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VIA ELECTRONIC SUBMISSION

U.S. Department of Health and Human Services, Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building, Room 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 or Docket HHS-OCR-2018-0002**

Dear Secretary Azar:

Thank you for the opportunity to comment on the Department of Health and Human Services' ("HHS") proposed rule, "Protecting Statutory Conscience Rights in Health Care" ("Proposed Rule"), published on January 26, 2018.¹ As a coalition dedicated to advancing women's and LGBTQ rights, The Alliance: State Advocates for Women's Rights & Gender Equality ("The Alliance") is committed to supporting all families and ensuring meaningful access to health care, especially as it relates to sexual and reproductive health and family planning.

The Proposed Rule would introduce broad and poorly defined language to the existing law that already provides ample protection for the ability of health care providers to refuse to participate in a health care service to which they have moral or religious objections. While the Proposed Rule purports to provide clarity and guidance in implementing existing federal religious exemptions, it instead creates ambiguity and confusion, as well as the potential for patient exposure to medical care that fails to comply with established medical practice guidelines, negating long-standing principles of informed consent, and undermining the ability of health facilities to provide care in an orderly and efficient manner. Importantly, the Proposed Rule fails to account for the significant burden that will be imposed on patients—a burden that is disproportionately experienced by women, people of color, immigrants, people living with disabilities, and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals. These communities already experience severe health disparities and discrimination which the Proposed Rule will exacerbate, leading to poorer health outcomes. By issuing the Proposed Rule along with the newly created "Conscience and Religious Freedom Division," HHS seeks to use the Office for Civil Rights' ("OCR") limited resources in order to affirmatively allow institutions, insurance companies, and almost anyone involved in patient care to use their personal beliefs to deny people the care they need.

We urge HHS to withdraw the Proposed Rule in its entirety. What follows are specific and general comments, organized by theme and accompanied by our rationale.

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].

I. The Proposed Rule seeks to deny medically necessary care.

The Proposed Rule, while cloaked in the language of non-discrimination, is designed to deny care and exclude disadvantaged and vulnerable patient populations. The adverse consequences of health care refusals and other forms of discrimination are well documented. As HHS stated in its proposed rulemaking for § 1557,

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

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

The federal government argues that robust religious refusals, as implemented by this Proposed Rule, will facilitate open and honest conversations between patients and physicians.³ As an outcome of this Proposed Rule, the government believes that patients, particularly those who are “minorities,” including those who identify as people of faith, will face fewer obstacles in accessing care.⁴ The Proposed Rule will not achieve these outcomes. Instead, it will increase barriers to care, harm patients by allowing health care professionals to ignore established medical guidelines, and undermine open communication between providers and patients. The harm caused by this Proposed Rule will fall hardest on those most in need of care.

II. Expanding religious refusals exacerbates the barriers to care that vulnerable communities already face.

Women, immigrants, individuals living with disabilities, LGBTQ individuals, people living in rural communities, and people of color face severe health and health care disparities, and these disparities are compounded for individuals who hold these multiple identities.⁵ For example, among adult women, 15.2 percent of those who identified as lesbian or gay reported being unable to obtain medical care in the last year due to cost, as compared to 9.6 percent of straight individuals.⁶ Women of color experience

² Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,194 (Sept. 8, 2015) (codified at 45 C.F.R. pt. 2).

³ 83 Fed. Reg. 3917.

⁴ *Id.*

⁵ See, e.g., Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), <http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx>; Sandy E. James et al., *The Report of the U.S. Transgender Survey 93–126* (2016), www.ustranssurvey.org/report; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), <http://www.lambdalegal.org/publications/when-health-care-isnt-caring>; Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2016), <https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care>.

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

health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.⁷ Meanwhile, people of color in rural America are more likely to live in an area with a shortage of health professionals, with 83% of majority-Black counties and 81% of majority-Latinx counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs). 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.⁸ These disparities exist across the board; Black women, for example, are three to four times more likely than white women to die during or after childbirth.⁹ Moreover, the disparity in maternal mortality is growing rather than decreasing,¹⁰ which in part may be due to the reality that women have long been subject to discrimination in health care settings. Women's pain is routinely undertreated and often dismissed¹¹ and due to gender biases and gaps in research, doctors often offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.¹² LGBTQ individuals also encounter high rates of discrimination in health care.¹³ Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a doctor or other health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity.¹⁴

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

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

⁸ See 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>.

⁹ 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-irving-story-explains-why>.

¹⁰ See *id.*

¹¹ 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).

¹² 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).

¹³ See, e.g., *When Health Care Isn't Caring*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf. A survey examining discrimination against LGBTQ people in health care more than half of respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health care status; or health care professionals being physically rough or abusive.

¹⁴ 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.

a. The Proposed Rule harms women.

Broadly-defined and widely-implemented refusal clauses undermine access to basic health services for all, but can particularly harm low-income women. The burdens on low-income women can be insurmountable when women and families are uninsured,¹⁵ underinsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services nor travel to another location. This is especially true for immigrant women. In comparison to their U.S. born peers, immigrant women are more likely to be uninsured.¹⁶ Notably, immigrant, Latinx women have far higher rates of uninsurance than Latinx women born in the United States (48 percent versus 21 percent, respectively).¹⁷ 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.¹⁸ Young Black women noted that they were shamed by providers when seeking sexual health information and contraceptive care in part, due to their age, and in some instances, sexual orientation.¹⁹

New research also shows that women of color in many states disproportionately receive their care at Catholic hospitals, subjecting them to treatment that does not comply with the standards of care.²⁰ In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.²¹ In New Jersey, for example, women of color make up 50 percent of women of reproductive age in the state, yet have twice the number of births at Catholic hospitals compared to their white counterparts.²² These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provides guidance on wide range of hospital matters, including reproductive health care. In practice, the ERDs prohibit the provision of emergency contraception, sterilization, abortion, fertility services, and some treatments for ectopic pregnancies. Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals and as a result, women were delayed care or transferred to other facilities, risking their health.²³ The Proposed Rule gives health care providers, such as Catholic hospitals, a license to opt

¹⁵ In 2016, an estimated 11 percent of women between the ages of 19 to 64 were uninsured. Single mothers, women of color, and low-income women are more likely to be uninsured. KAISER FAMILY FOUND., *Women's Health Insurance Coverage* 3 (Oct. 31, 2017), <http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage>.

