparities. Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care (we discuss this further below).

There is an urgent need for OCR to address these disparities, yet the Proposed Rule seeks instead to prioritize the expansion of existing religious refusal laws beyond their statutory requirements to create new religious exemptions. The Proposed Rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.

B. The evidence does not support the existence of the problem the Proposed Rule purports to address

Rather than focusing on the overarching aim of ensuring that all people in this country have access to the health care they need, the Proposed Rule seeks to empower health care providers, whose very jobs are to deliver health care, to instead deny not only health care services but even information about services to which they might personally object. It would create additional barriers to care in a health care system already replete with obstacles, particularly for people with limited incomes or those who are LGBT.

Through prior rulemaking in this area, HHS has already created mechanisms by which any provider who believes they have been subject to discrimination in violation of any of the federal health care refusal statutes may file a complaint with OCR and seek redress. Complaints have been filed and resolved through this process. And HHS has the ability to decline to fund entities that engage in violations of these laws. Individual health care providers who wish to exercise a conscientious objection to participating in certain health care services have the ability to do so and HHS, through OCR, already has the tools it needs to protect those rights. Rather than seeking to engage in a sweeping new rulemaking effort that would inappropriately

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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.

[5] *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.

[6] *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.

[7] *See id.*

shift the balance too far in the direction of care denial, the agency should instead devote its resources to expanding access to health care for all.

1. Discrimination against LGBT people in health care is pervasive

LGBT people, women, and other vulnerable groups already face significant barriers to getting the care they need.[8] The Proposed Rule will compound the barriers to care that LGBT individuals face, particularly the effects of ongoing and pervasive discrimination, by inviting providers to refuse to provide services and information vital to LGBT health.

As a civil rights organization that has been advocating for the LGBT community for over four decades, we at NCLR see firsthand the negative effects of stigma and discrimination on LGBT people seeking care. Despite significant gains in societal acceptance and legal protections, we still face hostility and ill treatment simply for being who we are, and sometimes the consequences are fatal. For example, NLCR currently represents the parents of a transgender youth who died by suicide after being denied appropriate care and discharged prematurely by a hospital in southern California.[9]

LGBT people of all ages continue to face discrimination in health care on the basis of their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes that "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[10] This surfaces in a wide variety of contexts, including physical and mental health care services.[11] 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.[12] They concluded that discrimination, as well as insensitivity or disrespect on the part of health care providers, were key barriers to health care access.[13]

There is a growing body of research documenting how LGBT people encounter barriers in the health care system and suffer disproportionately from a variety of conditions due to health care

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[8] *See, e.g.,* Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care; Sandy E. James et al., *The Report of the U.S. Transgender Survey* 93–126 (2016), www.ustranssurvey.org/report; 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; 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.

[9] *See* http://www.nclrights.org/cases-and-policy/cases-and-advocacy/case-prescott-v-rchsd/.

[10] *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).

[11] 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.

[12] 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.

[13] *Id*.

access issues compounded by stigma and discrimination. In 2010, Lambda Legal found that fifty-six percent of lesbian, gay, and bisexual survey respondents (out of 4,916 total respondents) experienced health-care discrimination in forms such as refusal of health care, excessive precautions used by health-care professionals, and physically rough or abusive behavior by health-care professionals. Seventy percent of transgender and gender nonconforming respondents experienced the same, and sixty-three percent of respondents living with HIV/AIDS had experienced health-care discrimination. In addition, low-income LGBT people and LGBT people of color experienced increased barriers to health care. Approximately seventeen percent of low-income lesbian, gay, and bisexual respondents and twenty-eight percent of low-income transgender respondents reported harsh language from health-care providers compared to under eleven percent of LGB respondents and twenty-one percent of transgender respondents, overall.[14] 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.[15]

A recent survey conducted by the Center for American Progress found that among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:

- 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation;
- 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation;
- 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner;
- 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them;
- 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[16]

Among transgender people who had visited a doctor or health care providers' office in the past year:

- 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity;

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[14] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination against LGBT People and People with HIV*, 2010, https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isntcaring.pdf.

[15] 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.

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

- 12 percent said a doctor or other health care provider refused to give them health care related to gender transition;
- 23 percent said a doctor or other health care provider intentionally used the wrong name;
- 21 percent said a doctor or other health care provider used harsh or abusive language when treating them;
- 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[17]

When LGBT patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In the CAP study, nearly one in five LGBT 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 LGBT people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.[18] 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.

