



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 Community Catalyst in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.¹

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers and foundations, providing leadership and support to change the health care system so it serves everyone - especially vulnerable members of society.

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 pregnancy⁵ 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 Prophylaxis (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.”

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 pregnancies⁸ -- 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

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-Apr; 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

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](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 al*, accessed here: [http://www.contraceptionjournal.org/article/S0010-7824\(14\)00358-8/fulltext](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](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.

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.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 helping end 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

6. 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

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 al, *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 A 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 obtain health care and have real consequences for those denied the care they need because of a clinician's 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.

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](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

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

7. 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

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

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 Americans with Disabilities Act (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 any individual or entity with an “articulable connection” to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a moral or religious objection 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

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

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

9. 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 counseling⁵⁹ 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 Constitution, ignores congressional intent, fosters confusion, and harms patients contrary to the

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.*

Department's stated mission. For all of these reasons, Community Catalyst calls on the Department to withdraw the proposed rule in its entirety.

Respectfully submitted,

A handwritten signature in cursive script that reads "Robert Restuccia".

Robert Restuccia
Executive Director
Community Catalyst