¹⁶ Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, *CONTRACEPTION* 8 (2018), [http://www.contraceptionjournal.org/article/S0010-7824\(18\)30065-9/pdf](http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf).

¹⁷ *Id.* at 8, 16.

¹⁸ CTR. FOR REPROD. RIGHTS, NAT'L LATINA INST. FOR REPROD. HEALTH & SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter *Reproductive Injustice*]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, *The State of Black Women & Reproductive Justice* 32-33 (2017), available at http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

¹⁹ *Reproductive Injustice*, *supra* note 10, at 16-17. Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT (2018), available at <https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf>.

²⁰ Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT (2018), available at <https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf>.

²¹ *Id.* at 12.

²² *Id.* at 9.

²³ Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, *AM. J. PUB. HEALTH* (2008), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/>.

out of evidence-based care that the medical community endorses. This would place more women, particularly women of color, in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services. For many, this choice does not exist.

b. The Proposed Rule harms LGBTQ communities.

LGBTQ people continue to face discrimination in many areas of their lives, including health care, on the basis of their sexual orientation and gender identity. HHS' Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."²⁴ LGBTQ people face discrimination in a wide variety of services affecting access to health care, including reproductive services, adoption and foster care services, child care, homeless shelters, and transportation services – as well as physical and mental health care services.²⁵ In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.²⁶ They concluded that discrimination as well as insensitivity or disrespect on the part of health care providers were key barriers to health care access, and that increasing efforts to provide culturally sensitive services would help close the gaps in health care access.²⁷

Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.²⁸ Numerous federal courts

²⁴ *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health>, (last accessed on Mar. 8, 2018).

²⁵ HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), <https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people>.

²⁶ Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.

²⁷ *Id.*

²⁸ See, e.g., *EEOC v. R.G. & G.R. Harris Funeral Homes*, No. 16-2424 (6th Cir. Mar. 7, 2018); *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (Title IX and Equal Protection Clause); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *A.H. ex rel. Handling v. Minersville Area School District*, 3:17-CV-391, 2017 WL 5632662 (M.D. Pa. Nov. 22, 2017) (Title IX and Equal Protection Clause); *Stone v. Trump*, ---F.Supp.3d ---, No. 17-2459 (D. Md. Nov. 21, 2017) (Equal Protection Clause); *Doe v. Trump*, ---F.Supp.3d ---, 2017 WL 4873042 (D.D.C. Oct. 30, 2017) (Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, ---F.Supp.3d ---, 2017 WL 4310756 (S.D. Cal. Sept. 27, 2017) (Section 1557); *E.E.O.C. v. Rent-a-Center East, Inc.*, ---F.Supp.3d ---, 2017 WL 4021130 (C.D. Ill. Sept. 8, 2017) (Title VII); *Brown v. Dept. of Health and Hum. Serv.*, No. 8:16DCV569, 2017 WL 2414567 (D. Neb. June 2, 2017) (Equal Protection Clause); *Smith v. Avanti*, 249 F.Supp.3d 1194 (D. Colo. 2017) (Fair Housing Act); *Students & Parents for Privacy v. U.S. Dep't of Educ.*, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); *Mickens v. Gen. Elec. Co.* No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hosp. of Cent. Conn.*, 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. Jul. 5, 2016) (Section 1557); *Doe v. State of Ariz.*, No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016) (Title VII); *Dawson v. H&H Elec., Inc.*, No. 4:14CV00583 SWW, 2015 WL 5437101 (E.D. Ark. Sept. 15, 2015) (Title VII); *U.S. v. S.E. Okla. State Univ.*, No. CIV-15-324-C, 2015 WL 4606079 (W.D. Okla. 2015) (Title VII); *Rumble v. Fairview Health Serv.*, No. 14-cv-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (Section 1557); *Finkle v. Howard Cty.*, 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); *Lopez v. River Oaks Imaging & Diagnostic*

have found that federal sex discrimination statutes reach these forms of gender-based discrimination.²⁹ In Minnesota, Gender Justice brought one of the first cases to extend this to discrimination in health care under Section 1557.³⁰ In 2012, the Equal Employment Opportunity Commission (EEOC) likewise held that “intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII.”³¹

Yet, such discrimination in health care is rampant. Twenty-nine percent of transgender individuals were refused services by a health care provider on the basis of their perceived or actual gender identity and 29 percent experienced unwanted physical contact from a health care provider.³² Additionally, the 2015 U.S. Transgender Survey found that 23 percent respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.³³

The federal government's role in ending such discrimination cannot be understated. Data obtained by Center for American Progress (CAP) under a FOIA request indicates HHS' enforcement was effective in resolving issues of anti-LGBTQ discrimination. CAP received information on closed complaints of discrimination based on sexual orientation, sexual orientation-related sex stereotyping, and gender identity that were filed with HHS under Section 1557 of the ACA from 2012 through 2016.

- “In approximately 30% of these claims, patients alleged denial of care or insurance coverage simply because of their gender identity – not related to gender transition.”
- “Approximately 20% of the claims were for misgendering or other derogatory language.”
- “Patients denied care due to their gender identity or transgender status included a transgender woman denied a mammogram and a transgender man refused a screening for a urinary tract infection.”³⁴

The Proposed Rule would undermine the gains of Section 1557, and could allow religiously affiliated hospitals to not only refuse to provide transition related treatment for transgender people, but to also deny surgeons who otherwise have admitting privileges to provide transition related surgery in

Grp., Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); *Mitchell v. Axcan Scandipharm, Inc.*, No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); *Tronettiv. Healthnet Lakeshore Hosp.*, No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII).

²⁹ See, e.g., *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act). See also Statement of Interest of the United States at 14, *Jamal v. Saks*, No. 4:14-cv-02782 (S.D. Tex. Jan. 26, 2015).

³⁰ *Rumble v. Fairview Health Serv.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015).

³¹ *Macy v. Holder*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, *12 (Apr. 20, 2012).

³² Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AMERICAN PROGRESS, (Jan. 18, 2018),

https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

³³ NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey 5* (2016), available at <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf> [hereinafter 2015 U.S. Transgender Survey].

³⁴ Sharita Gruberg & Frank J. Bewkes, Center for American Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (March 7, 2018), available at <https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/>.

the hospital. Transition-related care is not only medically necessary, but for many transgender people it is lifesaving.