Health-care disparities in general are often more pronounced in rural areas in the United States, and this is further compounded for LGBT individuals, often due to a lack of cultural competency. This hinders physical and mental health providers from meeting the health needs of rural communities.[19] The lack of connection to positive, affirming resources also isolates LGBT youth, making them more susceptible to self-destructive behavior patterns.[20] Isolation continues into adulthood, when LGBT populations are more likely to experience depression and engage in high-risk behaviors.[21]

NCLR has been holding convenings of LGBT people in rural communities for the past several years, and we hear consistently about difficulties in accessing adequate health care. The challenges our community faces in these rural settings include having few providers with LGBT competency, difficulty maintaining health insurance coverage due to employment challenges, transportation difficulties to get to what medical providers there are, food deserts, and specific health conditions that are often more prevalent among LGBT people because of having to live with discrimination and social isolation, including poor eating habits, smoking, and substance abuse.

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[17] *Id*.
[18] *Id*.
[19] Cathleen E. Willging, Melina Salvador, and Miria Kano, "Pragmatic Help Seeking: How Sexual and Gender Minority Groups Access Mental Health Care in a Rural State," *Psychiatric Services* 57, no. 6 (June 2006): 871–4, http://doi.org/10.1176/ps.2006.57.6.871.
[20] Colleen S. Poon and Elizabeth M. Saewyc, "Out Yonder: Sexual-Minority Adolescents in Rural Communities in British Columbia," *American Journal of Public Health* 99, no. 1 (January 2009): 118–24, http://doi.org/10.2105/AJPH.2007.122945.
[21] Trish Williams et al., "Peer Victimization, Social Support, and Psychosocial Adjustment of Sexual Minority Adolescents," *Journal of Youth and Adolescence* 34, no. 5 (October 2005): 471–82, https://doi.org/10.1007/s10964-005-7264-x.

In rural areas, if care is denied for religious reasons, there may be no other sources of health and life-preserving medical care.[22] The ability to refuse care to patients would therefore leave many individuals in rural communities with no health care options. Medically underserved areas already exist in every state,[23] with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[24] 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.[25]

In addition to geographic challenges, the problems for patients presented by the expansion of refusal provisions in both federal and state law have been exacerbated by the growth in health care systems owned and operated by religious orders. Mergers between Catholic and nonsectarian hospitals have continued as hospital consolidation has intensified. Catholic hospitals and health systems must follow the church's Ethical and Religious Directives for Catholic Health Care Services ("Directives"), which prohibit a wide range of reproductive health services, such as contraception, sterilization, abortion care, and other needed health care.[26] Nonsectarian hospitals must often agree to comply with these Directives in order to merge with Catholic hospitals.[27]

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's care was delayed or they were transferred to other facilities at great risk to their health.[28] The reach of this type of religious refusal of care is growing with the proliferation of religiously affiliated entities that provide health care and related services.[29] New research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than are white women to give birth in Catholic hospitals.[30]

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[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] 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).

[24] 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/.

[25] 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.

[26] U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.

[27] Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 Yale L. J. 2470, 2488 (2015).

[28] 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/.

[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* 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.

Refusals in the context of reproductive health care sometimes run in both directions – they prevent access to contraception and abortion, but also to assisted reproductive technologies (ART) to enable pregnancy. Not only does this infringe on individuals' right to information and care, for those with certain medical conditions it directly contravenes the standard of care. For individuals with cancer, for example, the standard of care includes education and informed consent around fertility preservation, according to the American Society for Clinical Oncology and the Oncology Nursing Society.[31] Refusals to educate patients about or to provide ART, or to facilitate ART when requested, are contrary to the standard of care.

While religiously-based objections to contraception and abortion are well known and have posed access barriers for years, less evident is how these types of refusals can also affect the LGBT community. Not only are LGBT people affected by denials of reproductive health care, other types of medically necessary care, such a transition-related care, are also frequently refused.

Many religious health care providers are opposed to infertility treatments altogether or are opposed to providing it to certain groups of people such as members of the LGBT community.[32] Health care providers have even sought exemptions from state antidiscrimination laws to avoid providing reproductive services to lesbian parents.[33] For example, in one case, an infertility practice group subjected a woman to a year of invasive and costly treatments only to ultimately deny her the infertility treatment that she needed because she is a lesbian.[34] When doctors at the practice group recognized that the woman needed in vitro fertilization to become pregnant, every doctor in the practice refused, claiming that their religious beliefs prevented them from performing the procedure for a lesbian.[35] Because this was the only clinic covered by her health insurance plan, the woman had to pay out-of-pocket for the treatment at another clinic, which subjected her to serious financial harm.

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

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[31] 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).

