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 Ave SW
Washington, DC 20201

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

To Whom It May Concern:

I am writing on behalf of People For the American Way ("PFAW") in response to the request for public comment regarding the proposed rule by the Department of Health and Human Services ("HHS") entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26, 2018. PFAW is a progressive advocacy organization established to promote and protect civil and constitutional rights, including religious liberty and freedom from discrimination. Founded in 1981 by a group of civic, educational, and religious leaders, PFAW now has hundreds of thousands of members nationwide. Over its history, PFAW has conducted extensive education, outreach, legislative and regulatory advocacy, and other activities to promote these values. PFAW strongly supports the principle that the First Amendment and appropriate federal law and regulations should be a shield for the free exercise of religion, protecting individuals of all faiths. PFAW is concerned, however, about efforts to transform this important shield into a sword to obtain accommodations that significantly harm others, which also violates the Establishment Clause.

PFAW is very concerned about the fact that every day, too many individuals, particularly women and LGBTQ people, people of color, and rural Americans, face discrimination and other barriers to accessing lifesaving health care. PFAW is concerned that the proposed regulation ignores the prevalence of discrimination and the damage it causes and will undoubtedly lead to increased discrimination and flat-out denials of care for some of the most vulnerable members of our community. Sweeping religious exemptions that obstruct access to care are a fundamental distortion of the principle of freedom of religion. Americans deserve better.

Many people, particularly women and LGBTQ people, people of color, and rural Americans, already face significant barriers to obtaining adequate health care.

Women and LGBTQ people, people of color, rural Americans, and other vulnerable groups around the country already face enormous barriers to getting the care they need, including

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refusals of care by providers based on personal beliefs.[1] Accessing quality care and overcoming outright discrimination is an even greater challenge for those living in areas with already limited access to health care providers. The proposed regulation threatens to make access even harder, and for some people nearly impossible.

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

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

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[1] e.g. Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx; Sandy E. James et al., *The Report of the U.S. Transgender Survey* 93–126 (2016), http://www.ustranssurvey.org/report; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), https://www.lambdalegal.org/publications/when-health-care-isnt-caring; National Women's Law Center, *The Patient Should Come First: Refusals to Provide Reproductive Health Care* (2017), http://www.lambdalegal.org/publications/when-health-care-isnt-caring; Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2016), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care

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

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

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

The proposed regulation attempts to inappropriately broaden religious exemptions in a way that threatens to lead to dangerous denials of medically necessary care.

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

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

Doctors may be misled into believing they may refuse on religious grounds to administer an HIV test or prescribe PrEP to a gay or bisexual man, or refuse screening for a urinary tract infection for a transgender man.[6] In fact, medical staff may interpret the regulation, including the broad new definition of "referral," to indicate not only that they can refuse to provide specific care, but also can decline to even tell a patient where she or he would be able to obtain lifesaving services or even inform patients of their treatment options. This puts the health of the patient, and potentially that of others, at risk. The proposed regulation could lead a physician to refuse to provide fertility treatments to a same-sex couple, or a pharmacist to refuse to fill a prescription for hormone replacement therapy for a transgender person.

In addition, by unlawfully redefining the statutory term "assisting in the performance" of a procedure, the rule could encourage health care workers to obstruct or delay access to a health

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

[6] Id.

care service even when they have only a tangential connection to delivering that service, such as scheduling a procedure or running lab tests to monitor side-effects of a medication. For example, the extension and broadening of this clause will impair LGBTQ patients' access to care services if interpreted—as the proposed rule improperly appears to do—to permit providers to choose patients based upon sexual orientation, gender identity, or family structure.

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

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.[7] For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling,[8] and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.[9] Under the proposed rule, HHS would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such funds are generally conditioned. The proposed rule creates uncertainty about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to

[7] U.S. Department of Health & Human Services, *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority* 3923-24 (2018), https://www.federalregister.gov/documents/2018/01/26/2018-01226/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority ("Rule"); U.S. Department of Health & Human Services, *Title X Family Planning* (2018), https://www.hhs.gov/opa/title-x-family-planning/index.html; National Family Planning & Reproductive Health Association, *Title X an Introduction to the Nation's Family Planning Program* (2017), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf ("NFPRHA")

[8] e.g. *Consolidated Appropriations Act of 2017* Public Law No: 115-31, 131 Stat. 135 (2017), https://www.congress.gov/bill/115th-congress/house-bill/244/text/pl?