Religiously affiliated health care providers are also employers subject to Title VII. In Minnesota, Gender Justice obtained an EEOC determination that a health care provider with a health insurance plan that excluded transition-related care violated Title VII. Gender Justice has brought a lawsuit against this provider under Section 1557.³⁵ The Proposed Rule could create legal conflicts for health care providers that must continue to follow Title VII and Section 1557.

Lesbian, gay, and bisexual people also continue to face discrimination in health care. Fear of discrimination causes many LGB people to avoid seeking health care, and, when they do seek care, LGB people are frequently not treated with the respect that all patients deserve. The study "When Health Care Isn't Caring" found that 56 percent of LGB people reported experiencing discrimination from health care providers – including refusals of care, harsh language, or even physical abuse because of their sexual orientation.³⁶ Almost 10 percent of LGB respondents reported that they had been denied necessary health care expressly because of their sexual orientation.³⁷ Delay and avoidance of care due to fear of discrimination compound the significant health disparities that affect the lesbian, gay, and bisexual population. These disparities include:

- LGB individuals are more likely than their heterosexual peers to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities.³⁸
- Lesbian and bisexual women report poorer overall physical health than heterosexual women.³⁹
- Gay and bisexual men report more cancer diagnoses and lower survival rates, higher rates of cardiovascular disease and risk factors, as well as higher total numbers of acute and chronic health conditions.⁴⁰
- Gay and bisexual men and other men who have sex with men (MSM) accounted for more than half (56 percent) of all people living with HIV in the United States, and more than two-thirds (70 percent) of new HIV infections.⁴¹
- Bisexual people face significant health disparities, including increased risk of mental health issues and some types of cancer.⁴²

This discrimination affects not only the mental health and physical health of LGBTQ people, but that of their families as well. One pediatrician in Alabama reported that "we often see kids who haven't seen a pediatrician in 5, 6, 7 years, because of fear of being judged, on the part of either their immediate

³⁵ See *Hearing in Case to End Discrimination in Trans Health Coverage*, Gender Justice (March 23, 2018), <http://www.genderjustice.us/news/2018/3/23/tovarhearing>.

³⁶ LAMBDA LEGAL, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV 5* (2010), available at http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

³⁷ *Id.*

³⁸ David J. Lick, Laura E. Durso & Kerri L. Johnson, *Minority Stress and Physical Health Among Sexual Minorities*, 8 PERS. ON PSYCHOL. SCI. 521 (2013), available at <http://williamsinstitute.law.ucla.edu/research/health-and-hiv-aids/minority-stress-and-physical-health-among-sexual-minorities/>.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ CTRS FOR DISEASE CONTROL & PREVENTION, *CDC Fact Sheet: HIV Among Gay and Bisexual Men 1* (Feb. 2017), <https://www.cdc.gov/nchstp/newsroom/docs/factsheets/cdc-msm-508.pdf>.

⁴² HUMAN RIGHTS CAMPAIGN ET AL., *Health Disparities Among Bisexual People* (2015) available at <http://hrc-assets.s3-website-us-east-1.amazonaws.com/files/assets/resources/HRC-BiHealthBrief.pdf>.

family or them [identifying as LGBTQ]".⁴³ It is therefore crucial that LGBTQ individuals who have found unbiased and affirming providers, be allowed to remain with them. If turned away by a health care provider, 17 percent of all LGBTQ people, and 31 percent of LGBTQ people living outside of a metropolitan area, reported that it would be "very difficult" or "not possible" to find the same quality of service at a different community health center or clinic.⁴⁴

c. The Proposed Rule harms people living with disabilities.

Many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously-affiliated providers. Historically, people with disabilities who rely on these services have sometimes faced discrimination, exclusion, and a loss of autonomy due to provider objections. Group homes have, for example, refused to allow residents with intellectual disabilities who were married to live together in the group home.⁴⁵ Individuals with HIV – a recognized disability under the ADA – have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. One man with HIV was refused care by six nursing homes before his family was finally forced to relocate him to a nursing home 80 miles away.⁴⁶ Given these and other experiences, the Proposed Rule's extremely broad proposed language 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.

Many people with disabilities live or spend much of their day in provider-controlled settings where they often receive supports and services. They may rely on a case manager to coordinate necessary services, a transportation provider to get them to community appointments, or a personal care attendant to help them take medications and manage their daily activities. Under the Proposed Rule, any of these providers could believe they are entitled to object to providing a service covered under the regulation and not even tell the individual where they could obtain that service, how to find an alternative provider, or even whether the service is available to them.

A denial based on someone's personal moral objection will impact every facet of life for a person living with disabilities, including visitation rights, autonomy, and access to the community. Due to limited provider networks in some areas and to the important role that case managers and personal care attendants play in coordinating care, it may be more difficult for people with disabilities and older adults to find an alternate providers who can help them. For example, home care agencies and home-based hospice agencies in rural areas are facing significant financial difficulties staying open. Seven percent of all zip codes in the United States do not have any hospice services available to them.⁴⁷ Finding providers competent to treat people with certain disabilities can increase the challenge. Add in the

⁴³ HUMAN RIGHTS WATCH, *supra* note 28.

⁴⁴ Mirza, *supra* note 34.

⁴⁵ 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).

⁴⁶ 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.

⁴⁷ Julie A. Nelson & Barbara Stover Gingerich, *Rural Health: Access to Care and Services*, 22 HOME HEALTH CARE MGMT. PRAC. (2010), available at <http://globalag.igc.org/ruralaging/us/2010/access.pdf>.

possibility of a case manager or personal care attendant who objects to helping and the barrier to accessing these services can be insurmountable. Moreover, people with disabilities who identify as LGBTQ or who belong to a historically disadvantaged racial or ethnic group may be both more likely to encounter service refusals and also face greater challenges to accessing accommodations.

d. *The Proposed Rule harms people suffering from substance use disorders (SUD).*

Rather than promoting the evidence-based standard of care, the Proposed Rule would allow anyone from practitioners to insurers to refuse to provide, or even recommend, Medication Assisted Treatment (MAT) and other evidence-based interventions due simply to a personal objection.