[32] U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. (Directive 41 of the Ethical and Religious Directives for Catholic Health Care states: "Homologous artificial fertilization is prohibited when it separates procreation from the marital act in its unitive significance.")

[33] Douglas Nejaime et al., *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 Yale L.J. 2516, 2518 (2015). *See*, e.g., *N. Coast Women's Care Med. Grp., Inc. v. San Diego Cnty. Superior Court*, 189 P.3d 959 (Cal. 2008) (on the potential impact of healthcare refusal laws on same-sex couples).

[34] *Benitez v. N. Coast Women's Care Med. Grp., Inc.*, 106 Cal. App. 4th 978 (2003); *see also* LAMBDA LEGAL, BENITEZ V. NORTH COAST MEDICAL GROUP (Jul. 1, 2001), http://www.lambdalegal.org/in-court/cases/benitez-v-north-coast-womens-care-medical-group.

[35] *Id.*

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.

Religiously-based refusals can also result in the denial of other medically necessary care to LGBT people, particularly those who are transgender and in need of gender-affirming services. The following is one example that we learned about through a call to our Legal Help Line:

- Carl,[36] a transgender man, needed to undergo a hysterectomy and oophorectomy as part of his medically-supervised transition. Working with his healthcare providers, Carl obtained insurance coverage for the procedure. His surgeon, who had privileges at several hospitals in the area, scheduled the procedure at the hospital that was nearest to Carl and the surgeon. That hospital happened to be a religiously-affiliated facility. A few days before the procedure was scheduled to occur, Carl was informed that he could not have the procedure done at the hospital. According to the surgeon, the decision was made by the hospital's Ethics Committee. The reason Carl was given for the decision was that "the hospital does not perform that type of hysterectomy." Due to the short notice of the cancellation, the surgeon was unable to get the procedure moved to another hospital.

The foregoing barriers and challenges are evident in the stories we are hearing from NCLR supporters who are alarmed by the prospect of this Rule, including the following comments that have been submitted already to HHS:[37]

- I and many of my community members struggle to afford healthcare as it is, even with full time jobs. I live in a rural area and even if you do have health insurance, access to healthcare is very difficult. I do not see how my sexual orientation, religion, or other parts of me that one might disagree with at a personal level has anything to do with my right to receive healthcare. This regulation, whatever its intentions, will give those who are discriminatory the ability to act on this in a way that can harm the community and disproportionately provide support based on personal differences. I fear this will only further drive people apart.

- As a retired nurse educator I find this proposed rule unethical, immoral, unconscionable & inhumane. All health professionals essentially take an oath to treat & or take care of any person regardless of their race/religion/age/sexual orientation/ethnic background. And women have a right to choose their own reproduction health care. I strongly oppose this rule which promotes discrimination & urge HHS to withdraw it.

[36] This incident was reported to NCLR Legal Help Line attorneys; the name has been changed to protect the caller's privacy.
[37] Some have been edited slightly for length and clarity.

- If this rule is allowed to exist, it will allow emergency room staff to turn away people maimed by car accidents, mass shootings and terrorist attacks. Do you really want to be waiting for life saving care as you are interviewed (interrogated) to determine that you are the "right" sort of person who aligns with a hospital staff member's religious beliefs? You could easily die as you try to prove that you are "worthy" of their care.

- I happen to be a health care provider and I see LGBT people in my practice regularly. I understand the disadvantages they face every day as they go to work, to school, and even at home in their families and communities. Access to health care is a critical problem for many people, and HHS should not be making the problem worse by inviting health care institutions and providers to turn people away based on religious or moral reasons.

- I am a US citizen, I am also Romani Hindu. I am an intersex female and lesbian. I greatly oppose any rules or laws that would allow any person to establish their personal religious views as a means to hold others as a lesser person. This archaic way of thinking does not create a peaceful and free nation. I live in America that is said to be a free nation. Yet I am not free simply because of who I am. I have a difficult time finding the heath care I need because of discrimination. I am a senior citizen of America and have been denied medical care. Giving any person the right to discriminate for any purpose does great harm to an entire country.

- I am an LBGTX woman, married and the mother of two adult children. I travel frequently for work and have paid into my company's health insurance system for over 40 years. While I'm fairly confident that wouldn't be refused treatment locally, the thought that I might be refused treatment during an emergency while I'm traveling because I am a gay woman is both appalling and frightening.

