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Protecting Statutory Conscience Rights in Health Care; Delegations of Authority

Comments of the Center for Inquiry

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

The Center for Inquiry¹ (CFI) is an educational and advocacy organization that exists to promote reason, science, freedom of inquiry, and humanist values. CFI encourages evidence based research into science, pseudoscience, medicine and health, religion, and ethics. CFI and its membership are committed to the preservation of the constitutionally required separation between church and state, and to working to ensure the equal treatment of non-believers in society.

CFI is fully committed to the preservation of freedom of religion, a core American value enshrined in the First Amendment to the Constitution. Freedom of religion necessarily and rightfully includes freedom from religion. An individual is free to believe or not believe as he or she sees fit, and the government cannot seek to alter that choice. Religious freedom has never in American history, however, included the right to impose those beliefs onto others, or to harm them by acting on those beliefs. In recent years, many have sought to turn religious freedom from this noble protection of matters at a core of an individual's conscience, a shield to protect against government overreach, into a weapon to permit individuals to force their religious beliefs and practices onto others. In the name of religious freedom, people have sought the legal right to be exempted from laws in all areas, and in particular from civil rights laws protecting disadvantaged and marginalized groups in society from discrimination.

This effort to weaponize the concept of religious freedom is in particular prevalent in the area of health care. CFI believes a health care provider's personal beliefs should never determine the care a patient receives. That is why we strongly oppose the Department of Health and Human

¹ <http://www.centerforinquiry.net>

Services’ (the “Department”) proposed rule (“Proposed Rule”), which seeks to permit discrimination in all aspects of health care.²

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

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

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

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

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

The Proposed Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion, contraceptive, and other reproductive health care, and transition-related care. Specifically, the Department and OCR are attempting to require a broad swath of entities to allow individuals to refuse “*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added).”³ Read in conjunction with the rest of the Proposed Rule, it is clear this is intended to allow any entity involved in a patient’s care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal religious beliefs to determine a patient’s access to care.

While the Proposed Rule claims to provide exemptions based on “religious beliefs or moral convictions,”⁴ it is evident that the driving force behind this is the privileging of religion. The non-religious represent a large and fast growing demographic in the United States. Recent surveys have placed the number of religiously non-affiliated (including atheists, agnostics, and

² 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].

³ *See id.* at 3882.

⁴ *Id.*

those answering ‘nothing in particular’) at almost 23% of the population.⁵ This number increased from only 16% in 2007, leaving the unaffiliated as “now second in size only to evangelical Protestants among major religious groups in the U.S.”⁶ Among younger Americans, the representation of the religiously unaffiliated is even higher. Among Older Millennials, those born between 1981 and 1989, 34% identify as religiously unaffiliated; Younger Millennials (born between 1990 and 1996) are 36% unaffiliated.⁷ The religiously unaffiliated community and the non-religious are not requesting these exemptions. Instead, it is religious groups, motivated by a religiously grounded opposition to reproductive health care and to LGBTQ rights, which are seeking them. CFI and other representatives of the secular, non-religious community oppose these exemptions on behalf of their memberships.

The Proposed Rule takes an individual’s personal religious beliefs, or the beliefs of the owners of a health care provider, and places them squarely above the health care needs of individuals. As these comments demonstrate, the individuals who will suffer most from this privileging of religion are those who are most vulnerable, and who comprise groups already disadvantaged and marginalized in society. Such privileging of religion is contrary to the government’s constitutionally mandated responsibility to ensure “neutrality between religion and religion, and between religion and non-religion.”⁸

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

Already existing refusal of care laws are used across the country to deny patients the care they need.⁹ The Proposed Rule attempts to expand these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in “any lawful health services or research activity” based on religious beliefs or moral convictions specifically related to the service or research activity to which they object.¹⁰ 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.¹¹ Such an attempted expansion

⁵ See 2014 Religious Landscape Study, *America’s Changing Religious Landscape*, PEW RESEARCH CENTER (2015), <http://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/>.

⁶ *Id.*

⁷ *Id.*

⁸ *Epperson v. Arkansas*, 393 U.S. 97, 104 (1968).

⁹ See, e.g., *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT’L WOMEN’S L. CTR. (2017), <https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/>; Catherine Weiss, et al., *Religious Refusals and Reproductive Rights*, AM. CIVIL LIBERTIES UNION (2002), <https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report>; Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1 (2018), <https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf>.