According to the Centers for Disease Control and Prevention (CDC), over 63,000 people in the U.S. died from drug overdose in 2016.⁴⁸ The latest numbers show a 2017 increase in emergency department overdose admissions of 30% across the country, and up to 70% in some areas of the Midwest.⁴⁹ The clear, evidence-based treatment standard for opioid use disorder (OUD) is medication-assisted treatment (MAT).⁵⁰ Buprenorphine, methadone, and naltrexone are the three FDA-approved drugs for treating patients with opioid use disorder. MAT is so valuable to treatment of addiction that the World Health Organization considers buprenorphine and methadone "Essential Medications."⁵¹ Buprenorphine and methadone are, in fact, opioids. However, while they operate on the same receptors in the brain as other opioids, they do not produce the euphoric effect of other opioids but simply keep the user from experiencing withdrawal symptoms. They also keep patients from seeking opioids on the black market, where risk of death from accidental overdose increases. Patients on MAT are less likely to engage in dangerous or risky behaviors because their physical cravings are met by the medication, increasing their safety and the safety of their communities.⁵² Naloxone is another medication key to saving the lives of people experiencing an opioid overdose. This medication reverses the effects of an opioid and can completely stop an overdose in its tracks.⁵³ Information about and access to these medications are crucial factors in keeping patients suffering from SUD from losing their jobs, losing their families, and losing their lives.

The stigma associated with drug use hinders access to lifesaving care.⁵⁴ America's prevailing cultural consciousness, after decades of treating the disease of addiction as largely a criminal justice and not a public health issue, generally perceives drug use as a moral failing and drug users as less deserving

⁴⁸ Holly Hedegaard M.D., et al. *Drug Overdose Deaths in the United States, 1999-2016*, NAT'L CTR. FOR HEALTH STATISTICS 1-8 (2017).

⁴⁹ *Vital Signs*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vitalsigns/opioid-overdoses/>.

⁵⁰ U.S. DEP'T HEALTH & HUM. SERV., PUB NO. (SMA)12-4214, *MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS* (2012), <https://store.samhsa.gov/shin/content/SMA12-4214/SMA12-4214.pdf>; National Institute on Drug Abuse, *Effective Treatments for Opioid Addiction*, <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction>.

⁵¹ World Health Organization, 19th WHO Model List of Essential Medicines (April 2015), http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf

⁵² OPEN SOC'Y INST., *BARRIERS TO ACCESS: MEDICATION-ASSISTED TREATMENT AND INJECTION-DRIVEN HIV EPIDEMICS 1* (2009), <https://www.opensocietyfoundations.org> [<https://perma.cc/YF94-88AP>].

⁵³ See James M. Chamberlain & Bruce L. Klein, *A Comprehensive Review of Naloxone for the Emergency Physician*, 12 AM. J. EMERGENCY MED. 650 (1994).

⁵⁴ Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL'Y 49, 56 (2010); German Lopez, *There's a highly successful treatment for opioid addiction. But stigma is holding it back.*, Vox, Nov. 15, 2017, <https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone>.

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.⁵⁵ One commissioner even quoted the Bible as he voted to shut it down. Use of naloxone to reverse overdose has been decried as “enabling these people” to go on to overdose again.⁵⁶

In this frame of mind, only total abstinence is seen as successful treatment for SUD, usually as a result of a 12-step or faith-based program. MAT is considered by many to be simply “substituting one drug for another drug.”⁵⁷ This belief is so common that even the former Secretary of HHS is on the record as opposing MAT because he didn’t believe it would “move the dial,” since people on medication would be not “completely cured.”⁵⁸ The scientific consensus is that SUD is a chronic disease, and yet many recoil from the idea of treating SUD with medication like any other illness such as diabetes or heart disease.⁵⁹ 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.”⁶⁰

People with SUD already suffer due to stigma and have a difficult time finding appropriate care. For example, it can be difficult to find access to local methadone clinics in rural areas.⁶¹ Other roadblocks, such as artificial caps on the number of patients to whom doctors can prescribe buprenorphine, further prevent people with SUD from receiving appropriate care.⁶² Only one-third of treatment programs across the country provide MAT, even though treatment with MAT can cut overdose mortality rates in half and is considered the gold standard of care.⁶³ The current Secretary of HHS has noted that expanding access to MAT is necessary to save lives and that it will be “impossible” to quell the opioid epidemic without increasing the number of providers offering the evidence-based

⁵⁵ 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>.

⁵⁶ 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.

⁵⁷ Lopez, *supra* note 75.

⁵⁸ Eric Eyre, *Trump officials seek opioid solutions in WV*, CHARLESTON GAZETTE-MAIL, May 9, 2017, https://www.wvgazette.com/news/health/trump-officials-look-for-opioid-solutions-in-wv/article_52c417d8-16a5-59d5-8928-13ab073bc02b.html.

⁵⁹ Nora D. Volkow et al., *Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic*, 370 NEW ENG. J. MED. 2063, <http://www.nejm.org/doi/full/10.1056/NEJMp1402780>.

⁶⁰ 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

⁶¹ Christine Vestal, *In Opioid Epidemic, Prejudice Persists Against Methadone*, STATELINE, Nov. 11, 2016, <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/11/11/in-opioid-epidemic-prejudice-persists-against-methadone>

⁶² 42 C.F.R. §8.610.

⁶³ Matthais Pierce, et al., *Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England*, 111:2 ADDICTION 298 (Nov. 2015); Luis Sordo, et al., *Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies*, BMJ (2017), <http://www.bmj.com/content/357/bmj.j1550>.; Alex Azar, Secretary, U.S. Dep’t of Health & Hum. Serv., Plenary Address to National Governors Association, (Feb. 24, 2018), <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/plenary-address-to-national-governors-association.html>.

standard of care.⁶⁴ The Proposed Rule instead allows misinformation and personal beliefs to further obstruct access to lifesaving treatment.

III. The ability to refuse care to patients leaves many individuals with no health care options.

Across the country refusals of care based on personal beliefs have been invoked in countless ways to deny patients the care they need.⁶⁵ 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.⁶⁶ Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.⁶⁷ In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.⁶⁸ In Washington State, Legal Voice took on a case where a religiously affiliated hospital denied a transgender patient gender affirming surgery. 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.⁶⁹ 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.⁷⁰

Patients living in less densely populated, rural areas already face a myriad of barriers to care including less access to health insurance coverage, lower incomes, and lower rates of paid sick leave. This is in addition to the universal costs of transportation, taking time from work, and other incidentals that go along with obtaining care in the first place. For many, the sheer distance to a healthcare facility can be a significant barrier to getting care. For example, more than half of rural women live more than 30 minutes away from a hospital that provides basic obstetric care.⁷¹ 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 example, a 2015 survey of nearly 28,000

⁶⁴ Azar, *supra* note 84.

⁶⁵ See, e.g., *supra* note 3.