- I am a 75 year-old lesbian living in San Francisco. As an R.N. and an LCSW, I have worked in the healthcare field for my entire adult life. The proposed rule entitled "Protecting Statutory Conscience Rights in Health Care" would give permission to mistreat or not treat an entire group of citizens. This is outrageous! This would be against any oath that a healthcare provider has taken to provide healthcare to all - without exception. An individual's personal opinions or biases have no place in the healthcare field. HHS should not promote discrimination of any kind. I am sure this proposed rule would prove to be unconstitutional if tested in our courts - and it surely would be. This proposed rule should be withdrawn immediately! It's shocking that it's even been suggested.

- In many small communities there is a limited number of health care providers. Allowing this kind of bigotry and prejudice could be life-threatening to any number of people. I know of no religion that preaches withholding life-saving care from anyone. The whole idea of government sponsored bigotry is outrageous and about as un-American as you can get.

- In the last year alone, I had to be taken by ambulance to Emergency Rooms in Northern and Southern California due to a heart issue. I also had to go to an Emergency Room in

Rochester, NY. I dare to think what might have happened to me if the health care providers refused service because my same sex spouse was with me and they "objected" to our relationship.

- I fear we will return to the days where we could be refused health care because of who we love. In 2008, I had to carry legal papers with me to the emergency room so that my partner, before marriage was legal, could be informed about my illness and be involved in making decisions. We were lucky to have a nurse who was also lesbian and while she was on duty I had excellent care. One of my care givers was not happy that I had a female partner and excused himself from the room to send in another therapist a few hours later. We cannot go back, lives are at stake.

- I have personally known people who have come within inches of death from complications due to HIV/AIDS because of the neglect of a doctor based on that doctor's personal beliefs. Discrimination and personal beliefs should not factor in to medical treatment, ever.

- In our community there is a shortage of health care providers to begin with, and if you reduce the number of providers that LGBT people can use, people will die.

- My children (one of whom is still a minor) are part of the LGBTQ community, and your rule would allow physicians to deny them lifesaving medical treatment, should they fall ill or have a medical emergency, such as a car accident or appendicitis, because they are gay or trans. They could die in the waiting area of the ER while someone who would be willing to treat them is located, and brought to the hospital, or in transit to a hospital where someone would treat them. It would allow doctors providing preventative care like pap smears to turn away my trans son, so that he wouldn't be able to find out if he had ovarian cancer until it was too late. Or to deny them vaccines for preventable diseases, or even just the flu. It would allow pharmacists to deny my children a prescription for antibiotics, because they feel morally or religiously opposed to their "lifestyle choices." It could have allowed one of my best friends to die from the heart attack he had a few years ago, because he's married to another man - because he was taken to a Catholic hospital by the ambulance crew. If it happened again, and your rule is in place, that hospital, one of the largest and most comprehensive in coverage in our area, could start turning people away en mass, for simply not being Catholic. In a predominantly Mormon state, that means about half the population.

The fear expressed throughout these comments is palpable. LGBT people are all too familiar with discrimination and hostile treatment, including in health care settings, and inviting health care institutions and providers to turn away people and deny them care would exacerbate the widespread mistreatment experienced by many LGBT people in the health care system today.

2. The Proposed Rule fits a troubling pattern at HHS

We are concerned that this overemphasis on the right to deny care rather than the right to receive it reflects a broader orientation on the part of the agency. In 2017, HHS adopted rules – with no prior public comment – vastly expanding existing religious exemptions from the

ACA's requirement of birth control coverage. This was followed by a Request for Information (RFI) regarding supposed barriers to participation in health care by religious entities, a puzzling choice given the proliferation of religiously affiliated health care systems in this country. The FY 2018 – 2022 HHS Strategic Plan also overemphasized accommodating religious beliefs and moral convictions of health care providers, while failing to mention key populations (like LGBT people) or include any measurable goals, as such a document is supposed to do. Taken together, these issuances from HHS signal an alarming approach to public health, one that elevates the personal religious beliefs of some health care providers far above patients' well-being.

C. The Proposed Rule fails completely to address its impact on patients

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

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.[38] The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions to bind the hands of providers and attempt to limit the types of care they can provide. This has profound implications for the core medical ethical precept of informed consent, and for the ability of health care providers to follow accepted standards of care for their patients.

1. 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.[39] This right relies on two factors: access to relevant and medically-accurate information about treatment choices and alternatives, and provider guidance based on generally

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

[39] TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).