¹⁰ The Church Amendments, 42 U.S.C. § 300a-7 (2018).

¹¹ See Rule *supra* note 2, at 3925.

goes beyond what the statute enacted by Congress allows. Furthermore, the Proposed Rule would expansively apply other provisions of the Church Amendments to, among other things, individuals working under global health programs funded by the Department thereby allowing global health providers and entities to refuse individuals the care they need contrary to the very purpose of such programs.

Similarly, the Proposed Rule defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. For example, the definition of “assist in the performance” greatly expands the types of services that can be refused to include merely “making arrangements for the procedure” no matter how tangential.¹² This means individuals not “assisting in the performance” of a procedure within the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, can now assert a new right to refuse. The Proposed Rule’s definition of “referral” similarly goes beyond any understanding of the term, allowing refusals to provide any information, including location or funding, that could help an individual to get the care they need.¹³

Furthermore, the Proposed Rule’s new and unwarranted expanded definitions often exceed, or are not in accordance with, existing definitions contained within the statutes the Proposed Rule seeks to enforce. Specifically, under the Coats and Weldon Amendments “health care entity” is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.¹⁴ 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.¹⁵ Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but goes directly against congressional intent. By expressly defining the term “health care entity” Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert.¹⁶

When these impermissibly broad definitions are combined with the expansive interpretations of the underlying statutes, they work together to further expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, one way the Weldon Amendment is expanded under the Proposed Rule is through the definition of “discrimination.”¹⁷ In particular, the Proposed Rule defines “discrimination” against a health care entity broadly to include a number of activities, including denying a grant or employment as well as an unspecified catch-all phrase “any activity reasonably regarded as discrimination.”¹⁸ In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is

¹² *Id.* at 3923.

¹³ *Id.* at 3924.

¹⁴ 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).

¹⁵ See Rule *supra* note 2, at 3924.

¹⁶ The doctrine of expression unius est exclusion alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.

¹⁷ See Rule *supra* note 2, at 3923-24.

¹⁸ *Id.* at 3924.

nonsensical and inappropriate. Further such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion.

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

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

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.¹⁹ 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.²⁰ Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.²¹ In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.²² Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.²³ 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.²⁴

These examples make clear that the motivation for these refusals is religious. The Proposed Rule's use of language including "moral convictions"²⁵ should not mask the true purpose here. It is religious owned hospitals, and religious health care providers who seek to deny important health care to individuals. As noted *supra*, there is no support for this right to refuse within the secular community. It is based solely on the modern notion that holding religious beliefs entitles

¹⁹ See, e.g., *Refusals to Provide Health Care Threatens the Health and Lives of Patients Nationwide* *supra* note 9.

²⁰ 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>.

²¹ 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.

²² See Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 29 (2018), <https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf>.

²³ See *The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), <https://nwlc-ciw49tixgw5l1bab.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.

²⁴ See Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 27 (2018), <https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf>.

²⁵ See Rule *supra* note 2.

an individual to exemptions from the rules and laws governing all of society, regardless of whether a third party is harmed by the granting of such exemptions.

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

Refusals of care based on personal religious beliefs already make it difficult for many individuals to access health care and have real consequences for those denied the care they need because of a provider or hospital's religious beliefs. When women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location, refusals bar access to necessary care.²⁶ 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.²⁷ In rural areas there may be no other sources of health and life preserving medical care.²⁸ In developing countries where many health systems are weak, health care options and supplies are often unavailable.²⁹ When these individuals encounter refusals of care, they may have nowhere else to go.

This reality is especially troubling because individuals who already face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, new research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.³⁰ These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on a wide range of hospital matters, including reproductive health care and can keep providers from offering the standard of care.³¹ 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.³² The reach of this type of

²⁶ 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>.

²⁷ 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>.

²⁸ 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/>.

²⁹ See Nurith Aizenman, *Health Care Costs Push a Staggering Number of People into Extreme Poverty*, NPR (Dec. 14, 2017), <https://www.npr.org/sections/goatsandsoda/2017/12/14/569893722/health-care-costs-push-a-staggering-number-of-people-into-extreme-poverty>; *Tracking Universal Health Coverage: 2017 Global Monitoring Report*, WORLD HEALTH ORG. & THE WORLD BANK (2017), <http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf>.