⁶⁶ 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>.

⁶⁷ 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.

⁶⁸ 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>.

⁶⁹ See *The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), <https://nwlrc-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.

⁷⁰ 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>.

⁷¹ 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>.

transgender adults nationwide found that respondents needed to travel much farther to seek care for gender dysphoria as for other kinds of care.⁷² This means if these patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In a recent study, nearly one in five LGBTQ people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBTQ communities living in rural areas, with 41% reporting it would be very difficult or impossible to find an alternative provider.⁷³ For these patients, being turned away by a medical provider is not just an inconvenience—it means being denied care entirely with nowhere else to go.

Medically underserved areas already exist in every state,⁷⁴ with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.⁷⁵ Many rural communities experience a wide array of mental health, dental health, and primary care health professional shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.⁷⁶ Among the many geographic and spatial barriers that exist, individuals in rural areas often must have a driver's license and own a private car to access care, as they must travel further distances for regular checkups, often on poorer quality roads, and have less access to reliable public transportation.⁷⁷ This scarcity of accessible services leaves survivors of intimate partner violence (IPV) in rural areas with fewer shelter beds close to their homes, with an average of just 3.3 IPV shelter beds per rural county as compared to 13.8 in urban counties.⁷⁸ Among respondents of one survey, more than 25 percent of survivors of IPV in rural areas have to travel over 40 miles to the nearest support service, compared to less than one percent of women in urban areas.⁷⁹ Other individuals in rural areas, such as people with disabilities, people with Hepatitis C, and people of color, have intersecting identities that further exacerbate existing barriers to care in rural areas. Racial and ethnic minority communities often live in concentrated parts of rural America, in communities experiencing rural poverty, lack of insurance, and health professional shortage areas.⁸⁰ People with disabilities experience difficulties finding competent physicians in rural areas who can provide experienced and specialized care for their specific needs, in buildings that are barrier free.⁸¹ Individuals with Hepatitis C infection find few providers in rural areas with the specialized knowledge to manage the emerging treatment options,

⁷² Sandy E. James et al., *The Report of the U.S. Transgender Survey* 99 (2016), www.ustranssurvey.org/report

⁷³ 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>.

⁷⁴ Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., <https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA>, (last visited Mar. 21, 2018).

⁷⁵ M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH (2010), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/>.

⁷⁶ Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations*, ECON. RESEARCH SERV. (2009), available at <https://www.ers.usda.gov/publications/pub-details/?pubid=44427>.

⁷⁷ Thomas A. Arcury et al., *The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region*, 40 HEALTH SERV. RESEARCH (2005) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361130/>.

⁷⁸ Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources*, 20 J. OF WOMEN'S HEALTH (Nov. 2011) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216064/>.

⁷⁹ *Id.*

⁸⁰ Janice C. Probst et al., *Person and Place: The Compounding Effects of Race/Ethnicity and Rurality on Health*, AM. J. PUB. HEALTH (2011), available at <http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1695>.

⁸¹ Lisa I. Iezzoni et al., *Rural Residents with Disabilities Confront Substantial Barriers to Obtaining Primary Care*, 41 HEALTH SERV. RESEARCH (2006), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1797079/>.

drug toxicities and side effects.⁸² All of these barriers will worsen if providers are allowed to refuse care to particular patients.

Meanwhile, immigrant, Latinx women and their families often face cultural and linguistic barriers to care, especially in rural areas.⁸³ These women often lack access to transportation and may have to travel great distances to get the care they need.⁸⁴ In rural areas, there may simply be no other sources of health and life preserving medical care. When these women encounter health care refusals, they have nowhere else to go.

IV. *The Proposed Rule's inappropriate expansion of religious exemptions may lead to dangerous denials of medically necessary treatments.*

The Proposed Rule claims to clarify current "religious refusal clauses" related to abortion and sterilization in three federal statutes, each of which 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 Proposed Rule, however, creates ambiguity about these limited circumstances, promoting an overly broad misinterpretation that extends beyond what the statutes permit. For example, section (d) of the 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." While longstanding legal interpretation singularly applies this section to participation in abortion and sterilization procedures, the Proposed Rule does not make this limitation clear. This ambiguity encourages an overly broad interpretation of the statute that empowers providers to refuse to provide *any* health care service or information for a religious or moral reason. This potentially includes not just sterilization and abortion procedures, but also Pre-Exposure Prophylaxis (PrEP), infertility care, treatments related to gender dysphoria, and HIV treatment, among other lifesaving services. This puts the health of the patient, and potentially that of others, at risk. 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.⁸⁵

Furthermore, by unlawfully redefining the statutory term "assisting in the performance" of a procedure, the Proposed Rule encourages health care workers to obstruct access to a health 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. The extension and broadening of this clause will impair patients' access to care services if interpreted to permit providers to choose patients based upon sexual orientation, gender identity, or family structure.

The Proposed Rule undermines both open communication between providers and patients and informed consent which is necessary to patient-centered decision-making. We are particularly

⁸² Sanjeev Arora et al., *Expanding access to hepatitis C virus treatment – Extension for Community Healthcare Outcomes (ECHO) Project: Disruptive Innovation in Specialty Care*, 52 HEPATOLOGY (2010), available at <http://onlinelibrary.wiley.com/doi/10.1002/hep.23802/full>.

⁸³ Michelle M. Casey et al., *Providing Health Care to Latino Immigrants: Community-Based Efforts in the Rural Midwest*, AM. J. PUB. HEALTH (2011), available at <http://ajph.aphapublications.org/doi/full/10.2105/AJPH.94.10.1709>.

⁸⁴ NAT'L LATINA INST. FOR REPROD. HEALTH & CTR. FOR REPROD. RIGHTS, NUESTRA VOZ, NUESTRA SALUD, NUESTRO TEXAS: THE FIGHT FOR WOMEN'S REPRODUCTIVE HEALTH IN THE RIO GRANDE VALLEY, 7 (2013), available at <http://www.nuestrotexas.org/pdf/NT-spread.pdf>.

⁸⁵ <https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/>

concerned that the Proposed Rule will be used to refuse medically necessary care to transgender patients. The Proposed Rule's extensive terms promotes the mistaken belief that treatments that have an incidental impact on fertility, such as some procedures used to treat gender dysphoria, are sterilization procedures. Treatments for serious medical conditions may have the incidental effect of causing or contributing to infertility; for example, a hysterectomy to treat gender dysphoria, chemotherapy to treat cancer, 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 an incidental effect on fertility, refusals will unlawfully include a dangerously broad range of medically needed treatments. Individuals seeking any kind of health care should be treated with dignity and respect, regardless of their reasons for needing these services. In order to ensure that patient decisions are based on free will, informed consent must be upheld in the patient-provider relationship. The Proposed Rule threatens this principle and may very well force individuals into harmful medical circumstances.