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

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."[40]The American Nursing Association similarly maintains that patient autonomy and self-determination are core ethical tenets of nursing. "Patients have the moral and 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."[41] Pharmacists are also expected to respect the autonomy and dignity of each patient.[42]

The Proposed Rule purports to improve communication between patients and providers,[43] but in reality it will have the opposite effect, deterring open, honest conversations that are vital to ensuring that a patient is able to be in control of their medical circumstances. Informed consent is intended to address 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. [44] 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.[45]

In order to ensure that patient decisions are based on free will, informed consent is essential to the patient-provider relationship. The Proposed Rule threatens this principle by inviting

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[40] *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.
[41] *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.
[42] *Code of Ethics for Pharmacists*, AM. PHARMACISTS ASS'N (1994).
[43] 83 Fed. Reg. 3917.
[44] BEAUCHAMP & CHILDRESS, *supra* note 39; Robert Zussman, *Sociological perspectives on medical ethics and decision-making*, 23 ANN. REV. SOC. 171-89 (1997).
[45] 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).

institutions and individual providers to withhold information about services to which they personally object, without regard for the patient's needs or wishes.

2. Standards of care

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 standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are not only important services in their own right, they are also part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[46] 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. It is alarming that a public health agency would actively encourage compromising patient health by facilitating departures from accepted standards of care.

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.[47] While some of these physicians might refer their patients to another provider who could provide the necessary care, another 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.[48] Meanwhile, the number of Catholic hospitals in the United States has increased by 22 percent since 2001, and they now control one in six hospital beds across the country.[49] 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

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[46] 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).

[47] 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/.

[48] 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/.

[49] 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.

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.[50]

As outlined below, there are significant questions regarding the authority of HHS to enforce the statutes cited in the Proposed Rule in the manner suggested. But even if the types of care denials this rule encourages are ultimately found to contravene federal law, we have grave concerns that the very promulgation of this Rule in its current form will encourage some health care providers and institutions to improperly restrict access to care for LGBT people, those seeking reproductive health care, and others, with harmful consequences. The ability to seek legal redress at a later date is cold comfort to a patient denied essential, even life-saving, care.

II. HHS has failed to establish its authority to issue the Proposed Rule

It is incumbent upon HHS to set forth with specificity the source of its purported authority to engage in this rulemaking, through which it seeks to reinterpret the scope of over two dozen federal statutes by, among other things, redefining key terms and adopting a wider array of enforcement tools. Absent such a detailed showing, the Proposed Rule should be withdrawn because, in addition to representing misguided and dangerous public health policy, it goes well beyond the authority of HHS and is therefore unlawful.

A. HHS has exceeded its rulemaking authority

The Proposed Rule exceeds HHS's authority under the various federal refusal statutes it references and seeks to enforce. An agency may not promulgate regulations that purport to have the force of law without delegated authority from Congress.[51] Yet none of the 25 statutory provisions cited by the Proposed Rule delegates authority to HHS to engage in rulemaking as contemplated in the Proposed Rule. Specifically, nothing within the 25 statutes cited by the Proposed Rule gives HHS the authority to require healthcare entities to provide assurances or certifications, to post the extensive notice included as Appendix A of the Proposed Rule, or to keep and make records available for review.[52] Nor does it give HHS the authority to conduct periodic compliance reviews or to subject healthcare entities to the full investigative process described in Section 88.7 of the Proposed Rule.[53]

The Department draws this purported authority not from the cited statutes but from its desire to implement a regulatory scheme "comparable to the regulatory schemes implementing other civil rights laws."[54] This desire arises from HHS's belief that the 25 cited statutes provide rights

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[50] 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.
[51] *Gonzales v. Oregon*, 546 U.S. 243, 274–75 (2006); *United States v. Mead*, 533 U.S. 218, 229–30 (2001); *Motion Picture Ass'n of Am., Inc. v. FCC*, 309 F.3d 796, 801 (D.C. Cir. 2002); *Amalgamated Transit Union v. Skinner*, 894 F.2d 1362, 1371 (D.C. Cir. 1990)*Pharm. Research & Mfrs. of Am. v. U.S. Dep't of Health & Human Servs.*, 43 F. Supp. 3d 28, 39–40 (D.D.C. 2014).
[52] *See* 83 Fed. Reg. at 3928–30.
[53] *Id.* at 3930–31.
[54] 83 Fed. Reg. 3904.

"akin to other civil rights to be free from discrimination on the basis of race, national origin, disability, etc."[55] Both the plain text and legislative history of these "other civil rights laws" distinguish them from the 25 statutes cited by the Proposed Rule, however. Each of the "other civil rights laws" cited by the Proposed Rule expressly authorizes HHS to promulgate regulations for their uniform implementation.