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>.

³¹ See *id.* at 10-13.

³² 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/>.

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.³³

In addition, in many of the countries where the Department implements global AIDS programs, many of the patients served already face numerous barriers to care, including a broad and harmful refusal provision contained within the statute governing such programs.³⁴

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

By expanding refusals of care the Proposed Rule will exacerbate the barriers to health care services patients need. It is evident that the harm caused by this Proposed Rule will fall hardest on those most in need of care by allowing individuals and health care entities to use their personal religious beliefs to dictate patient care. The Department should remember, under Executive Order 13563, an agency may only propose regulations where it has made a reasoned determination that the benefits justify the costs and where the regulations are tailored “to impose the least burden on society.”³⁵ 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.³⁶

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.³⁷ Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.³⁸

³³ 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>.

³⁴ See *The Mexico City Policy: An Explainer*, KAISER FAMILY FOUND. (June 1, 2017), <https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/>.

³⁵ 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>.

³⁶ See Rule *supra* note 2, at 3901-23.

³⁷ 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).

³⁸ 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

While the Proposed Rule seeks to establish itself as defending “Religious Freedom,”³⁹ it is important to note that the Supreme Court has firmly established that the Free Exercise Clause of the First Amendment to the Constitution provides no right to exemptions from laws of general applicability, even if the motivation for a request for an exemption is based in religion, unless the law concerned is one which invidiously discriminates against religion.⁴⁰ What the Proposed Rule seeks to provide is not a defense of religious freedom, but, instead, the enshrining of religious privilege. The Proposed Rule does not protect the religious practices of those seeking to drink a hallucinogenic tea as a religious ritual,⁴¹ or the religious practices of a woman seeking to wear a head scarf while working at a clothes store.⁴² There the granting of a religious exemption did not inflict harm on a third party.⁴³ The defense of religious practices under the Proposed Rule is the ability of health care providers to use their religious practices to harm others. It seeks to grant to religious health care providers the ability to send away sick patients untreated simply because the religious beliefs of that provider view the patient as less deserving of care.

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.⁴⁴ For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling⁴⁵ and current regulations require that pregnant women receive “referral[s] upon request” for prenatal care and delivery, adoption, and/or pregnancy termination.⁴⁶ 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. The Proposed Rule creates uncertainty about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. Such actions are particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for low-income populations.⁴⁷ When it comes to Title X, the

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.

³⁹ *See, e.g.*, Rule *supra* note 2, at 3881 (“America’s Tradition of Conscience Protection, Religious Freedom, and the Right to be Free from Unlawful Discrimination.”)

⁴⁰ *See Employment Div. v. Smith*, 494 U.S. 872, 882 (1990).

⁴¹ *See Gonzales v. O Centro Espirita Beneficiente Uniao de Vegetal*, 546 U.S. 418, 423 (2006)

⁴² *See EEOC v. Abercrombie & Fitch Stores*, 575 U.S. ___, 135 S. Ct. 2028, 2033-34(2015).

⁴³ CFI notes that it believes all religious exemptions to generally applicable laws impermissibly privilege religion in violation of the Establishment Clause of the First Amendment. Those which impose burdens on third parties, however, are of even greater harm to society, and are also unconstitutional.

⁴⁴ *See* Rule *supra* note 2, at 3923-24. *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>.

⁴⁵ *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).

⁴⁶ *See* What Requirements Must be Met by a Family Planning Project?, 42 C.F.R. § 59.5(a)(5) (2000).

⁴⁷ *See* NFPRHA *supra* note 44.

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.⁴⁸

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

Existing refusals of care based on personal religious beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care. Hospital systems across the country use religious beliefs to prevent their employees from treating patients regardless of the professional, ethical, or moral convictions of these providers.⁴⁹ The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions, including foreign and international organizations, to bind the hands of providers and attempt to limit the types of care they can provide.

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making intended to help balance the power dynamics between health providers and patients and ensure patient-centered decision-making.⁵⁰ Informed consent requires providers disclose relevant and medically accurate information about treatment choices and alternatives so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.⁵¹ By allowing providers, including hospital and health care institutions, to refuse to provide patients with information, the Proposed Rule makes it impossible for patients to have full information regarding treatment options. While the Department claims the Proposed Rule improves communication between patients and providers, in truth it will deter open, honest conversations that are vital to ensuring that a patient can control their medical circumstances.⁵²

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore the standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.⁵³ Individuals seeking reproductive health care,

⁴⁸ See *id.*

⁴⁹ 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.

