

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 MICHAEL NEWMAN, State Bar No. 222993  
 Senior Assistant Attorney General  
 3 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 4 NELI N. PALMA, State Bar No. 203374  
 KARLI EISENBERG, State Bar No. 281923  
 5 STEPHANIE YU, State Bar No. 294405  
 Deputy Attorneys General  
 6 1300 I Street, Suite 125  
 P.O. Box 944255  
 7 Sacramento, CA 94244-2550  
 Telephone: (916) 445-2482  
 8 Fax: (916) 322-8288  
 E-mail: Neli.Palma@doj.ca.gov  
 9 *Attorneys for Plaintiff State of California, by and  
 through Attorney General Xavier Becerra*

10 IN THE UNITED STATES DISTRICT COURT  
 11 FOR THE NORTHERN DISTRICT OF CALIFORNIA

12  
 13  
 14  
 15 **STATE OF CALIFORNIA, BY AND THROUGH  
 ATTORNEY GENERAL XAVIER BECERRA,**

16 Plaintiff,

17 v.

18  
 19 **ALEX M. AZAR, IN HIS OFFICIAL CAPACITY  
 AS SECRETARY OF THE U.S. DEPARTMENT OF  
 20 HEALTH & HUMAN SERVICES; U.S.  
 DEPARTMENT OF HEALTH AND  
 21 HUMAN SERVICES; DOES 1-100,**

22 Defendants.

CASE NO. 4:19-cv-02769-HSG

**CALIFORNIA’S NOTICE OF MOTION  
 AND MOTION FOR PRELIMINARY  
 INJUNCTION, WITH MEMORANDUM  
 OF POINTS AND AUTHORITIES**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S.  
 Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

1 **TO THE DEFENDANTS, AND THEIR COUNSELS OF RECORD:**

2 **PLEASE TAKE NOTICE** that on October 10, 2019 at 2:00 p.m., in Courtroom 2 of the  
3 above-entitled court, located at 1301 Clay Street, Oakland, California, Plaintiff the State of  
4 California will and hereby does move this Court, under Local Rule 7-2, for a preliminary  
5 injunction staying implementation of the final rule, “Protecting Statutory Conscience Rights in  
6 Health Care; Delegations of Authority,” 84 Fed. Reg. 23170 (May 21, 2019) (to be codified at 45  
7 C.F.R. pt. 88).<sup>1</sup>

8 Because the Rule violates the Administrative Procedure Act (APA), as well as the Spending  
9 Clause and the Establishment Clause of the First Amendment to the U.S. Constitution, and will  
10 cause irreparable harm, the State seeks a preliminary injunction enjoining enforcement and  
11 implementation of the Final Rule or an order of postponement of the effective date of the Final  
12 Rule pursuant to 5 U.S.C. § 706(2) pending judicial review against Defendants Alex M. Azar, in  
13 his official capacity as Secretary of the U.S. Department of Health and Human Services, and the  
14 U.S. Department of Health and Human Services (HHS) (collectively, Defendants).

15 This motion is based on this notice, the Memorandum of Points and Authorities, the  
16 Declarations of Dr. David H. Aizuss (California Medical Association); Mari Cantwell  
17 (Department of Health Care Services); Pete Cervinka (California Department of Social Services);  
18 Mark Ghaly (California Health and Human Services Agency); Dr. Jeanne Harris-Caldwell  
19 (Health Services Association, California Community Colleges), Bruce Hinze (California  
20 Department of Insurance); Kevin Kish (Department of Fair Employment and Housing);  
21 Commissioner Ricardo Lara (California Department of Insurance); Dr. Joseph Morris (Board of  
22 Registered Nursing); Brandon Nunes (California Department of Public Health); Neli N. Palma  
23 (Attorney General’s Office); Frances Parmelee (California Community Colleges); Denise Pines  
24 (Medical Board of California) Stirling Price (California Department of State Hospitals); Jay  
25 Sturges (California Labor and Workforce Development Agency); Diane Toche (Health Care  
26 Services, California Department of Corrections and Rehabilitation); and Christopher M. Zahn

27  
28 <sup>1</sup> Available at <https://www.govinfo.gov/content/pkg/FR-2019-05-21/pdf/2019-09667.pdf>.



1 (American College of Obstetricians and Gynecologists), this Court's file, and any matters  
2 properly before the Court.

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

**TABLE OF CONTENTS**

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

	<b>Page</b>
INTRODUCTION .....	1
LEGAL AND FACTUAL BACKGROUND .....	2
I.    Regulatory Background .....	2
A.    2008 Executive Action.....	2
B.    2010-2018 Executive Actions.....	3
C.    2018 and 2019 Executive Action.....	3
II.   California Laws Balance Guaranteeing Access to Healthcare While Protecting Conscience.....	6
III.  California’s Sovereignty and Federal Funds Are Targeted By The Rule .....	7
IV.  The California Funding and Programs at Risk Under the Rule .....	9
LEGAL STANDARD.....	11
ARGUMENT.....	12
I.    California Is Likely to Succeed on the Merits .....	12
A.    The Rule Is Invalid Under the APA.....	12
1.    The Rule Is in Excess of Statutory Jurisdiction .....	12
2.    The Rule Is Contrary to Several Federal Statutes .....	14
a.    The Rule Conflicts with Section 1554 of the ACA .....	14
b.    The Rule Violates the ACA’s Nondiscrimination Provision .....	15
c.    The Rule Violates EMTALA.....	16
B.    The Rule Is Arbitrary and Capricious and Thus Invalid Under the APA.....	18
1.    Defendants Failed to Reasonably Explain Their Policy Reversal.....	18
2.    The Rule’s Stance on Title VII is Illogical in its Own Terms .....	21
3.    Defendants Failed to Meaningfully Respond to Comments Concerning the Rule’s Impacts .....	23
a.    Defendants Concede, but Dismiss, Harm to Rural Communities .....	24
b.    Defendants’ Dismissal of the Harm to the LGBTQ Community Does not Withstand Scrutiny .....	25
C.    The Rule Violates the Spending Clause.....	26
1.    The Rule is Unconstitutionally Coercive .....	26
2.    The Rule Is Unconstitutionally Ambiguous.....	27
3.    The Rule Places Conditions on Funding Already Accepted.....	29
4.    The Rule Places Conditions on Funding that is Unrelated to Protection of Conscience Objections .....	31

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

**TABLE OF CONTENTS**

(continued)

	<b>Page</b>
D. The Rule Violates the Establishment Clause .....	32
II. Absent an Injunction, California Will Suffer Irreparable Harm .....	33
A. Decreased Access to Healthcare and Disproportionate Impact on Vulnerable Communities .....	34
B. Consumer Confusion Resulting From Denials .....	35
C. Healthcare Industry Confusion and Unworkability .....	36
D. Public Harms If Federal Funding to Public Programs is Terminated .....	37
E. Immediate Economic Harm to the State .....	40
IV. The Balance of Equities and the Public Interest Favor Issuing an Injunction to Preserve the Status Quo .....	42
III. The Court Should Postpone the Effective Date of the Regulation Pending Judicial Review or Issue a Nationwide Injunction.....	42
CONCLUSION .....	43

**TABLE OF AUTHORITIES**

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

**Page**

**CASES**

*Allied Local & Reg'l Mfrs. Caucus v. EPA*  
215 F.3d 61 (D.C. Cir. 2000) .....23

*Am. Bar Ass'n v. U.S. Dep't of Educ.*  
370 F. Supp. 3d 1 (D.D.C. 2019) .....12

*Am. Fed'n of Gov't Employees, Local 2924 v. Fed. Labor Relations Auth.*  
470 F.3d 375 (2006) .....21

*Am. Trucking Ass'ns, Inc. v. City of Los Angeles*  
559 F.3d 1046 (9th Cir. 2009).....39

*Ansonia Bd. of Educ. v. Philbrook*  
479 U.S. 60 (1986) .....22, 33

*Arc of Cal. v. Douglas*  
757 F.3d 975 (9th Cir. 2014).....11, 42

*Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*  
548 U.S. 291 (2006) .....28

*Bresgal v. Brock*  
843 F.2d 1163 (9th Cir. 1987).....43

*Bruff v. N. Miss. Health Servs., Inc.*  
244 F.3d 495 (5th Cir. 2001).....21

*Burwell v. Hobby Lobby Stores, Inc.*  
573 U.S. 682 (2014) .....33

*California v. Azar*  
No. 19-cv-01184-EMC, 2019 WL 1877392 (N.D. Cal. Apr. 26, 2019) ..... *passim*

*California v. Azar*  
911 F.3d 558 (9th Cir. 2018).....42, 43

*California v. United States*  
No. C 05-00328, 2008 WL 744840 (N.D. Cal. Mar. 18, 2008) .....17

*Catholic League for Religious & Civil Rights v. City & Cty. of S.F.*  
624 F.3d 1043 (9th Cir. 2010) (en banc).....32

*Cent. United Life Ins. Co. v. Burwell*  
827 F.3d 70 (D.C. Cir. 2016) .....13

**TABLE OF AUTHORITIES**

(continued)