Title VI of the Civil Rights Act of 1964,[56] for example, which prohibits discrimination on the basis of race, color, or national origin in federal funding, states that "[e]ach Federal department and agency which is empowered to extend Federal financial assistance to any program or activity . . . is authorized and directed to effectuate the provisions of [Title VI] with respect to such program or activity by issuing rules, regulations, or orders of general applicability."[57] Title VI soon became the model for other nondiscrimination laws.[58]

Most recently, in Section 1557 of the Patient Protection and Affordable Care Act of 2009 (ACA), Congress clarified that the protections of Title VI, Title IX, the Age Discrimination Act, and Section 504 of the Rehabilitation Act of 1973 apply to all health programs or activities that receive federal financial assistance.[59] Congress explicitly granted HHS the authority to promulgate regulations to implement Section 1557.[60] Section 1553 of the ACA, which contains one of the refusal provisions cited by the Proposed Rule, does *not* contain such a grant.[61] Rather, Section 1553 gives HHS the authority to "receive complaints of discrimination" based on its provisions.[62] When Congress has explicitly granted an agency rulemaking authority in one section of a statute, the lack of such a grant in another section of the statute clearly indicates that Congress did not intend the agency to exercise rulemaking authority over that section.[63] The ACA conforms to the pattern Congress has followed for the past half-century: When it intends to grant HHS the kind of rulemaking authority claimed by the Proposed Rule, it does so expressly. The lack of such an explicit grant in any of the 25 cited statutes is

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[55] *Id.* at 3903.

[56] 42 U.S.C. 2000d *et seq*.

[57] Pub. L. No. 88-352, Title VI, § 602, 78 Stat. 252 (1964) (codified at 42 U.S.C. § 2000d-1).

[58] Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, both of which prohibit disability discrimination, explicitly refer to Title VI's enforcement provisions. *See* 29 U.S.C. § 794a(a)(2) (Section 504); 42 U.S.C. § 12133 (ADA). The Age Discrimination Act of 1975 not only permitted but required the Department to promulgate regulations to carry out its nondiscrimination provisions. 42 U.S.C. § 6103(a)(1). Title IX of the Education Amendments Act of 1972, which prohibits sex discrimination in education, contained delegation language that exactly mirrors that of Title VI. 20 U.S.C. § 1682.

[59] *See* Pub. L. 111-148, Title I, § 1557 (2010) (codified at 42 U.S.C. § 18116(a)). Congress did not include conscience protections in Section 1557, strongly implying that it does not see them as being "akin to," 83 Fed. Reg. at 3904, or "on an equal basis" with "other civil rights laws," *id*. at 3896. See *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 600 (2004) (noting that relationship with other federal statutes can be useful in statutory interpretation).

[60] 42 U.S.C. § 18116(c). The Department did so on May 18, 2016. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376 (May 18, 2016) (to be codified at 45 C.F.R. part 92). The final rule contains no mention of conscience protections.

[61] *See* 42 U.S.C. § 18113.

[62] *Id*.

[63] *See Amalgamated Transit Union*, 894 F.2d at 1371 ("[O]n the few occasions when Congress intended to give UMTA broad rulemaking authority . . . it did so expressly.").

therefore clear evidence that HHS does not have congressional authority to promulgate the Proposed Rule.

B. The Proposed Rule violates the Administrative Procedure Act

Even if HHS could promulgate a rule such as this based on its general authority to engage in rulemaking, that authority is not without limits. Under the Administrative Procedure Act (APA), "agency action, findings, and conclusions found to be… arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," "contrary to a constitutional right," or "in excess of statutory jurisdiction, authority, or limitations" shall be held unlawful and set aside.[64] An agency must provide "adequate reasons" for its rulemaking, in part by "examin[ing] the relevant data and articulat[ing] a satisfactory explanation for its action including a rational connection between the fact found and the choice made."[65] In addition, an agency can only change an existing policy if it provides a "reasoned explanation" for disregarding or overriding the basis for the prior policy.[66]

1. The Proposed Rule is arbitrary and capricious

In promulgating this Proposed Rule, HHS acted in an arbitrary and capricious manner in violation of the APA, and as a result the rule should be withdrawn in its entirety. The Proposed Rule is arbitrary and capricious on a number of grounds.

HHS fails to provide "adequate reasons" or a "satisfactory explanation" for this rulemaking based on the underlying facts and data. As stated in the Proposed Rule itself, between 2008 and November 2016, the Office of Civil Rights received ten complaints alleging violations of federal religious refusal laws; OCR received an additional 34 such complaints between November 2016 and January 2018. By comparison, during a similar time period from fall 2016 to fall 2017, OCR received *over 30,000 complaints* alleging either civil rights or HIPAA violations. These numbers demonstrate that rulemaking to enhance enforcement authority over religious refusal laws is not warranted.