V. *The Proposed Rule lacks safeguards to protect patients from harmful refusals of care.*

The Proposed Rule does not limit exemptions in order to protect patients' rights under the law and ensure that they receive medically warranted treatment. Extensive religious accommodations need to be accompanied by equally extensive patient protections to safeguard medical needs and guarantee accurate information and quality health services. Under Executive Order 12866, when engaging in rulemaking, "each agency shall assess both the costs and the benefits of the intended regulation and, recognizing that some costs and benefits are difficult to quantify, propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify the costs."⁸⁶ 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."⁸⁷ The Proposed Rule fails on all counts; although the Proposed Rule attempts to quantify the costs of compliance, it 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.⁸⁸ Moreover, the Establishment Clause of the First Amendment requires the government to adequately account for these types of consequences when considering whether to grant religious exemptions and bars granting an exemption when it would detrimentally affect any third party.⁸⁹ Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.⁹⁰

⁸⁶ Executive Order 12866 on Regulatory Planning and Review (September 30, 1993).

⁸⁷ 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>.

⁸⁸ See Rule *supra* note 1, at 94-177.

⁸⁹ 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).

⁹⁰ 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 Proposed Rule also conflicts with many federal patient protections, profoundly undermining the federal government's ability to properly enforce federal laws. While patient protections are subject to religious exemptions provided under federal statute, they are not subject to exemptions that extend beyond federal law, including many of the exemptions expanded in the Proposed Rule. The Proposed Rule's lack of patient safeguards conflicts with the well-established standard under Title VII of the Civil Rights Act which ensures that employers can consider the effect that providing a religious accommodation would have on coworkers, customers, and patients, as well as factors including public safety and public health.⁹¹ The Proposed Rule allows for none of these considerations, instead requiring automatic exemptions. 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.⁹² Under EMTALA, all hospitals are required to comply, regardless of religious affiliation.⁹³ 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 also undermines Title X as it allows health care entities to receive grants and contracts while refusing to provide key services required by those programs.⁹⁴ Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling⁹⁵ and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination.⁹⁶ Under the Proposed Rule, HHS allows entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties these funds are generally conditioned upon.⁹⁷ Every year millions of low-income, under-insured, and uninsured individuals rely on Title X clinics to access services they otherwise might not be able to afford.⁹⁸ At best, the Proposed Rule creates confusion and at worst, it promotes dangerous discrimination.

Medical practice guidelines and standards of care establish the boundaries of medical care that patients can expect to receive and that providers should be expected to deliver. The health services

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.

⁹¹ *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>.

⁹² 42 U.S.C. § 1295dd(a)-(c) (2003).

⁹³ 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).

⁹⁴ *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>.

⁹⁵ *See, e.g., Consolidated Appropriations Act of 2017*, Pub. L. No. 115-31, 131 Stat. 135 (2017).

⁹⁶ *See What Requirements Must be Met by a Family Planning Project?*, 42 C.F.R. § 59.5(a)(5) (2000).

⁹⁷ *See, e.g., Rule supra* note 1, at 180-185.

⁹⁸ *See id.*

impacted by refusals are often related to reproductive and sexual health, which are implicated in a wide range of common health treatment and prevention strategies. Information, counseling, referral and provisions of contraceptive and abortion services are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer. Many of these conditions disproportionately affect women of color.⁹⁹ The expansion of these refusals as outlined in the Proposed Rule puts women, particularly women of color, who experience these medical conditions at greater risk for harm.

a. Pregnancy prevention

The importance of the ability of women to make decisions for themselves to prevent or postpone pregnancy is well-established within the medical guidelines across a range of practice areas. Millions of women live with chronic conditions such as cardiovascular disease, diabetes, lupus, and epilepsy, which if not properly controlled, can lead to health risks to the pregnant woman or even death during pregnancy. Denying these women access to contraceptive information and services violates medical standards that recommend pregnancy prevention for these medical conditions. For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care.¹⁰⁰ Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until they are ready to become pregnant.¹⁰¹

Moreover, women who are struggling to make ends meet are disproportionately impacted by unintended pregnancy. In 2011, 45% of pregnancies in the U.S. were unintended – meaning that they were either unwanted or mistimed.¹⁰² Low-income women have higher rates of unintended pregnancy as they are least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy.¹⁰³ The Institute of Medicine has documented negative health effects of unwanted pregnancy for mothers and children. Unwanted

⁹⁹ For example, Black women are three times more likely to be diagnosed with lupus than white women. Latinx and Asian, Native American, and Alaskan Native women also are likely to be diagnosed with lupus. Office on Women's Health, *Lupus and women*, U.S. DEP'T HEALTH & HUM. SERV. (May 25, 2017), <https://www.womenshealth.gov/lupus/lupus-and-women>. Black and Latinx women are more likely to experience higher rates of diabetes than their white peers. Office of Minority Health, *Diabetes and African Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Jul. 13, 2016), <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18>; Office of Minority Health, *Diabetes and Hispanic Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (May 11, 2016), <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63>. Filipino adults are more likely to be obese in comparison to the overall Asian population in the United States. Office of Minority Health, *Obesity and Asian Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Aug. 25, 2017), <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=55>. Native American and Alaskan Native women are more likely to be diagnosed with liver and kidney/renal pelvis cancer in comparison to non-Hispanic white women. Office of Minority Health, *Cancer and American Indians/Alaska Natives*, U.S. DEP'T OF HEALTH & HUM. SERV. (Nov. 3, 2016), <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=31>.

¹⁰⁰ AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE S115, S117 (2017), available at: http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf

¹⁰¹ *Id.* at S114.

¹⁰² *Unintended Pregnancy in the United States*, Guttmacher Inst. (Sept. 2016), <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>.