	<u>Page</u>
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	
26	
27	
28	

<i>City &amp; Cnty. of San Francisco v. Trump</i> 897 F.3d 1225 (9th Cir. 2018).....	40
<i>City &amp; Cnty. of San Francisco v. Sessions</i> No. 18-cv-05146-WHO, 2019 WL 1024404 (N.D. Cal. Mar. 4, 2019).....	29
<i>City of Portland, v. EPA</i> 507 F.3d 706 (D.C. Cir. 2007) .....	23
<i>Clovis Unified Sch. Dist. v. Cal. Office of Admin. Hr'g</i> 903 F.2d 635 (9th Cir. 1990).....	29
<i>Corp. of Presiding Bishop of Church of Jesus Christ of Latter-day Saints v. Amos</i> 483 U.S. 327 (1987).....	32
<i>Ctr. for Biological Diversity v. U.S. Bureau of Land Mgmt.</i> 698 F.3d 1101 (9th Cir. 2012).....	25
<i>Cty. of Santa Clara v. Trump</i> 250 F. Supp. 3d 497 (N.D. Cal. 2017) .....	37
<i>Cutter v. Wilkinson</i> 544 U.S. 709 (2005).....	33
<i>Del. Dep't of Nat. Res. &amp; Env'tl. Control</i> 785 F.3d 1 (D.C. Cir. 2015) .....	25
<i>Encino Motorcars, LLC v. Navarro</i> 136 S. Ct. 2117 (2016).....	12, 20, 23, 26
<i>Estate of Thornton v. Caldor</i> 472 U.S. 703 (1985).....	32, 33
<i>F.C.C. v. Fox Television Stations, Inc.</i> 556 U.S. 502 (2009).....	18
<i>Ferrer v. CareFirst, Inc.</i> 265 F.Supp. 3d 50 (D.D.C. 2017) .....	15
<i>Franklin v. Gwinnett Cty. Pub. Sch.</i> 503 U.S. 60 (1992).....	29
<i>Grant v. Fairview Hosp. &amp; Healthcare Servs.</i> No. Civ. 02-4232JNEJGL, 2004 WL 326694 (D. Minn. Feb. 18, 2004).....	21

**TABLE OF AUTHORITIES**

(continued)

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

**Page**

*Int’l Rehabilitative Scis., Inc., v. Sebelius*  
688 F.3d 994 (9th Cir. 2012).....19

*Jackson v. East Bay Hosp.*  
246 F.3d 1248 (9th Cir. 2001).....17

*Knight v. Conn. Dep’t of Health*  
275 F.3d 156 (2nd Cir. 2001).....21

*La. Pub. Serv. Comm’n v. FCC*  
476 U.S. 355 (1986).....12

*League of Women Voters of U.S. v. Newby*  
838 F.3d 1 (D.C. Cir. 2016) .....35

*Melendres v. Arpaio*  
695 F.3d 990 (9th Cir. 2012).....34

*Mereigh v. N.Y. & Presbyterian Hosp.*  
no. 16-cv-5583 (KBF), 2017 WL 5195236 (S.D. N.Y. Nov. 9, 2017) .....21

*Michigan v. EPA*  
268 F.3d 1075 (D.C. Cir. 2001) .....12

*Morales v. Trans World Airlines, Inc.*  
504 U.S. 374 (1992).....40

*Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*  
463 U.S. 29 (1983).....18, 20, 23

*N. Coast Women’s Care Med. Group, Inc. v. San Diego Cty. Superior Court*  
44 Cal. 4th 1145 (2008) .....7

*New York v. United States*  
505 U.S. 144 (1992).....31

*NFIB v. Sebelius*  
567 U.S. 519 (2012).....26, 27, 29, 30

*NIFLA v. Becerra*  
138 S. Ct. 2361 (2018).....9

*Nken v. Holder*  
556 U.S. 418 (2009).....12

**TABLE OF AUTHORITIES**

(continued)

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

**Page**

*Noesen v. Med. Staffing Network*  
232 Fed.Appx. 581 (7th Cir. 2007).....21

*Opuku-Boateng v. State of Cal.*  
95 F.3d 1461 (9th Cir. 1996).....21

*Oregon v. Azar*  
No. 6:19-CV-00317-MC, 2019 WL 1897475 (D. Or. Apr. 29, 2019).....43

*Pennhurst State School and Hosp. v. Halderman*  
451 U.S. 1 (1981).....27, 28

*Peterson v. Hewlett Packard Co.*  
358 F.3d 599 (9th Cir. 2004).....22

*Planned Parenthood v. Casey*  
505 U.S. 833 (1992).....25

*Ragsdale v. Wolverine World Wide, Inc.*  
535 U.S. 81 (2002).....13

*Rodriguez v. City of Chicago*  
156 F.3d 771 (7th Cir. 1998).....22

*Rosa H. v. San Elizario Indep. Sch. Dist.*  
106 F.3d 648 (5th Cir. 1997).....29

*S. Dakota v. Dole*  
483 U.S. 203 (1987).....26, 31

*Shelton v. Univ. of Med. & Dentistry of N.J.*  
223 F.3d 220 (3d Cir. 2000).....21, 22

*Smith v. Metro. Sch. Dist. Perry Twp.*  
128 F.3d 1014 (7th Cir. 1997).....29

*State of Connecticut v. U.S.*  
No. 3:09-cv-00054-RNC (D. Conn. Jan. 15, 2009) .....3

*State v. Bureau of Land Mgmt.*  
286 F. Supp. 3d 1054 (N.D. Cal. 2018) .....34

*State v. U.S. Bureau of Land Mgmt.*  
277 F. Supp. 3d 1106 (N.D. Cal. 2017) .....18

**TABLE OF AUTHORITIES**

(continued)

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

**Page**

*Stormans Inc. v. Selecky*  
844 F. Supp. 2d 1172 (W.D. Wash. 2012).....21

*Sutton v. Providence St. Joseph Med. Ctr.*  
192 F.3d 826 (9th Cir. 1999).....22

*Tex. Monthly, Inc. v. Bullock*  
489 U.S. 1 (1989).....32

*United States v. Lee*  
455 U.S. 252 (1982).....33

*Util. Air Regulatory Grp. v. EPA*  
134 S. Ct. 2427 (2014).....14

*Valle del Sol Inc. v. Whiting*  
732 F.3d 1006 (9th Cir. 2013).....35

*Washington v. Azar*  
No. 1:19-CV-03040-SAB, 2019 WL 1868362 (E.D. Wash. Apr. 25, 2019).....43

*Winter v. Nat. Res. Def. Council, Inc.*  
555 U.S. 7 (2008).....11

**STATUTES**

Cal. Bus. & Prof. Code  
§ 125.6.....6  
§ 733.....6

Cal. Civ. Code  
§ 51(b).....7  
§ 51(e)(5).....7

Cal. Health & Safety Code  
§ 1281.....7  
§ 1317(a).....7  
§ 1317(e).....7  
§ 1345.....7  
§ 1367(i).....7  
§ 1367.25.....7  
§ 1367.25(c).....7



**TABLE OF AUTHORITIES**

(continued)

	<b><u>Page</u></b>
1	
2	
3	8
4	7
5	7, 17
6	7
7	7
8	7
9	7
10	
11	7
12	7
13	
14	6
15	
16	11, 12, 42
17	2
18	12, 26
19	12
20	15
21	11
22	2
23	5
24	5
25	2
26	2
27	41
28	16
	16
	21, 23
	21
	23
	23
	23
	41
	13
	14, 34
	15

**TABLE OF AUTHORITIES**

(continued)

**Page**

**CONSTITUTIONAL PROVISIONS**

United States Constitution

First Amendment.....	9
Article I, § 8, cl. 1 .....	26
Establishment Clause .....	2, 32, 33
Spending Clause.....	<i>passim</i>

**OTHER AUTHORITIES**

Cal. Code Regs.

Title 22 § 71203(a)(2)(A).....	41
Title 28 § 1300.67 .....	7

Code of Federal Regulations

Title 29 § 1605.2 .....	22
Title 45 § 88.4(a)(3), (5) .....	39
Title 45 § 92.1 .....	15
Title 45 § 156.230(a).....	40

151 Cong. Rec. H176-77 (Jan. 25, 2005).....	17
---	----

73 Fed. Reg. 78072 (Dec. 19, 2008) .....	2, 3, 16, 33
--	--------------

74 Fed. Reg. 10207 (Mar. 10, 2009).....	3
---	---

76 Fed. Reg. 9968 (Feb. 23, 2011).....	3, 16
--	-------

83 Fed. Reg. 3880 (Jan. 26, 2018) .....	<i>passim</i>
---	---------------

84 Fed. Reg. 23170 (May 21, 2019) .....	<i>passim</i>
---	---------------

Commission Decision on Coverage of Contraception, EEOC 2000 WL 33407187 (Dec. 14, 2000).....	15
---	----

Section 507(d)(1) of Division B of Public Law 115-245, the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (H.R. 6157) (HHS Appropriations Act).....	2, 5, 13
--	----------

Kim Worobec, <i>HHS’ New Provider Conscience Regulations</i> , 21 Health Law 35 (April 2009).....	3
--	---

**MEMORANDUM OF POINTS AND AUTHORITIES****INTRODUCTION**

Under the guise of an “anti-discrimination” framework, Defendants’ new Rule, “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority,” seeks to strip patients of their access to vital, life-saving healthcare services in order to promote a nebulous, untethered “right” to object to such services. The Rule allows any healthcare provider, entity, or individual to deny critical healthcare to patients—and does not require that any justification, notice, or alternative referral be given to the patient or employer to offset such denial. Under the Rule, any individual who is loosely affiliated with the provision of care is emboldened to deny healthcare to a patient, even in the case of an emergency. For instance, the Rule could prevent a female who had been sexually assaulted from obtaining information and emergency contraception for pregnancy prevention. And the Rule is not limited to women’s reproductive healthcare, including abortion and contraception; it affects virtually all medical services, including healthcare services for lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) individuals and children. Far from preventing discrimination, this Rule only opens the door to widespread, unfettered discrimination against Californians, including those populations that have historically faced obstacles to obtaining care, for which the state has prioritized more accessible, better care and for which the state has prioritized providing more accessible, better care.

The Rule also unfairly targets the State of California and its existing laws, regulations, and policies that already balance conscience protections with patient rights. It threatens to terminate billions of dollars in federal funding that support state public healthcare and other programs unless California capitulates to the Rule’s unlawful provisions. The Rule frustrates California’s public health interests and goals of full and equal healthcare by, among other things, curtailing Californians’ access to reproductive care, and other public health programs, chilling Californians’ ability to access care, including in rural communities, further exacerbating long-term health problems. The Rule also requires the State to immediately establish a costly and onerous bureaucratic structure to ensure compliance with the Rule’s vastly expanded provisions, including compliance by any downstream sub-recipients, inclusive of counties and cities.