HHS also fails to adequately assess the costs imposed by this Proposed Rule, both by underestimating quantifiable costs, and by neglecting to address the costs that would result from delayed or denied care. Under Executive Order 12866, when engaging in rulemaking, "each agency shall assess both the costs and the benefits of the intended regulation and, recognizing that some costs and benefits are difficult to quantify, propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify the costs."[67] Under Executive Order 13563, an agency must "tailor its regulations to impose the least burden on society" and choose "approaches that maximize net benefits (including

[64] 5 U.S.C. § 706(2)(A), (B), (C).
[65] *Encino Motorcars, LLC v. Navarro*, 136 S.Ct. 2117, 2125 (June 20, 2016) (citing *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 103 (1983)).
[66] *Id*. at 2125-26.
[67] Executive Order 12866 on Regulatory Planning and Review (September 30, 1993).

potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity)."[68]

HHS has failed to take the appropriate steps to ensure that the Proposed Rule is consistent with applicable law and does not conflict with the policies or actions of other agencies. Under Executive Order 12866, in order to ensure that agencies does not promulgate regulations that are "inconsistent, incompatible, or duplicative with its other regulations of those of other Federal agencies," each agency must include any significant regulatory actions in the Unified Regulatory Agenda.[69] HHS failed to include any reference to this significant regulation in its regulatory plans, and therefore failed to put impacted entities, including other federal agencies, on notice of possible rulemaking in this area. In addition, prior to publication in the Federal Register, the Proposed Rule must be submitted to the Office of Information and Regulatory Affairs (OIRA), within the Office of Management and Budget (OMB), to provide "meaningful guidance and oversight so that each agency's regulatory actions are consistent with applicable law, the President's priorities, and the principles set forth in this Executive order [12866] and do not conflict with the policies or actions of another agency."[70] According to OIRA's website, HHS submitted the Proposed Rule to OIRA for review on January 12, 2018, one week prior to the Proposed Rule being published in the Federal Register. Standard review time for OIRA is often between 45 and 90 days; one week was plainly insufficient time for OIRA to review the rule, including evaluating the paperwork burdens associated with implementing it. In addition, it is extremely unlikely that within that one week timeframe, OIRA could or would have conducted the interagency review necessary to ensure that this Proposed Rule does not conflict with other federal statutes or regulations.

The timing of the Proposed Rule also illustrates a lack of sufficient consideration. The Proposed Rule was published just two months after the close of a public comment period for a Request for Information closely related to this Rule.[71] The 12,000-plus public comments were not all posted until mid-December, one month before this Proposed Rule was released. Nearly all of the comments submitted at that time related to the subjects covered by the Proposed Rule—namely, the refusal of care by federally funded health care institutions or their employees on the basis of personal beliefs. This short period of time calls into question the comprehensiveness of the review of the Request for Information and whether the Proposed Rule was developed in an arbitrary and capricious manner.

The Proposed Rule also conflicts with several key federal statutes, as well as the U.S. Constitution. It makes no mention of Title VII,[72] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[73] With respect to religion, Title VII requires reasonable accommodation of

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[68] Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Sec. 1 (b).
[69] Executive Order 12866, at Sec. 4(b),(c).
[70] *Id*. at Sec. 6(b).
[71] "Removing Barriers for Religious and Faith-Based Organizations To Participate in HHS Programs and Receive Public Funding," 82 Fed. Reg. 49300 (Oct. 25, 2017).
[72] 42 U.S.C. § 2000e-2 (1964).
[73] *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.

employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[74] 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.[75]

Furthermore, the language in the Proposed Rule could put health care entities in the untenable position of being forced to hire people who intend to refuse to perform essential elements of the job for which they are being hired. 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. 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.

The Proposed Rule also conflicts with the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which 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.[76] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[77] 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 – such as those experiencing an ectopic pregnancy or miscarriage - not receiving necessary care. The Proposed Rule fails to explain how entities will be able to comply with the new regulatory requirements in a manner consistent with the statutory requirements of EMTALA, making the Proposed Rule unworkable.

Finally, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant

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[74] *See id.*

[75] 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.

[76] *See* 42 U.S.C. s 1295dd(a)-(c)

[77] *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).

religious exemptions to existing legal requirements and, in fact, bars granting an exemption when it would detrimentally affect any third party.[78] It requires an agency to "take adequate account of the burdens" that an exemption "may impose on nonbeneficiaries" and must ensure that any exemption is "measured so that it does not override other significant interests."[79] The proposed exemptions clearly impose burdens on and harm others and thus, violate the clear mandate of the Establishment Clause.