¹⁰³ Lawrence B. Finer & Stanley K. Henshaw, *Disparities in rates of unintended pregnancy in the United States, 1994 and 2001*, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90-6 (2006).

pregnancy is associated with maternal morbidity and risky health behaviors as well as low-birth weight babies and insufficient prenatal care.¹⁰⁴

b. Sexually transmitted infections (STIs)

Religious refusals also impact access to sexual health care more broadly. Contraceptives and access to preventative treatment for sexually transmitted infections are a critical aspect of health care. The CDC estimates that 20 million new sexually transmitted infections occur each year. Chlamydia remains the most commonly reported infectious disease in the U.S., while HIV/AIDS remains the most life threatening. Women, especially young women, and Black women, are hit hardest by Chlamydia — with rates of Chlamydia 5.6 times higher for Black than for white Americans.¹⁰⁵ Consistent use of condoms results in an 80 percent reduction of HIV transmission, and the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the World Health Organization all recommend the condom use be promoted by providers.¹⁰⁶

c. Ending a Pregnancy

While there are numerous reasons for why a person would seek to end a pregnancy, there are many medical conditions in which ending a pregnancy is recommended as treatment. These conditions include: preeclampsia and eclampsia, certain forms of cardiovascular disease, and complications for chronic conditions. Significant racial disparities exist in rates of and complications associated with preeclampsia.¹⁰⁷ For example, the rate of preeclampsia is 61% higher for Black women than for white women, and 50% higher than women overall.¹⁰⁸ 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.¹⁰⁹ ACOG and American Heart Association recommend

¹⁰⁴ INSTITUTE OF MEDICINE COMMITTEE ON UNINTENDED PREGNANCY, *THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES* (Sarah S. Brown & Leon Eisenberg eds., 1995).

¹⁰⁵ *Sexually Transmitted Disease Surveillance 2016*, CTR. FOR DISEASE CONTROL & PREVENTION (Sept. 2017), https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf.

¹⁰⁶ American Academy of Pediatrics Committee on Adolescence, *Condom Use by Adolescents*, 132 PEDIATRICS (Nov. 2013), <http://pediatrics.aappublications.org/content/132/5/973>; American Academy of Pediatrics, American College of Obstetricians and Gynecologists, March of Dimes Birth Defects Foundation. *Guidelines for perinatal care*. 6th ed. Elk Grove Village, IL; Washington, DC: American Academy of Pediatrics; American College of Obstetricians and Gynecologists; 2007; American College of Obstetricians and Gynecologists. *Barrier methods of contraception*. Brochure (available at http://www.acog.org/publications/patient_education/bp022.cfm). Washington, DC: American College of Obstetricians and Gynecologists; 2008 July; World Health Organization, UNAIDS, UNFPA, *Position statement on condoms and HIV prevention*, UNICEF (2009), https://www.unicef.org/aids/files/2009_position_paper_condoms_en.pdf.

¹⁰⁷ Sajid Shahul et al., *Racial Disparities in Comorbidities, Complication, and Maternal and Fetal Outcomes in Women With Preeclampsia/eclampsia*, 34 HYPERTENSION PREGNANCY (Dec. 4, 2015), <http://www.tandfonline.com/doi/abs/10.3109/10641955.2015.1090581?journalCode=ihp20>.

¹⁰⁸ Richard Franki, *Preeclampsia/eclampsia rate highest in black women*, OB.GYN. NEWS (Apr. 29., 2017), <http://www.mdedge.com/obgynnews/article/136887/obstetrics/preeclampsia/eclampsia-rate-highest-black-women>.

¹⁰⁹ AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *GUIDELINES FOR PERINATAL CARE* 232 (7th ed. 2012).

that a pregnancy be avoided or ended for certain conditions such as severe pulmonary hypertension.¹¹⁰ Many medications can cause significant fetal impairments, and therefore the Federal Food and Drug Administration and professional medical associations recommend that women use contraceptives to ensure that they do not become pregnant while taking these medications.¹¹¹ In addition, some medical guidelines counsel patients to end a pregnancy if they are taking certain medications for thyroid disease.¹¹²

d. Emergency contraception

The Proposed Rule will magnify the harm in circumstances where women are already denied the standard of care. A 2005 study of Catholic hospital emergency rooms by Ibis Reproductive Health for Catholics for Choice found 55 percent would not dispense emergency contraception under any circumstances.¹¹³ These hospitals violated the standards of care established by medical providers regarding treatment of sexual assault. Medical guidelines state that survivors of sexual assault should be provided emergency contraception subject to informed consent and that it should be immediately available where survivors are treated.¹¹⁴ At the bare minimum, survivors should be given comprehensive information regarding emergency contraception.¹¹⁵

e. Artificial Reproductive Technology (ART)

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

¹¹⁰ Mary M. Canobbio et al., *Management of Pregnancy in Patients With Complex Congenital Heart Disease*, 135 CIRCULATION e1-e39 (2017); Debabrata Mukherjee, *Pregnancy in Patients With Complex Congenital Heart Disease*, AM. COLL. CARDIOLOGY (Jan. 24, 2017), <http://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/01/24/14/40/management-of-pregnancy-in-patients-with-complex-chd>.

¹¹¹ ELEANOR BIMLA SCHWARZ M.D. M.S., et al., *Documentation of Contraception and Pregnancy When Prescribing Potentially Teratogenic Medications for Reproductive-Age Women*, 147 Annals of Internal Medicine. (Sept. 18, 2007).

¹¹² For example, the American College of Obstetricians and Gynecologists specifically recommends that if a woman taking Iodine 131 becomes pregnant, their physician should caution them to consider the serious risks to the fetus, and consider termination. American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 37: Thyroid disease in pregnancy* 100 OBSTETRICS & GYNECOLOGY 387-96 (2002).

¹¹³ Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 ANNALS EMERGENCY MED. 105-10 (Aug. 2005), [http://www.annemergmed.com/article/S0196-0644\(05\)00083-1/pdf](http://www.annemergmed.com/article/S0196-0644(05)00083-1/pdf)

¹¹⁴ *Committee Opinion 592: Sexual Assault*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Apr. 2014), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co592.pdf?dmc=1&ts=20170213T2116487879>; *Management of the Patient with the Complaint of Sexual Assault*, AM. COLL. EMERGENCY MED. (Apr. 2014), <https://www.acep.org/Clinical---Practice-Management/Management-of-the-Patient-with-the-Complaint-of-Sexual-Assault/#sm.00000bexmo6ofmepmultb97nfbh3r>.

¹¹⁵ *Access to Emergency Contraception H-75.985*, AMA (2014), <https://policysearch.ama-assn.org/policyfinder/detail/emergency%20contraception%20sexual%20assault?uri=%2FAMADoc%2FHOD.xml-0-5214.xml>.