1       The Rule violates the Administrative Procedure Act (APA), the Spending Clause, and the  
2 Establishment Clause of the United States Constitution; impedes access to basic healthcare and  
3 upends California's priorities in providing care for its residents, including reproductive, LGBTQ,  
4 and emergency care; threatens billions of dollars in federal funding to California; and encourages  
5 discrimination against vulnerable patients, including women and LGBTQ individuals. Because  
6 the Rule will cause immediate irreparable harm, the State seeks a preliminary injunction  
7 enjoining enforcement and implementation of the Rule or, in the alternative, an order postponing  
8 of the effective date of the Rule pending judicial review. 5 U.S.C. § 706(2).

## 9                               LEGAL AND FACTUAL BACKGROUND

### 10       I.     REGULATORY BACKGROUND

#### 11               A.     2008 Executive Action

12       On December 19, 2008, HHS issued a final rule to "provide for the enforcement of the  
13 Church Amendments<sup>2</sup>...the Public Health Service Act [Coats-Snowe Amendment]<sup>3</sup> and the  
14 Weldon Amendment."<sup>4</sup> 73 Fed. Reg. 78072, 78074, 78098 (Dec. 19, 2008). The rule purported  
15 to authorize HHS to terminate and/or compel the return of all HHS funds from state and local  
16 governments that violate its prohibition against "discrimination on the basis that [a] health entity  
17 does not provide, pay for, provide coverage of, or refer for abortion" and further required any  
18 recipients of HHS funds to certify compliance with the rule. *Id.* at 78074, 78098, 78099. In  
19 response to comments expressing concerns that the rule could invite "discriminat[ion] against  
20 certain classes of patients, including illegal immigrants, drug and alcohol users, patients with  
21 disabilities or patients with HIV, or on the basis of race or sexual preference," Defendants

22  
23 <sup>2</sup> The Church Amendments generally state that no individual or entity funded under certain HHS  
programs may be required to perform or assist in a sterilization procedure or abortion. 42 U.S.C.  
§§ 300a-7(b)(1)-(2).

24 <sup>3</sup> The Coats-Snowe Amendment bars a government from discriminating against a health care  
25 entity on the basis that, *inter alia*, the entity refuses to undergo training in the performance of  
induced abortions, to require or provide such training, to perform such abortions, or to provide  
26 referrals for such training or such abortions. 42 U.S.C. § 238n(a).

27 <sup>4</sup> The Weldon Amendment, which has been included in every appropriations bill for HHS since  
2005, bars federal funding to a government that discriminates on the basis of not covering or  
28 providing abortions. *See* Section 507(d)(1) of Division B of Public Law 115-245, the Department  
of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and  
Continuing Appropriations Act, 2019 (H.R. 6157) (HHS Appropriations Act).

1 confirmed that discrimination is “outside the scope” of federal conscience laws: “[G]iven the  
2 strong national policies embodied in federal civil rights laws that protect individuals from  
3 unlawful discrimination based on their federally protected individual characteristics, and that  
4 ensure that federally supported programs are available to all without discrimination, we believe  
5 that federal civil rights protections prevail.” *Id.* at 78080.

6 The 2008 rule went into effect on January 20, 2009, except that its certification requirement  
7 never took effect, as it was subject to the information collection approval process under the  
8 Paperwork Reduction Act, which was never completed. 76 Fed. Reg. 9968, 9971 (Feb. 23, 2011).

### 9 **B. 2010-2018 Executive Actions**

10 On March 10, 2009, three months after the 2008 rule took effect, HHS proposed to rescind  
11 that rule, and moved to stay litigation challenging the 2008 rule, noting that a new round of  
12 rulemaking was underway. 74 Fed. Reg. 10207 (Mar. 10, 2009).<sup>5</sup> Instead, in 2011, HHS  
13 amended the 2008 rule by removing provisions containing definitions of terms, requirements,  
14 prohibitions, and the certification requirement. *See generally* 73 Fed. Reg. 78072, 76 Fed. Reg.  
15 9968. The 2011 rule also noted that federal conscience laws “were never intended to allow  
16 providers to refuse to provide medical care to an individual because the individual engaged in  
17 behavior the health care provider found objectionable.” 76 Fed. Reg. 9973-74. HHS confirmed  
18 that “[n]o statutory provision, however, requires promulgation of a rule.” *Id.*; 76 Fed. Reg. at  
19 9975 (the Church, Weldon, and Coats-Snowe Amendments do not require “promulgation of  
20 regulations for their interpretation.”). The 2011 rule designated the Office for Civil Rights (OCR)  
21 of HHS to “receive complaints based on the Federal health care provider conscience protection  
22 statutes,” and to “coordinate the handling of complaints with funding components from which the  
23 entity, to which a complaint has been filed, receives funding.” 76 Fed. Reg. at 9975, 9977.

### 24 **C. 2018 and 2019 Executive Action**

25 Between 2008 and January 26, 2018—approximately ten years—OCR states that it had  
26 received a total of 44 complaints. 83 Fed. Reg. 3880, 3886 (Jan. 26, 2018). In spite of the limited

27 \_\_\_\_\_  
28 <sup>5</sup> *State of Connecticut v. U.S.*, No. 3:09-cv-00054-RNC (D. Conn. Jan. 15, 2009), Dkt. 93; Kim  
Worobec, *HHS’ New Provider Conscience Regulations*, 21 Health Law 35 at 37 (April 2009).

1 number of complaints received, on January 26, 2018, Defendants issued a Notice of Proposed  
2 Rulemaking (NPRM) to vastly expand implementation and enforcement of over two dozen  
3 federal conscience laws. *Id.*

4 The NPRM proposed a broad exemption to opt out of healthcare services on the basis of  
5 “conscience, religious beliefs, or moral convictions” not only to medical providers but also to  
6 anyone with an “articulable connection” to the provision of that service, including helping to  
7 make a referral for that service. 83 Fed. Reg. at 3881, 3923. Specific scenarios included  
8 abortion, sterilization, euthanasia, certain vaccinations if there is a connection to use of “aborted  
9 fetal tissue,” contraception, gender transition/gender dysphoria, tubal ligations, hysterectomies,  
10 assisted suicide, and referrals for advanced directives, and “other health services.” 83 Fed. Reg.  
11 at 3903. HHS also proposed to grant responsibility for enforcement of two dozen federal  
12 conscience laws to OCR by conferring OCR with the authority to not only receive complaints, but  
13 also to initiate compliance reviews, conduct investigations, supervise and coordinate compliance,  
14 and use broad enforcement tools to address violations, including temporarily withholding  
15 payments; denying use of HHS funds; suspending award activities; terminating HHS funds; and  
16 withholding new HHS funds. 83 Fed. Reg. at 3931.

17 HHS received over 242,000 comments to the NPRM.<sup>6</sup> Comments in opposition came from  
18 a broad array of individuals, major medical associations, public health experts, state and local  
19 governments, healthcare providers, and other patient advocacy organizations.

20 On May 21, 2019, HHS issued the final rule (Rule). Despite the over 242,000 comments,  
21 the Rule is largely identical to the NPRM. Like the proposed rule, the final rule conflicts with  
22 existing law and impedes the provision of and access to medical information and healthcare by  
23 attempting to create limitless categories under which medical information and care can be  
24 refused. The final Rule so conflicts by misconstruing and exceeding the bounds of federal  
25 statutes, including well-established statutory language and definitions. For example, the Rule

26 \_\_\_\_\_  
27 <sup>6</sup>Comments are available at  
28 <https://www.regulations.gov/docketBrowser?rpp=50&so=DESC&sb=postedDate&po=0&dct=PS&D=HHS-OCR-2018-0002>. Although the website shows 72,417 comments, the Rule lists 242,000 comments as of the date the Rule was published. 84 Fed. Reg. at 23180, n. 41.

1 broadly and unclearly defines “assist in the performance” of an activity to encompass an action  
2 that has a “specific, reasonable, and articulable connection” to furthering a procedure, health  
3 service program, or research activity, including “counseling, referral, training, or otherwise  
4 making arrangements” for the procedure, health program, or research activity. 84 Fed. Reg. at  
5 23263. Only the Church Amendments refer to (but do not define) “assist in the performance” of  
6 an activity, and nothing in that statutory scheme envisions the broad definition in the Rule. 42  
7 U.S.C. § 300a-7. In fact, Congress’s specific references to “counsel[ing]” in a separate Church  
8 Amendment provision, “training” in the Coats-Snowe Amendment, and “refer for” in the Weldon  
9 Amendment demonstrate Congress’s intent to keep these actions separate in meaning from  
10 “assist[ing] in the performance.”

11 “Health care entity” is defined in the Coats-Snowe Amendment and the Weldon  
12 Amendment, yet the Rule expands the definition to include “health care personnel,” as distinct  
13 from a “health care professional,” such as a doctor, nurse or other licensed medical provider.<sup>7</sup>  
14 Thus, the Rule suggests significantly broader categories of personnel could refuse to provide  
15 services—potentially including even a receptionist making an appointment for a patient.

16 The term “health care entity” is expanded to include “a plan sponsor, issuer, or third-party  
17 administrator, or any other kind of health care organization, facility, or plan.” 84 Fed. Reg. at  
18 23264. This definition allows broad categories of individuals and entities, even those with no  
19 ethical obligation to the patient or involvement in direct patient care, to deny healthcare.

20 The Rule’s definition of “referral or refer for” includes “the provision of information in  
21 oral, written, or electronic form (including names, addresses, phone numbers, email or web  
22 addresses, directions, instructions, descriptions, or other information resources), where the

23 \_\_\_\_\_  
24 <sup>7</sup> Compare 42 U.S.C. § 238n(c)(2) (defining “health care entity” to include “an individual  
25 physician, a postgraduate physician training program, and a participant in a program of training in  
26 the health professions”) and P.L. 115-245, the Department of Defense and Labor, Health and  
27 Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act,  
28 2019 (H.R. 6157), Div. B, sec. 507(d)(2) (defining “health care entity” to include “an individual  
physician or other health care professional, a hospital, a provider-sponsored organization, a health  
maintenance organization, a health insurance plan, or any other kind of health care facility,  
organization, or plan”) with 84 Fed. Reg. at 23264 (defining “health care entity” to include  
“health care personnel” and describing listed entities included in the definition as “illustrative, not  
exhaustive”).