In promulgating a regulation that is inconsistent with federal statutes and regulations, as well as the Constitution, HHS engaged in arbitrary and capricious rulemaking, and its conduct was further compounded by a failure by OIRA to engage in appropriate oversight and review. For these reasons, the Proposed Rule should be withdrawn.

2. The Proposed Rule is not in accordance with law and exceeds statutory authority

The Proposed Rule is also not in accordance with law because much of its language exceeds the plain parameters and intent of the underlying statutes it purports to enforce. It 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. Therefore, the Proposed Rule violates the APA and should be withdrawn.

For example, the Church Amendments prohibit federal funding recipients from discriminating against those who refuse to perform, or "assist in the performance" of, sterilizations or abortions on the basis of religious or moral objections, as well as those who choose to provide abortion or sterilization.[80] The statute does not contain a definition for the phrase "assist in the performance." Instead the Proposed Rule creates a definition, but one that is not in accordance with the Church Amendments themselves. The proposed definition includes participation "in any activity with an *articulable connection* to a procedure, health service or health service program, or research activity" and greatly expands the types of services that can be refused to include merely "making arrangements for the procedure" no matter how tangential.[81] 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, could now assert a new right to refuse. As Senator Church stated from the floor of the Senate during debate on the Church Amendments: "The amendment is meant to give protection to the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions. There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal

[78] 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)); *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 18 n.8 (1989); *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).
[79] *Cutter*, 544 U.S. at 720, 722; see also *Thornton*, 472 U.S. at 709-10.
[80] 42 USC 300a-7.
[81] 83 Fed. Reg. 3892.

to perform what would otherwise be a legal operation."[82] This overly broad definition opens the door for religious and moral refusals from precisely the type of individuals that the amendment's sponsor himself sought to exclude. This arbitrary and capricious broadening of the amendment's scope goes far beyond what was envisioned when the Church Amendments were enacted.

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 applicable standards of care.

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.[83] Any information distributed by any method, including online or print, regarding any service, procedure, or activity could be refused by an individual or entity if the information given would lead to a service, activity, or procedure to which the provider objects.

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.[84] 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.[85] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but contravenes congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms HHS now attempts to insert.[86]

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."[87] Under this definition, virtually any member of the health care workforce could ostensibly refuse to serve a patient in any way.

The Weldon Amendment is expanded under the Proposed Rule by defining "discrimination" against a health care entity broadly to include a number of activities, including denying a grant

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[82] S9597, https://www.gpo.gov/fdsys/pkg/GPO-CRECB-1973-pt8/pdf/GPO-CRECB-1973-pt8.pdf (emphasis added). Senator Church went on to reiterate that "[t]his amendment makes it clear that Congress does not intend to compel the courts to construe the law as coercing religious affiliated hospitals, doctors, or nurses to perform surgical procedures against which they may have religious or moral objection." S9601 (emphasis added).
[83] 83 Fed. Reg. 3895.
[84] 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).
[85] 83 Fed. Reg. 3893.
[86] 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.
[87] 83 Fed. Reg. 3894.

or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[88] Such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion and undermining 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.[89] 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."[90] In seeking to craft a regulatory scheme mirroring "other civil rights laws," HHS is in fact hampering enforcement of the very civil rights laws it claims to be emulating.

Moreover, 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 – the denial may be for any reason at all.[91] The preamble uses language such as "those who choose not to provide" or "would rather not" as justification for a refusal. This unbounded license to deny care is made more dangerous by the fact that 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. The Proposed Rule does not have any provisions that stipulate that patients must be given notice that they may be refused certain health care services on the basis of religious or moral beliefs.

The Proposed Rule also purports to equip OCR with a range of enforcement tools that it in fact lacks the authority to employ, including referring matters to the Department of Justice "for additional enforcement,"[92] something not contemplated within any of the statutes referenced in the Proposed Rule. These measures, combined with the impermissibly broad definitions and other inappropriately expansive interpretations of the underlying statutes, would have a chilling effect on the provision of a range of medically necessary health care services.

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[88] 83 Fed. Reg. 3892.

[89] *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).

[90] *Burwell v. Hobby Lobby Stores, Inc*., 134 S. Ct. 2751, slip op. at 46 (2014).

[91] 83 Fed. Reg. 3890-91.

[92] 83 Fed. Reg. 3898.

Conclusion

The Proposed Rule departs from the core mission of HHS, would undermine patient care, and is contrary to law. We therefore urge that it be withdrawn.

If you have any questions regarding these comments, please contact Julianna S. Gonen, PhD, JD, NCLR Policy Director, at jgonen@nclrights.org or 202-734-3547.

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