Nursing Society.¹¹⁶ Refusals to educate patients about or to provide ART occur for two reasons: refusal based on religious beliefs about ART itself and refusals to provide ART to LGBTQ individuals because of their LGBTQ identity. In both situations, refusals to educate patients about ART and fertility preservation, and to facilitate ART when requested, are against the standard of care.

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

f. HIV Health

For HIV, in addition to consistent condom use, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are an important part of prevention for those at high risk for contracting HIV. The American College of Obstetricians and Gynecologists recommends that PrEP be considered for individuals at high risk of contracting HIV.¹¹⁷ Under the Proposed Rule, an insurance company could refuse to cover PrEP or PEP because of a religious belief. Refusals to promote and facilitate condom use because of religious beliefs and refusals to prescribe PrEP or PEP because of a patient's perceived or actual sexual orientation, gender identity, or perceived or actual sexual behaviors is in violation of the standards of care and harms patients already at risk for experiencing health disparities. Both PrEP and PEP have been shown to be highly effective in preventing HIV infection. Denying access to this treatment would adversely impact vulnerable, highest risk populations including gay and bisexual men.

VI. The Proposed Rule hinders state efforts to protect patients' health and safety.

HHS claims that its new interpretations of federal law supersede laws passed by state and local governments to ensure patients' access to health care. The preamble of the Proposed Rule discusses 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.¹¹⁸ The Proposed Rule also 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.¹¹⁹ By allowing providers to broadly refuse care to patients based on their religious or moral beliefs, the Proposed Rule creates

¹¹⁶ Alison W. Loren et al., *Fertility Preservation for Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500-10 (July 1, 2013); Ethics Committee of the American Society for Reproductive Medicine, *Fertility preservation and reproduction in patients facing gonadotoxic therapies: a committee opinion*, 100 AM. SOC'Y REPROD. MED. 1224-31 (Nov. 2013), http://www.allianceforfertilitypreservation.org/_assets/pdf/ASRMGuidelines2014.pdf; Joanne Frankel Kelvin, *Fertility Preservation Before Cancer Treatment: Options, Strategies, and Resources*, 20 CLINICAL J. ONCOLOGY NURSING 44-51 (Feb. 2016).

¹¹⁷ ACOG Committee Opinion 595: *Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (May 2014), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Preexposure-Prophylaxis-for-the-Prevention-of-Human-Immunodeficiency-Virus>.

¹¹⁸ See, e.g., Rule, *Supra* note 1, at 3888-89.

¹¹⁹ See *id.*

conflicts with hundreds of state and local nondiscrimination laws around the country that apply to health care. It further hinders the enforcement of and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. This directly contradicts HHS' 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.

VII. HHS' rulemaking process failed to follow required procedures.

Although agencies have general authority to engage in rulemaking, that authority is not without limits. Under the Administrative Procedure Act, "agency action, findings, and conclusions found to be... arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," "contrary to a constitutional right," or "in excess of statutory jurisdiction, authority, or limitations" shall be held unlawful and set aside.¹²⁰ An agency must provide "adequate reasons" for its rulemaking, in part by "examin[ing] the relevant data and articulat[ing] a satisfactory explanation for its action including a rational connection between the fact found and the choice made."¹²¹ Additionally, an agency can only change an existing policy if it provides a "reasoned explanation" for disregarding or overriding the basis for the prior policy.¹²² HHS failed to provide "adequate reasons" or a "satisfactory explanation" for this rulemaking based on the underlying facts and data; between 2008 and November 2016, the Office of Civil Rights ("OCR") received 10 complaints alleging violations of federal religious refusal laws; an additional 34 similar complaints were received between November 2016 and January 2018. By comparison, from fall 2016 to fall 2017, OCR received over 30,000 complaints alleging either civil rights or HIPAA violations. These numbers demonstrate that rulemaking to enhance enforcement authority over religious refusal laws is not warranted. The Proposed Rule is arbitrary and capricious and should be completely withdrawn.

VIII. Conclusion

The Proposed Rule is a radical departure from HHS' mission to combat discrimination, protect patient access to care, and eliminate health disparities. We urge HHS to withdraw the Proposed Rule which poses tangible harm to millions of people who need meaningful access to health care.

Sincerely,

The Alliance: State Advocates for Women's Rights & Gender Equality

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¹²⁰ 5 U.S.C. § 706(2)(A), (B), (C).

¹²¹ *Encino Motorcars, LLC v. Navarro*, 136 S.Ct. 2117, 2125 (June 20, 2016) (citing *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 103 (1983)).

¹²² *Id.* at 2125-26.

* **The California Women's Law Center** ("CWLC") is a statewide, nonprofit law and policy center advocating for justice for women and girls through impact litigation, policy advocacy and education. CWLC's priorities include reproductive justice, gender discrimination, violence against women, and women's health. Since its inception in 1989, CWLC has fought for unburdened and equal access to reproductive health choices for all women.

***The Southwest Women's Law Center** is a non-profit policy and advocacy Law Center founded in 2005 to advance opportunities for women and girls in the State of New Mexico. We work to ensure that women have equal access to quality, affordable healthcare, including reproductive services and information. Our work strongly supports protections for individuals without regard to sexual orientation as we advocate to eliminate stereotypes and biases that women and LGBTB individuals often face.

*Based in Minnesota, **Gender Justice** serves the upper Midwest through strategic and impact litigation, policy advocacy, and public education to address the causes and consequences of gender inequality. Gender Justice expands the rights and access to justice for women, LGBTQ people, and all people who experience barriers based on gender bias and stereotypes

* **Legal Voice** is a non-profit public interest organization that works in the Pacific Northwest to advance the legal rights of women and LGBTQ people through public impact litigation, legislation, and legal rights education. Since its founding in 1978 as the Northwest Women's Law Center, Legal Voice has sought to ensure that women and LGBTQ people's rights to self-determination, access to health care, and freedom from both discrimination and violence are a reality.

* **The Women's Law Project** (WLP) is a Pennsylvania-based nonprofit women's legal advocacy organization providing legal representation, policy advocacy, and public education on a wide range of legal issues related to women's health, well-being, and equality. Grounded in the perspective that equality for women and girls cannot be achieved without reproductive freedom, which includes equal access to the full range of reproductive healthcare, WLP has been working to protect and advance reproductive rights in Pennsylvania since it opened in 1974.