1 purpose or reasonably foreseeable outcome of provision of the information is to assist a person in  
2 receiving funding or financing for, training in, obtaining, or performing a particular health care  
3 service, program, activity, or procedure.” Thus, under the Rule, even the posting of notices,  
4 would be considered a “referral.” 84 Fed. Reg. at 23264.

## 5 **II. CALIFORNIA LAWS BALANCE GUARANTEEING ACCESS TO HEALTHCARE WHILE** 6 **PROTECTING CONSCIENCE**

7 With over 39 million residents, California is the nation’s most populous state. Sturges Dec.  
8 ¶ 5. Ensuring access to healthcare is a key element in shaping overall health and well-being of  
9 California residents, and is therefore a critical component of the State’s public health programs  
10 and laws. California laws carefully balance conscience protections with Californians’ right to full  
11 and equal access to healthcare. *See e.g.*, Cal. Prob. Code § 4736 (permitting a healthcare provider  
12 to decline a healthcare decision for reasons of conscience, but requiring notification to the patient,  
13 assistance in transfer, and continuing care until transfer); Cal. Bus. & Prof. Code § 733 (a  
14 healthcare licentiate “shall not obstruct a patient in obtaining a prescription drug or device,” but  
15 providing a process for the licentiate to decline with advance written notice to the employer if a  
16 reasonable accommodation can be offered without undue hardship, while ensuring timely  
17 prescriptions to the patient); *see also* Aizuss Dec. ¶¶ 17-22, 26-29 (recognizing existing laws  
18 already balance patients’ rights with physicians’ conscience rights).

19 California laws also protect patients from discrimination in healthcare, including through  
20 the state’s regulation of its licensed healthcare professionals. Cal. Bus. & Prof. Code § 125.6 (a  
21 licensed healthcare professional is subject to discipline if he or she refuses or aids in the refusal of  
22 licensed activities on the basis of sex, race, color, religion, ancestry, national origin, disability,  
23 medical condition, genetic information, marital status, sexual orientation, citizenship, primary  
24 language, or immigration status). California’s Unruh Civil Rights Act, Civil Code sections 51 *et*  
25 *seq.*, also bars business establishments from discriminating in the delivery of services and goods,  
26 including discrimination based on sex, which includes gender identity and gender expression.  
27  
28



1 Cal. Civ. Code § 51(b);<sup>8</sup> *N. Coast Women’s Care Med. Group, Inc. v. San Diego Cty. Superior*  
 2 *Court*, 44 Cal. 4th 1145, 1158 (2008).

3 With respect to reproductive health, California laws require healthcare coverage for  
 4 maternity services (Cal. Health & Safety Code §§ 1345, 1367(i); Cal. Code Regs., tit. 28,  
 5 § 1300.67; Cal. Ins. Code §§ 10123.865, 10123.866), support procreative choice (Cal. Health &  
 6 Safety Code § 123462(b)), and—consistent with the Affordable Care Act’s Women’s Health  
 7 Amendment (42 U.S.C. § 300gg-13(a)(4))—require coverage of all Food and Drug  
 8 Administration (FDA)-approved drugs, devices, and other products for women (Cal. Health &  
 9 Safety Code § 1367.25; Cal. Ins. Code § 10123.196(b)(1)). But a religious employer may request  
 10 a health care service plan contract that does not cover FDA-approved contraceptive methods that  
 11 are contrary to the religious employer’s religious tenets. Cal. Health & Safety Code § 1367.25(c);  
 12 Cal. Ins. Code § 10123.196(e); *see also* Cal. Penal Code §§ 13823.11(e)(1); (e)(2), (g)(4)(A),  
 13 (g)(4)(B); Cal. Health & Safety Code § 1281 (requiring pregnancy prevention treatment for  
 14 sexual assault survivors, but also establishing an advance accommodation process for hospitals).  
 15 And no employer shall require a licensed provider to participate in an abortion “if the employee or  
 16 other person has filed a written statement with the employer or the hospital, facility, or clinic  
 17 indicating a moral, ethical, or religious basis for refusal to participate.” Cal. Health & Safety  
 18 Code §§ 123420(a), 123466. To balance this exemption with the needs of the patient, this  
 19 provision does not apply to “medical emergency situations” and miscarriages. Cal. Health &  
 20 Safety Code § 123420(d); Cal. Health & Safety Code §§ 1317(a), (e).

### 21 **III. CALIFORNIA’S SOVEREIGNTY AND FEDERAL FUNDS ARE TARGETED BY THE RULE**

22 The Rule explicitly targets California and its laws and policies balancing conscience  
 23 protections and patient rights.<sup>9</sup> The Rule states that it seeks to resolve confusion caused by  
 24 OCR’s “high-profile” closing of three Weldon Amendment complaints against California. 84

25 <sup>8</sup> “For purposes of this section . . . ‘Sex’ includes. . . pregnancy, childbirth, or medical conditions  
 26 related to pregnancy or childbirth. ‘Sex’ also includes, but is not limited to, a person’s gender.  
 27 ‘Gender’ means sex, and includes a person’s gender identity and gender expression. ‘Gender  
 28 expression’ means a person’s gender-related appearance and behavior whether or not  
 stereotypically associated with the person’s assigned sex at birth.” Cal. Civ. Code § 51(e)(5).

<sup>9</sup> Indeed, the Rule mentions California no less than 44 times. *See generally* 84 Fed. Reg. 23170.

1 Fed. Reg. at 23178-23179. The three complaints,<sup>10</sup> which were filed by a religious organization,  
2 churches and a church-run school, and employees of a religiously affiliated university, alleged  
3 that the Department of Managed Health Care (DMHC) (the California agency responsible for  
4 regulating managed care health plans) contacted seven health plans on August 22, 2014 about  
5 their offering products without abortion coverage, and requiring those health plans to include  
6 abortion coverage.<sup>11</sup>

7 On June 21, 2016, OCR closed the three complaints in favor of California, finding that the  
8 Weldon Amendment was not violated because the seven health plans that received the letter had  
9 not objected to providing such coverage on religious or moral grounds, which is a requirement for  
10 protection under the Weldon Amendment. Palma Dec. Ex. B, letter from OCR to complainants.  
11 Additionally, OCR noted that after receipt of DMHC's August 22, 2014 letter, the health plans  
12 voluntarily modified their health products. *Id.* Citing *NFIB v. Sebelius*, 567 U.S. 519 (2012),  
13 OCR determined that this approach avoided a "potentially unconstitutional" application of  
14 Weldon, given Weldon's consequence to rescind "all funds appropriated under the  
15 Appropriations Act to the State of California—including funds provided to the State not only by  
16 HHS but also by the Departments of Education and Labor, as well as other agencies." *Id.* OCR  
17 also noted that one of the health plans received an exemption to allow it to offer a plan product  
18 excluding abortion services for "religious employers" as defined under California Health and  
19 Safety Code section 1367.25(c)(1). *Id.*

20 But on August 30, 2018, OCR informed California that it had reviewed a September 2017  
21 complaint based on the closed DMHC complaints and determined that OCR had sufficient  
22 authority and cause to investigate the allegations under the Weldon, Coats-Snowe, and Church  
23 Amendments, thus reopening the previously closed investigation. The Rule states that HHS and  
24 OCR no longer agree with OCR's prior interpretation of the Weldon Amendment expressed in the  
25 June 21, 2016 finding in favor of California. 84 Fed. Reg. at 23179. The Rule states that HHS

26 \_\_\_\_\_  
27 <sup>10</sup> OCR Complaint Nos. 14–193604, 15–193782, and 15–195665.

28 <sup>11</sup> DMHC explained in its August 22, 2014 letter that the Knox-Keene Act requires the provision of basic healthcare services and the California Constitution prohibits health plans from discriminating against women who choose to terminate a pregnancy.

1 “continues to hold the views it expressed” in the NPRM, *id.*, which noted that despite the  
 2 constitutional concerns cited in OCR’s June 21, 2016 letter, HHS nonetheless remained obligated  
 3 “to not make certain funding available to covered entities that discriminate in violation of the  
 4 Weldon Amendment.” 83 Fed. Reg. at 3890.

5 The promulgation of the Rule sets up an unavoidable conflict between OCR and California  
 6 by expanding the scope of the Weldon protection to *any* reason for refusing such coverage, not  
 7 just religious and moral objections. Although “health care entity” is defined by the Weldon  
 8 Amendment (and the Coats-Snowe Amendment), the Rule illegally broadens the definition to  
 9 include “a plan sponsor, issuer, or third party administrator,” thus allowing an employer, as  
 10 expressly stated by the Rule, to deny coverage for reproductive services to its employees.

11 On top of the reopening of the DMHC investigation, on January 17, 2019, OCR issued a  
 12 letter to California entitled a Notice of Violation, regarding California’s Reproductive FACT Act,  
 13 and concluded that California had violated the Weldon Amendment and the Coats-Snowe  
 14 Amendment.<sup>12</sup> Palma Dec. Ex. C, notice of violation.

#### 15 **IV. THE CALIFORNIA FUNDING AND PROGRAMS AT RISK UNDER THE RULE**

16 California receives billions of dollars in federal funds largely under the Labor, Health and  
 17 Human Services Appropriations Act for labor, education, and health and human services Sturges  
 18 Dec. ¶ 7; Ghaly Dec. ¶ 9; Toche Dec. ¶ 12; Palma Dec. Ex. A, 2018-19 Cal. Dep’t. Educ. Budget,  
 19 at 9-12. Some of these federal dollars support programs run by state agencies and some funds are  
 20 passed on to local governments and other sub-grantees. Sturges Dec. ¶ 8; Ghaly Dec. ¶ 8.