⁵⁰ See TOM BEAUCHAMP & JAMES CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (4th ed. 1994); CHARLES LIDZ ET AL., *INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY* (1984).

⁵¹ See *id.*

⁵² See Rule *supra* note 2, at 3917.

⁵³ 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:

regardless of their reasons for needing these services, should be treated with dignity and respect. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them.

In addition, the Proposed Rule ignores the many providers with deeply held moral convictions that affirmatively motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. Moreover, the Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.⁵⁴ No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion.

The Department is Abdicating its Responsibility to Patients

The Proposed Rule exceeds OCR's authority by abandoning OCR's mission to address health disparities and discrimination that harms patients.⁵⁵ Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only nonsensical but is affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce. They will place a significant and burdensome requirement on health care providers and impose unique challenges for those working in other countries by taking resources away from patient care without adding any benefit.

The Department, including OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.⁵⁶ If finalized, however, the Proposed Rule will represent a radical

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).

⁵⁴ See The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).

⁵⁵ *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.").

⁵⁶ 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

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.⁵⁷

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.⁵⁸ And these disparities do not occur in isolation. Black women, for example, are three to four times more likely than white women to die during or after childbirth.⁵⁹ Further, the disparity in maternal mortality is growing rather than decreasing,⁶⁰ which in part may be due to the reality that women have long been the subject of discrimination in health care and the resulting health disparities. For example, women's pain is routinely undertreated and often dismissed.⁶¹ And due to gender biases and disparities in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.⁶² Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.⁶³ Eight percent of lesbian, gay, bisexual,

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.

⁵⁷ 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>.

⁵⁸ 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>.

⁵⁹ 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>.

⁶⁰ See *id.*

⁶¹ See, e.g., Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001).

⁶² See, e.g., Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. OF THE AM. HEART ASS'N 1 (2015).

⁶³ See, e.g., *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf. A survey examining discrimination against LGBTQ people in health care more than half of respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care

and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.⁶⁴

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.⁶⁵

The Proposed Rule Conflicts with Other Existing Federal Law

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals to care it would create.

For example, the Proposed Rule makes no mention of Title VII,⁶⁶ the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.⁶⁷ 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.⁶⁸ 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.⁶⁹

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

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

⁶⁴ 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.

⁶⁵ See *supra* note 55.

⁶⁶ 42 U.S.C. § 2000e-2 (1964).

⁶⁷ *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>.

⁶⁸ See *id.*

⁶⁹ 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.

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.⁷⁰ Under EMTALA every hospital is required to comply – even those that are religiously affiliated.⁷¹ Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA’s requirements. This could result in patients in emergency circumstances not receiving necessary care.

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

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.⁷² 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.⁷³

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, privileges religious belief and religious groups, violates multiple federal statutes and the Constitution, ignores congressional intent, fosters confusion, and harms patients contrary to the Department’s stated

⁷⁰ 42 U.S.C. § 1295dd(a)-(c) (2003).

⁷¹ 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).

⁷² *See, e.g., Rule, Supra* note 2, at 3888-89.

⁷³ *See id.*

mission. For all of these reasons, CFI calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

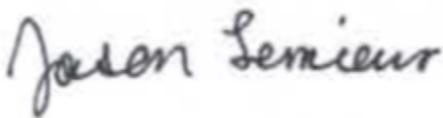
The Center for Inquiry

A handwritten signature in black ink, appearing to read "Robyn Blunner". The signature is fluid and cursive, with a long horizontal stroke at the end.

Robyn Blunner,
President and CEO, Center for Inquiry

A handwritten signature in black ink, appearing to read "Nicholas J. Little". The signature is stylized and cursive, with a prominent vertical stroke.

Nicholas J. Little,
Vice President and General Counsel, Legal Director, Center for Inquiry

A handwritten signature in black ink, appearing to read "Jason Lemieux". The signature is cursive and clearly legible.

Jason Lemieux
Director of Government Affairs, Center for Inquiry