[9] *What Requirements Must Be Met by a Family Planning Project?* 42 C.F.R. § 59.5(a) (5) (2000), https://www.gpo.gov/fdsys/granule/CFR-2007-title42-vol1/CFR-2007-title42-vol1-sec59-5

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.[10]

The proposed rule also threatens informed consent, a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health care providers and patients and ensure patient-centered decision-making.[11] Informed consent requires providers to disclose relevant and medically accurate information about treatment choices and alternatives so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.[12] By allowing providers, including hospitals and other health care institutions, to refuse to provide patients with information, the proposed rule makes it impossible for patients to have full information regarding treatment options. While HHS claims that the proposed rule improves communication between patients and providers, in truth it will deter open, honest conversations that are vital to ensuring that a patient can control their medical circumstances.[13]

The proposed rule conflicts with other existing federal law.

For example, the proposed rule makes no mention of Title VII,[14] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission ("EEOC") guidance on Title VII.[15] With respect to religion, Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[16] 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, the EEOC

[10] See NFPRHA
[11] Tom Beauchamp & James Childress, *Principles Of Biomedical Ethics* 4th Ed (1994); Charles Lidz Et Al., *Informed Consent: A Study Of Decisionmaking In Psychiatry* (1984)
[12] Id.
[13] Rule at 3917
[14] 42 U.S.C. § 2000e-2 (1964), https://www.gpo.gov/fdsys/granule/USCODE-2010-title42/USCODE-2010-title42-chap21-subchapVI-sec2000e-2/content-detail.html
[15] U.S. Equal Employment Opportunity Commission, *Title VII of the Civil Rights Act of 1964* (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm
[16] Id.

filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[17]

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. It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

In addition, the proposed rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion, thereby inviting confusion and great danger to patient health. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition, or if medically warranted to transfer the person to another facility.[18] Under EMTALA every hospital is required to comply—even those that are religiously affiliated.[19] Because the proposed rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances not receiving necessary care.

The proposed rule will make it harder for states and local governments to protect patients' health and safety, including their nondiscrimination laws.

The Department claims that its unwarranted new interpretations of federal law supersede laws passed by state and local governments to ensure patients' access to health care. By claiming to allow individuals and institutions to refuse care to patients based on the providers' religious or moral beliefs in such a sweeping way, however, the proposed rule creates conflicts with

[17] Reed L. Russell, *EEOC Office of Legal Counsel letter responding to a request for public comment from a federal agency or department* (2008), https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html

[18] 42 U.S.C. § 1295dd(a)-(c) (2003)

[19] In order to effectuate the law's important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. e.g. *Shelton v. University of Medicine and Dentistry of New Jersey ABC*, 223 F.3d 220, 228 (3rd Cir. 2000); *In the Matter of Baby "K"*, 16 F.3d 590, 597 (4th Cir. 1994); *Noesen 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).

hundreds of state and local nondiscrimination laws around the country that apply to health care. It therefore is disingenuous for HHS to claim that the proposed rule "does not impose substantial direct effects on States," "does not alter or have any substantial direct effects on the relationship between the Federal government and the States," and "does not implicate" federalism concerns under Executive Order 13132.

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 HHS 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.[20] 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.[21]

The proposed regulation lacks safeguards to protect patients from harmful refusals of care and violates the Establishment Clause.

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

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

Specifically, the Supreme Court has ruled that a religious accommodation "must be measured so that it does not override other significant interests,"[22] "impose unjustified burdens on others,"[23] or have a "detrimental effect on any third party."[24] But that is precisely what the proposed rule would do, transforming the shield of religious accommodation into a sword that would harm others, particularly patients who are dependent on receiving adequate medical care.

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[20] Rule at 3888-89

[21] Id.

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

[23] *Cutter,* 544 U.S. at 726; *Texas Monthly, Inc. v. Bullock,* 480 U.S. 1, 18n.8 (1989) (accommodations may not impose "substantial burdens" on others)

[24] *Burwell v. Hobby Lobby Stores, Inc.,* 134 S.Ct. 2751, 2781 n.37 (2014) (citing *Cutter,* 544 U.S. at 720)

Conclusion

The proposed rule goes far beyond established law, violates the Constitution, and most importantly will put the health and potentially even the lives of many patients across the country at risk. We urge you to withdraw the proposed rule.

Sincerely,

Marge Baker
Executive Vice President for Policy and Program
People For the American Way