21 The California Health & Human Services Agency (CHHS) expects to receive \$77.6 billion  
 22 in federal funding for fiscal year 2019-2020 (almost half of its budget), and the Rule places at risk  
 23 federal funds from HHS. Ghaly Dec. ¶ 8; *see* 84 Fed. Reg. at 23177, 23262 (section 88.6(d)(iii)  
 24 of the Rule makes clear that an OCR “determination of noncompliance [will be used] to inform

25 <sup>12</sup> As a sign of Defendants’ arbitrary targeting of California, this notice of violation notes that  
 26 California’s Attorney General wrote OCR stating that “[G]iven the status of pending litigation  
 27 regarding the [FACT] Act, this office has no plans to enforce the Act against any facility.” *See*  
 28 *generally NIFLA v. Becerra*, 138 S. Ct. 2361 (2018) (concluding that the plaintiffs were likely to  
 succeed on their claim that the FACT Act violated the First Amendment). Yet Hawaii’s virtually  
 identical response to OCR’s investigation of a comparable law passed Hawaii were “resolved  
 without having to find Hawaii in violation.” 84 Fed. Reg. at 23177.

1 [HHS's] decision whether to approve, renew, or modify Federal funding to the recipient," and the  
2 Rule notes that OCR has already made a determination of noncompliance against California).  
3 CHHS programs provide critical healthcare services, social services, mental health services,  
4 alcohol and drug abuse services, income assistance, and public health services to Californians  
5 from all walks of life. Ghaly Dec. at ¶¶ 2, 5. At risk are federal funds like the approximately \$63  
6 billion the Department of Health Care Services (DHCS) received in the 2018-19 State Fiscal  
7 Year. *Id.* at ¶¶ 11-12; Cantwell Dec. at ¶¶ 2, 7. DHCS administers and oversees multiple  
8 federally-funded programs providing healthcare services for *one-third of Californians*, including  
9 Medicaid, the Children's Health Insurance Program, and several other health-related federal  
10 grants programs. Cantwell Dec. at ¶¶ 2, 7; Ghaly Dec. ¶ 12.

11 The Rule puts at risk about \$1.5 billion for the California Department of Public Health.  
12 Nunes Dec. ¶¶ 9, 12, 16, 19; Ghaly Dec. ¶¶ 16-18. These funds support programs related to  
13 emergency preparedness, chronic and infectious disease prevention including vaccinations and  
14 STD control, environmental health programs, healthcare facility licensing programs, and  
15 programs helping the state address the opioid crisis, among others. Nunes Dec. ¶¶ 5, 9, 12, 16,  
16 19; Ghaly Dec. ¶¶ 16-1. The Rule also jeopardizes funding for the California Department of  
17 Social Services (CDSS), including nearly \$2.5 billion for various child welfare and refugee  
18 assistance programs and \$6 billion for the In-Home Supportive Services program which helps  
19 provide care and support for California's seniors and people with disabilities, among others.  
20 Ghaly Dec. ¶ 14; Cervinka Dec. ¶¶ 7, 9-13. The Rule may also impact \$4.2 million for mental  
21 health services provided through the Department of State Hospitals (DSH). Price Dec. ¶ 14. The  
22 Rule also places at risk the federal share of over \$89 million California Correctional Health Care  
23 Services (CCHCS) receives annually to support the current level of healthcare by civil service  
24 and contracted staff and facilities to the inmate population of the California Department of  
25 Corrections and Rehabilitation. Toche Dec. ¶ 12.

26 The Rule also places at risk funding from the U.S. Department of Labor, including funding  
27 to support employment programs under Title III of the Social Security Act, (unemployment  
28 insurance programs), the Workforce Innovation and Opportunity Act, the Occupational Safety

1 and Health Act, and the Jobs for Veterans State grants program under 38 U.S.C. § 4102A(b)(5).  
2 Sturges Dec. ¶¶ 7-9. The California Unemployment Development Department expects to receive  
3 nearly \$900 million in fiscal year 2018-2019 to provide short-term income to unemployed  
4 individuals, fund local workforce development boards, and provide services to job seekers and  
5 employers. *Id.* at ¶¶ 5, 8. The California Department of Industrial Relations expects to receive  
6 \$38 million in fiscal year 2018-2019 to protect occupational health and safety, promote  
7 apprenticeships, and promote labor standards. *Id.* at ¶¶ 8-9.

8 The California Department of Education expects to receive \$3.8 billion in federal funding  
9 in fiscal year 2018-19 to support instruction, including migrant education, adult education,  
10 education for homeless children, special education, and vocational education; \$584 million for  
11 instructional support, including curriculum services and wellness in education programs; and \$3.8  
12 billion for special programs, including child care and state preschool programs. Palma Dec. Ex.  
13 A, 2018-19 Cal. Dep't. Educ. budget, at 11-12.

14 California's public colleges and universities receive hundreds of millions of dollars in  
15 funding for education, including for the largest system of higher education in the nation, and for  
16 medical and scientific research from the National Institutes of Health and the Centers for Disease  
17 Control and Prevention. Harris-Caldwell Dec. ¶ 2; Parmelee Dec. ¶¶ 4-9; Dkt. No. 1 at 37-38.

## 18 LEGAL STANDARD

19 To obtain a preliminary injunction, the plaintiff must demonstrate that (1) it "is likely to  
20 succeed on the merits," (2) it "is likely to suffer irreparable harm in the absence of preliminary  
21 relief," (3) "the balance of equities tips in [its] favor," and (4) "an injunction is in the public  
22 interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Courts evaluate these  
23 factors on a "sliding scale approach," such that serious questions going to the merits and a  
24 balance of hardships that tips sharply towards the plaintiff can support issuance of preliminary  
25 relief, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the  
26 injunction is in the public interest." *Arc of Cal. v. Douglas*, 757 F.3d 975, 983 (9th Cir. 2014).  
27 The APA also provides that "the reviewing court [...] may issue all necessary and appropriate  
28 process to postpone the effective date of an agency action." 5 U.S.C. § 705. This remedy is

1 available “to the extent necessary to prevent irreparable injury” and to preserve the status quo  
 2 pending judicial review proceedings. *Id.*; *Nken v. Holder*, 556 U.S. 418, 425 (2009).

### 3 **ARGUMENT**

#### 4 **I. CALIFORNIA IS LIKELY TO SUCCEED ON THE MERITS**

##### 5 **A. The Rule Is Invalid Under the APA**

6 The Rule must be held “unlawful and set aside” because it is “not in accordance with the  
 7 law” and is “in excess of statutory jurisdiction.” 5 U.S.C. §§ 706(2)(A), 706(2)(C). Here,  
 8 Congress did not delegate to Defendants the ability to promulgate a rule that puts billions of  
 9 dollars at risk and undercuts access to healthcare. *Michigan v. EPA*, 268 F.3d 1075, 1081 (D.C.  
 10 Cir. 2001) (an agency’s rulemaking power is limited to the authority delegated to it by Congress).  
 11 Moreover, the Rule is arbitrary and capricious because Defendants have failed to “give adequate  
 12 reasons for [their] decisions” and therefore “cannot carry the force of law.” *Encino Motorcars,*  
 13 *LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016); *see supra* Section I(B)(1). This makes the Rule  
 14 “procedurally defective” and, as such, the court need not even reach California’s other challenges,  
 15 including whether the agency has exceeded its authority in order to set aside the agency action.  
 16 *Encino Motorcars*, 136 S. Ct. at 212; *see also Am. Bar Ass’n v. U.S. Dep’t of Educ.*, 370 F. Supp.  
 17 3d 1, 33-34 (D.D.C. 2019).

##### 18 **1. The Rule Is in Excess of Statutory Jurisdiction**

19 Defendants have acted in excess of statutory authority by conferring broad enforcement  
 20 powers to OCR without statutory basis, and by granting themselves authority to alter statutory  
 21 definitions in a manner inconsistent with statute. Federal agencies, “literally [have] no power to  
 22 act . . . unless and until Congress confers power upon” them. *La. Pub. Serv. Comm’n v. FCC*,  
 23 476 U.S. 355, 374 (1986); 5 U.S.C. § 706(2)(C). In determining whether Defendants exceeded  
 24 their statutory authority, the court must first ascertain whether the statute “has directly spoken to  
 25 the precise question at issue”; if the statute is unambiguously clear, “that is the end of the matter.”  
 26 *Chevron*, 467 U.S. at 842-843. Second, if the statute admits of some ambiguity, then courts must  
 27 determine whether the agency’s interpretation is “reasonable” by applying normal canons of  
 28 statutory construction, looking not only to the law’s text, but also to its structure, purpose, and



1 legislative history. *Id.* at 844. Agency interpretation is unreasonable if it conflicts with the  
2 statute. *Ragsdale v. Wolverine World Wide, Inc.*, 535 U.S. 81, 95-96 (2002).

3 Although the Rule proposes to enforce over two dozen statutes, only one statute speaks  
4 directly to the HHS’s power to enforce. Section 1553 of the Affordable Care Act (ACA) states:  
5 “The Office for Civil Rights of the Department of Health and Human Services is designated to  
6 receive complaints of discrimination based on this section.” 42 U.S.C. § 18113(d). The plain text  
7 of the statute only confers onto OCR the power to receive complaints of discrimination. There is  
8 no directly granted authority—under Section 1553 or any other federal conscience law—for  
9 “robust” use of enforcement tools that could halt funding or suspend award activities. 84 Fed.  
10 Reg. 23254. Yet the Rule purports to expand OCR’s enforcement authority to do precisely that.  
11 *See* 84 Fed. Reg. 23271-72 (to be codified at Section 88.7(i)(3)(i)-(vii)) (allowing OCR to effect  
12 compliance by withholding, suspending, and terminating federal funding or suspending award  
13 activities).

14 Agency action also fails under step one of a *Chevron* test when the agency attempts to alter  
15 or add additional criteria beyond those in the governing statute. *Cent. United Life Ins. Co. v.*  
16 *Burwell*, 827 F.3d 70, 72–73 (D.C. Cir. 2016) (rejecting a rule that amended the *statutory* criteria  
17 for fixed indemnity insurance). The Rule’s implementation of specific penalties for  
18 noncompliance with two dozen laws, 84 Fed. Reg. at 23272, is unmoored from any statutory text.  
19 Although the Weldon Amendment purports to strip noncompliant entities of broad categories of  
20 federal funding (which raises its own legal problems), nothing in the Weldon Amendment, or  
21 elsewhere in federal law, supports the separate, discretionary enforcement mechanisms asserted in  
22 the Rule. *See* P.L. 115-245, the Department of Defense and Labor, Health and Human Services,  
23 and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (H.R. 6157),  
24 Div. B, sec. 507(d)(1); 84 Fed. Reg. 23254. Additionally, Defendants have offered no authority  
25 to suggest that the Weldon Amendment allows Defendants to use the Weldon Amendment’s  
26 enforcement mechanisms to enforce other, separate statutes.

27 Agency action may be deemed unreasonable at *Chevron* step two if it would bring about  
28 “an enormous and transformative expansion in [the agency’s] regulatory authority” without clear

1 congressional authorization. “When an agency claims to discover in a long-extant statute an  
2 unheralded power to regulate a significant portion of the American economy, we typically greet  
3 its announcement with a measure of skepticism. We expect Congress to speak clearly if it wishes  
4 to assign to an agency decisions of vast economic and political significance.” *Util. Air*  
5 *Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2444 (2014). Here, Congress has not assigned to HHS  
6 authority to transform the delivery of healthcare to patients and to decide how two dozen statutes  
7 (including some dating back half a century) are defined and implemented—and Congress  
8 certainly has not done so “clearly.” In seeking “an enormous and transformative expansion in  
9 [administrative] regulatory authority” without clear statutory basis, *id.*, the Rule exceeds statutory  
10 authority.

## 11 **2. The Rule Is Contrary to Several Federal Statutes**

12 Because the Rule creates barriers to obtaining healthcare, impedes timely access to  
13 healthcare, and encourages discrimination, it cannot be reconciled with ACA sections 1554 and  
14 1557. The Rule also conflicts with the Emergency Medical Treatment & Labor Act (EMTALA).

### 15 **a. The Rule Conflicts with Section 1554 of the ACA**

16 Congress prohibits the Secretary of HHS from promulgating any regulation that “(1) creates  
17 any unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2)  
18 impedes timely access to health care services; (3) interferes with communications regarding a full  
19 range of treatment options between the patient and provider; (4) restricts the ability of health care  
20 providers to provide full disclosure of all relevant information to patients making health care  
21 decisions; [or] (5) violates the principles of informed consent and the ethical standards of health  
22 care professionals.” 42 U.S.C. § 18114. But here, the Rule creates barriers and impedes access to  
23 healthcare for women (including in emergencies), people with disabilities, LGBTQ individuals,  
24 as well as residents of rural communities. *See infra* Section I(B)(3). Such barriers violate section  
25 1554. *See California v. Azar*, 19-cv-01184-EMC, 2019 WL 1877392, at \*24 (N.D. Cal. Apr. 26,  
26 2019) (HHS likely violated Section 1554 where Title X rule “obfuscate[s] and obstruct patients  
27 from receiving information and treatment for their pressing medical needs”).

28 ///



1 Defendants justify their actions by citing a White Paper claiming there is “insufficient  
2 evidence to conclude that conscience protections have negative effects on access to care.” 84  
3 Fed. Reg. at 23251, n.345. But this White Paper actually details the dangers of decreased access  
4 caused by denials of care, including the death of patients. Palma Dec. Ex. D at S45-48. It also  
5 recommends taking steps to process objections to help with accompanying obligations of  
6 providers who assert them, “such as disclosure to employers and patients, and duties to refer, to  
7 impart accurate information, to provide urgently needed care and to reduce or eliminate refusal as  
8 an option for the care of ectopic pregnancy, inevitable spontaneous abortion, rape, and maternal  
9 illness,” steps which the Rule neglected. *Id.* at S53. Not only does the Rule fail to implement  
10 these obligations, it affirmatively prohibits them. The overwhelming evidence demonstrates that  
11 the Rule will impede timely access to care and impose unreasonable barriers. Cantwell Dec. ¶ 8;  
12 Lara Dec. ¶ 10; Zahn Dec. ¶ 8; Harris-Caldwell Dec. ¶¶ 13-15.

13 **b. The Rule Violates the ACA’s Nondiscrimination Provision**

14 The Rule is also unlawful because it permits providers to exclude patients from full and  
15 equal healthcare benefits and services, and permits providers and other healthcare personnel to  
16 discriminate on the basis of sex and disability. Section 1557 of the ACA prohibits discrimination  
17 under any health program or activity on the basis of classifications listed in four federal civil  
18 rights statutes—Title VI of the Civil Rights Act of 1964 (race, color, national origin, and sex),  
19 Section 504 of the Rehabilitation Act of 1973 (disability), Title IX of the Education Amendments  
20 (sex), and the Age Discrimination Act of 1975 (age). 42 U.S.C. § 18116(a); 20 U.S.C. § 1681(a);  
21 45 C.F.R. § 92.1; *see also Ferrer v. CareFirst, Inc.*, 265 F.Supp. 3d 50, 52-54 (D.D.C. 2017)  
22 (denial of full coverage resulting in women paying out of pocket for lactation services violates the  
23 ACA); Commission Decision on Coverage of Contraception, EEOC 2000 WL 33407187 (Dec.  
24 14, 2000) (coverage for preventive services but not contraception is sex discrimination); *see also*  
25 Zahn Dec., Ex. A (cautioning that conscience refusals should be evaluated because of their  
26 potential for discrimination).

27 But here, the Rule emboldens providers, insurers, plan sponsors (i.e., employers) and other  
28 healthcare personnel and entities to exempt themselves from providing a broad range of benefits

1 and services—including contraceptives (84 Fed. Reg. at 23176 (*citing Hellwege v. Tampa Family*  
 2 *Health Ctrs.*, 103 F. Supp. 3d 1303 (M.D. Fla. 2015)), emergency miscarriage management (*id.* at  
 3 n.27 (*citing Means v. U.S. Conference of Catholic Bishops*, No. 1:15-CV-353, 2015 WL 3970046  
 4 (W.D. Mich. June 30, 2015))), tubal ligations and hysterectomies (but not vasectomies) (*id.*), and  
 5 gender dysphoria and gender transition services (*id.* (*citing Minton v. Dignity Health*, No. 17–  
 6 558259 (Cal. Super. Ct. Apr. 19, 2017)))—to women and to the LGBTQ community. Several  
 7 organizations advocating for the rights of disabled individuals, also objected to the NPRM  
 8 because it will promote discrimination on the basis of disability. For example, they cite to  
 9 discrimination against individuals with HIV or persons who, due to their disabilities, are more  
 10 likely to live in provider-controlled settings and/or are more dependent on medical personnel to help  
 11 coordinate care. Palma Dec. Ex. N, Nat. Assoc. Councils Dev. Disabilities; Ex. T, Consortium for  
 12 Citizens with Disabilities; Ex. U, Disabilities Rights Educ. & Def. Fund; Ex. V, Disability  
 13 Coalition N.M. And whereas the prior rules confirmed that discrimination is “outside the scope”  
 14 of conscience laws, the Rule includes no such assurance. 73 Fed. Reg. at 78080; 76 Fed. Reg. at  
 15 9973-74. The Rule’s encouragement of discrimination directly violates Section 1557.

### 16 c. The Rule Violates EMTALA

17 The Rule conflicts with EMTALA, which requires all Medicaid and Medicare participating  
 18 hospitals with emergency rooms to provide an “appropriate medical screening examination” to  
 19 determine “whether or not an emergency medical condition . . . exists.” 42 U.S.C. § 1395dd(a).  
 20 If there is an emergency medical condition<sup>13</sup>, the hospital *must* treat the patient to the point of  
 21 stabilization, or transfer her to another facility. *Id.* at § 1395dd(b)(1). If the condition is not  
 22 stabilized, the hospital may not transfer the patient unless a physician signs a certification  
 23 weighing the risks of transfer. *Id.* at § 1395dd(c)(1); *see also* Aizuss Dec. ¶ 27.

24 \_\_\_\_\_  
 25 <sup>13</sup> An “emergency medical condition” is one “manifesting itself by acute symptoms of sufficient  
 26 severity (including severe pain) such that the absence of immediate medical attention could  
 27 reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a  
 28 pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious  
 impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part . . .” 42  
 U.S.C. § 1395dd(e)(1). An “emergency medical condition” also exists if there is no time to  
 transfer a pregnant woman before delivery, or the “transfer may pose a threat to the health or  
 safety of the woman or the unborn child.” *Id.*

1           The Rule is inconsistent with Congress’s directive in EMTALA—to prevent patients in  
2 need of emergency care from being turned away. *Jackson v. East Bay Hosp.*, 246 F.3d 1248,  
3 1254 (9th Cir. 2001). Under the Rule, emergency personnel may refuse to provide medically  
4 indicated and requested care. As an example of “discrimination,” the Rule refers to a scenario in  
5 which a hospital denied emergency medical care to a woman who experienced pregnancy  
6 complications likely to result in fetal death or stillbirth and risk of injury or death to the woman if  
7 she continued her pregnancy. 83 Fed. Reg. at 3888, n.36, 3889; 84 Fed. Reg. 23176, n.27 (*citing*  
8 *Means v. U.S. Conference of Catholic Bishops*, No. 1:15-CV-353, 2015 WL 3970046 (W.D.  
9 Mich. June 30, 2015)). Defendants also cite an American College of Obstetricians and  
10 Gynecologists (ACOG) ethics opinion outlining providers’ obligation to provide emergency  
11 care—apparently as a further example of the kind of “discrimination” the Rule is designed to  
12 address. *See* 83 Fed. Reg. at 3888; *see also* 84 Fed. Reg. at 23176, n.28.<sup>14</sup>

13           But, contrary to the Rule, courts construing federal conscience protections have noted that a  
14 balancing test is necessary in cases of emergency care: there is no indication “from the express  
15 language of the Weldon Amendment...that enforcing...EMTALA [or California’s equivalent law]  
16 to require medical treatment for emergency medical conditions would be considered  
17 ‘discrimination’ under the Weldon Amendment if the required medical treatment was abortion-  
18 related services.” *See e.g., California v. United States*, No. C 05-00328, 2008 WL 744840, at \*4  
19 (N.D. Cal. Mar. 18, 2008); *see also* Cal. Health & Safety Code § 123420(d).<sup>15</sup>

20           Yet in response to concerns that the Rule conflicts with EMTALA, Defendants assert only  
21 that “OCR intends to read every law passed by Congress in harmony to the fullest extent possible  
22 so that there is maximum compliance with the terms of each law.” 84 Fed. Reg. at 23183  
23 (neglecting to include any exceptions to the Rule or explanation to providers of how to comply  
24 with the Rule and EMTALA). This vague and conclusory statement gives little comfort when the  
25 Rule’s expansive definitions, including the Rule’s definitions of “assist in the performance” of

26 <sup>14</sup> *See* full ACOG opinion at Exhibit A to Zahn Dec.

27 <sup>15</sup> *See also* 151 Cong. Rec. H176-77 (Jan. 25, 2005) (statements by Rep. Weldon acknowledging  
28 requirements of EMTALA and noting that Weldon prohibits coercion in “nonlife-threatening  
situations,” but when the “mother’s life is in danger a health care provider must act to protect the  
mother’s life.”).

1 and “referral” could, contrary to EMTALA, protect providers who turn away a patient needing  
2 emergency care.

3 **B. The Rule Is Arbitrary and Capricious and Thus Invalid Under the APA**

4 A rule is arbitrary and capricious if the agency has “entirely failed to consider an important  
5 aspect of the problem,” “offered an explanation for its decision that runs counter to the evidence  
6 before the agency,” or “is so implausible that it could not be ascribed to a difference in view or  
7 the product of agency expertise.” *Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut.*  
8 *Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Where an agency departs from a prior policy, it must  
9 “display awareness that it is changing position,” show that “there are good reasons” for the  
10 reversal, and demonstrate that its new policy is “permissible under the statute.” *F.C.C. v. Fox*  
11 *Television Stations, Inc.*, 556 U.S. 502, 515 (2009). A more “detailed justification” is needed  
12 when “serious reliance interests” are at stake. *Id.* The Rule fails for all these reasons.

13 **1. Defendants Failed to Reasonably Explain Their Policy Reversal**

14 The Rule effects a significant change in policy from the 2011 rule that will impact the  
15 delivery of healthcare nationwide and how programs accepting federal funds are administered.  
16 The Rule relies largely on a purported spike in complaints; however, this justification is  
17 unsupported and is insufficient, especially given the number of regulated entities and individuals  
18 relying on the existing 2011 rule (and in opposition to the Rule). Defendants admit that OCR has  
19 received only 44 complaints over the last 10 years of alleged instances of violations of conscience  
20 rights. 83 Fed. Reg. at 3886.<sup>16</sup> Also, there is nothing in the recitation of OCR’s closure of the ten  
21 complaints prior to the 2016 election that suggests that OCR’s enforcement is in anyway deficient  
22 and in need of major overhaul. 83 Fed. Reg. 3886. An administration change does not authorize  
23 an unreasoned reversal of course. *State v. U.S. Bureau of Land Mgmt.*, 277 F. Supp. 3d 1106,  
24 1123 (N.D. Cal. 2017) (a new administration must give reasoned explanations for a policy change  
25 and address the findings underpinning a prior rule). Thus, a purported surge in complaints and  
26

27 \_\_\_\_\_  
28 <sup>16</sup> Although Defendants report receiving 343 complaints in 2018, 84 Fed. Reg. at 23229, they  
have failed to comply with FOIA requests for records of complaints. Dkt. No. 1 at 40-43.

1 complaint closures to date leading up to the NPRM cannot serve as any reasoned basis for such a  
2 dramatic policy reversal.

3 Defendants' justification that the Rule will increase access to healthcare is also  
4 unsubstantiated and runs counter to the evidence available in the record. Defendants say that they  
5 "expect[ ] any decrease in access to care to be outweighed by significant overall increases in  
6 access generated" by the Rule because the Rule will allow objecting practitioners to continue in  
7 the practice of medicine (or to enter the field). 84 Fed. Reg. at 23252. The sole evidence  
8 Defendants present to buttress this claim is a survey conducted in 2009.<sup>17</sup> Defendants' use of this  
9 data is problematic in several ways. First, the results are non-representative as the survey was  
10 offered online only to members of five religious medical groups.<sup>18</sup> Second, the data is a decade  
11 old. A summary memo prepared by the polling company includes the disclaimer that the  
12 respondents who participated in the survey "were self-selecting" and that the survey "is not  
13 intended to be representative of the entire medical profession nor of the entire membership rosters  
14 of these organizations." *Cf. Int'l Rehabilitative Scis., Inc., v. Sebelius*, 688 F.3d 994, 1002-04  
15 (9th Cir. 2012) (upholding HHS's decision after the agency weighed scientific studies that ran  
16 counter to the agency's decision, and finding they contained methodological deficiencies).<sup>19</sup>  
17 Finally, the survey's results are out of context: they were obtained in the wake of the proposed  
18 rescission of the 2008 rule. Over 80 percent of respondents said that it was either "very" or  
19 "somewhat" likely that they would limit the scope of their practice of medicine if the 2008 rule  
20 was replaced.<sup>20</sup> And it appears that the question posed to the respondents may have been  
21 misleading, in that it suggested that a rescission of the 2008 rule would leave providers with no  
22  
23

24 \_\_\_\_\_  
25 <sup>17</sup> The Rule cites the same 2009 survey in two different ways: a summary memo dated April 8,  
26 2009, Palma Dec. Ex. F (cited in n.316), and an undated document that combines the 2009  
27 results with a 2011 poll of the general public, Palma Dec. Ex. E (cited in n.309, 322, 340, 347,  
28 349).

<sup>18</sup> Palma Dec. Ex. F, April 8, 2009 summary memo.

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

1 protections in the abortion context.<sup>21</sup> To the contrary of the survey’s purported predictions, there  
 2 is no evidence of an exodus from the medical profession after the rescission of the 2008 rule in  
 3 February 2011. Indeed, Defendants themselves point out that religious providers such as  
 4 Ascension, the “nation’s largest religiously affiliated non-profit health care system” are thriving  
 5 and providing approximately \$2 billion in care, equal to Kaiser Permanente.<sup>22</sup> 84 Fed. Reg. at  
 6 23248. Moreover, the nation’s trusted major medical organizations raised grave concerns about  
 7 the legality and reasonableness of the proposed regulation. *See* ECF No. 1 at 17-20; Aizuss Dec.  
 8 generally. Therefore, the 2009 survey is shoddy foundation on which to build a Rule of such  
 9 broad scope and impact on patients’ access to healthcare. HHS’s determination that the Rule will  
 10 increase access “runs counter to the evidence before the agency” and is therefore arbitrary and  
 11 capricious. *State Farm*, 463 U.S. at 43; *see also California*, 2019 WL 1877392 at \*38 (rejecting  
 12 Defendants’ unsubstantiated claims that other providers are “waiting in the wings” to fill the void  
 13 left by their Title X rule).

14 Despite the substantial amounts of funding and critical programs at risk, Defendants have  
 15 failed to engage in reasoned decisionmaking, relying instead on conclusory and unsubstantiated  
 16 statements, as well as an outdated study concerning the Rule’s alleged public benefits. Given the  
 17 “serious reliance interests at stake,” Defendants’ “conclusory statements do not suffice to explain  
 18 its decision.” *Encino Motorcars*, 136 S. Ct. at 2127.

19 ///

20 ///

21 \_\_\_\_\_  
 22 <sup>21</sup> *Id.* at 2 (summarizing the inquiry posed to respondents as follows: “Without any names or  
 23 political parties being mentioned, respondents were provided with a short description of the new  
 24 conscience protection law and its recent inception: ‘**Just two months ago, a federal law known as ‘conscience protection’ went into effect after reports of doctors being discriminated against for declining to perform abortions. It protects doctors and other medical professionals who work at institutions that receive federal money from performing medical procedures to which they object on moral or religious grounds.**’) (emphasis in original).

25 <sup>22</sup> Also, employment in the healthcare has increased steadily, with a gain of about 2.3 million  
 26 employees by January 2019 since the publication of the current regulations in February 2011.  
 27 U.S. Bureau of Labor Statistics, Employment, Hours, and Earnings from the Current Employment  
 28 Statistics survey (National), All employees, thousands, education and health services, seasonally  
 adjusted, accessed through <https://beta.bls.gov/dataQuery/search>.



## 2. The Rule’s Stance on Title VII is Illogical in its Own Terms

The Rule creates an unworkable inconsistency with Title VII of the Civil Rights Act of 1964. It seeks to replace Title VII’s well-established religious accommodation process with a different standard for a segment of the healthcare industry as to a subset of medical procedures deemed to be under the Rule’s umbrella.<sup>23</sup> But the Rule raises too many uncertainties about when and how the alternative accommodation process will work, which demonstrates that the Rule was not the product of reasoned and logical decisionmaking. If an agency’s decision is “illogical on its own terms,” that decision is arbitrary and capricious. *Am. Fed’n of Gov’t Employees, Local 2924 v. Fed. Labor Relations Auth.*, 470 F.3d 375, 380 (2006).

Title VII (which applies to employers with 15 or more employees) makes it unlawful for employers to discriminate against any individual with regard to his or her compensation, terms, conditions, or privileges of employment, based on that employee’s religion. 42 U.S.C. § 2000e-2(a)(1). Employers are required to reasonably accommodate an employee’s religion unless doing so would constitute an undue hardship (*e.g.*, “more than a de minimis cost” to the employer). 42 U.S.C. § 2000(e)(j); *Opuku-Boateng v. State of Cal.*, 95 F.3d 1461, 1467-1468 (9th Cir. 1996). But the Rule now creates a carve out from Title VII for religious *and* conscience objections in the

---

<sup>23</sup> As in other industries, religious accommodations in healthcare have been examined under Title VII. *Stormans Inc. v. Selecky*, 844 F. Supp. 2d 1172, 1201 (W.D. Wash. 2012) (challenge to state law requiring pharmacies and pharmacists to dispense lawfully prescribed emergency contraceptives over their sincere religious belief); *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 227 (3d Cir. 2000) (state hospital’s offer to transfer nurse was reasonable accommodation for her religious beliefs which prevented her from assisting in emergency pregnancy termination procedures) *Knight v. Conn. Dep’t of Health*, 275 F.3d 156 (2nd Cir. 2001) (nurse consultant’s Title VII’s rights were not violated by prohibition against proselytizing); *Grant v. Fairview Hosp. & Healthcare Servs.*, 2004 WL 326694 (D. Minn. Feb. 18, 2004) (ultrasound technician offered a reasonable accommodation when hospital excused him from performing ultrasounds on women considering abortions; hospital did not have to permit him to provide religious counseling, as that accommodation would pose an undue hardship); *Mereigh v. N.Y. & Presbyterian Hosp.*, 2017 WL 5195236 (S.D. N.Y. Nov. 9, 2017) (hospital provided reasonable accommodation to nurse objecting to family planning services); *Noesen v. Med. Staffing Network*, 232 Fed.Appx. 581 (7th Cir. 2007) (no requirement under Title VII to shift pharmacist out of all initial customer contacts to avoid him speaking to customers seeking contraception); *Bruff v. N. Miss. Health Servs., Inc.*, 244 F.3d 495, 500 (5th Cir. 2001) (no duty to capitulate to an “inflexible position” of EAP counselor who wanted to refer all LGBTQ issues to other practitioners).

1 healthcare sector, but only for those entities, medical procedures and services regulated by the  
2 Rule.

3 The Rule first creates a different hiring process for regulated entities. Under Title VII's  
4 requirements for accommodation of religious beliefs, an applicant or employee is generally not  
5 entitled to an accommodation that relieves them of the obligation to perform the significant or  
6 core duties of the position. But under the Rule, regulated entities (and possibly sub-recipients and  
7 contractors) seemingly cannot inquire in advance if the employee would have any objection to  
8 performing all job functions. The Rule states that an employer "may," after hiring and no more  
9 than once per calendar year (unless there is "persuasive justification"), require an employee to  
10 inform the employer of conscience objections. 84 Fed. Reg. at 23263.<sup>24</sup> As a consequence,  
11 employers will be put in an untenable position where they may be hiring individuals who will not  
12 perform the core duties of the position. And unlike the Rule's restriction on dialogue, under Title  
13 VII "courts have noted that bilateral cooperation is appropriate [and consistent with Congress's  
14 goal of flexibility] in the search for an acceptable reconciliation of the needs of the employee's  
15 religion and the exigencies of the employer's business." *Ansonia Bd. of Educ. v. Philbrook*, 479  
16 U.S. 60, 69 (1986); *Shelton*, 223 F.3d at 227

17 The accommodation process is also changed for conscience objections. Under Title VII, "a  
18 sufficient religious accommodation need not be the 'most' reasonable one (in the employee's  
19 view), it need not be the one the employee suggests or prefers, and it need not be the one that  
20 least burdens the employee." *Ansonia Bd. of Educ.*, 479 U.S. at 68-69. The employer satisfies  
21 Title VII when it offers any reasonable accommodation. *Id.*; *Shelton*, 223 F.3d at 226; *Rodriguez*  
22 *v. City of Chicago*, 156 F.3d 771 (7th Cir. 1998). Also, "courts agree that an employer is not  
23 liable under Title VII when accommodating the employees' religious beliefs would require the  
24 employer to violate federal or state law," or if it would result in discrimination. *Sutton v.*  
25 *Providence St. Joseph Med. Ctr.*, 192 F.3d 826, 830-31 (9th Cir. 1999); *Peterson v. Hewlett*  
26 *Packard Co.*, 358 F.3d 599, 607 (9th Cir. 2004).

27 <sup>24</sup> "Persuasive justification" is not defined. Does an employer have to permit an employee to  
28 refuse to do portions of their job for several weeks or months before that is sufficient "persuasive  
justification" to question the employee, and how will that impact the delivery of healthcare?



1 But the Rule eliminates the undue hardship exemption, and states that there is no  
 2 discrimination if the employee “voluntarily accepts an effective accommodation.” 84 Fed. Reg.  
 3 at 23191. If there is no “effective” accommodation or the person is unwilling to accept any of the  
 4 options offered, the Rule is silent on what can be done with that employee. Arguably, the  
 5 employee cannot be fired because that would be discriminatory under the Rule. *Id.*

6 The administrative complaint process also appears to be different. HHS/OCR seems to give  
 7 itself authority to arbitrate Title VII claims in the healthcare context by stating that it will adopt a  
 8 “different approach” in resolving claims of discrimination. 84 Fed. Reg. at 23191. But EEOC  
 9 has enforcement authority under Title VII and utilizes the “reasonableness” standard. 42 U.S.C.  
 10 §§ 2000e-4, 2000e-5, 2000e-8; 42 U.S.C. § 2000(e)(j); 29 C.F.R. § 1605.2. The Rule is silent on  
 11 what should happen if OCR and EEOC arrive at different determinations about whether an  
 12 accommodation is sufficient or if EEOC applies the undue hardship exemption.

13 Due to the Rule’s discrepancies with Title VII, chaos is being created where it need not  
 14 exist. Employers and employees will struggle to figure out which system they are supposed to be  
 15 using, and if it is the conscience-objector approach, that is not fully explained. Defendants failed  
 16 to provide even the “minimal level of analysis” to explain how the alternative accommodation  
 17 process will work for affected employers and employees. *Encino Motorcars*, 136 S. Ct. at 2126.

### 18 **3. Defendants Failed to Meaningfully Respond to Comments** 19 **Concerning the Rule’s Impacts**

20 Defendants ignore a multitude of comments from major medical organizations, patient  
 21 advocacy organization, academics and experts, and individuals who raised concerns that the Rule  
 22 will limit access to healthcare, especially in rural areas, and to the LGBTQ community, and  
 23 women seeking reproductive healthcare. A rule is arbitrary and capricious if the agency “failed to  
 24 consider an important aspect of the problem[.]” *State Farm*, 463 U.S. at 43. An agency “must  
 25 respond to significant points raised during the public comment period.” *Allied Local & Reg’l*  
 26 *Mfrs. Caucus v. EPA*, 215 F.3d 61, 80 (D.C. Cir. 2000). An Agency must address “significant”  
 27 comments or those “which, if true, raise points relevant to the agency’s decision.” *City of*  
 28 *Portland, v. EPA*, 507 F.3d 706, 715 (D.C. Cir. 2007). Defendants failed to meet this standard.

1                   **a. Defendants Concede, but Dismiss, Harm to Rural Communities**

2           A significant number of organizations and individuals commented that expanded refusals  
3 would undercut access to healthcare, including in emergencies, for individuals living in rural  
4 communities.<sup>25</sup> Defendants concede that “patients in rural areas are more likely than patients in  
5 urban areas to suffer adverse health outcomes as a result of being denied care.” 84 Fed. Reg. at  
6 23253. Nevertheless, Defendants dismiss this undisputed harm by again advancing the  
7 unsupported assertion that the Rule will negate this harm by preventing providers from being  
8 “driven out” of the profession and maintaining that decreased access to healthcare and some  
9 procedures is better than “no healthcare at all” for rural communities. *Id.* at 23253-54. But, as  
10 pointed out by the National Organization for Women, patients in rural areas may not have other  
11 options for health and life preserving medical care if they are denied it under the Rule.<sup>26</sup>

12           Defendants also claim that rural patients are also “more likely to agree with providers in  
13 objecting to certain procedures encompassed” in the Rule. 84 Fed. Reg. at 23253. But by relying  
14 on these grossly unsupported generalizations, Defendants have failed to meaningfully consider  
15 the comments of patients in rural areas who have expressly confirmed that they too need, want,  
16 and deserve standard medical treatment and comprehensive medical care, including women  
17 seeking full reproductive healthcare and LGBTQ individuals.<sup>27</sup> Women in low-income rural  
18 areas will be particularly impacted by the Rule, especially as they endeavor to access  
19 contraceptive and reproductive services, including maternity care and abortion. *See Zahn Dec.*  
20 ¶¶ 8-10.<sup>28</sup> A Rule that allows providers to interfere with a woman’s access to contraceptives will  
21 lead to unintended pregnancies and further undue hardships for women. *Lara Dec.* ¶¶ 21-22. An

22 <sup>25</sup> *See e.g.*, Palma Dec. Ex. N, Nat. Assoc. Councils Dev. Disabilities, at 2.; Ex. L, Physicians for  
23 Reproductive Health, at 6; Ex. M, Assoc. Am. Med. Coll., at 5; Ex. G, Am. Acad. PAs, at 1; Ex.  
24 O, Or. Found. for Reproductive Health, at 6; Ex. P, N.C. Justice Center, at 5-6; Ex. Q, Nat. Center  
25 for Lesbian Rights; Ex. R, Anti-Defamation League, at 4; Ex. S, Justice in Aging, at 3.

26 <sup>26</sup> Palma Dec. Ex. W; *see also* Palma Dec. Ex. AA at 14 (insurance may limit options available if  
27 care is denied).

28 <sup>27</sup> *See e.g.*, Palma Dec. Ex. Z, Family Voices; Ex. AA, individual comments.

<sup>28</sup> “Whereas a single, affluent professional might experience such a refusal as inconvenient and  
seek out another physician, a young mother of three depending on public transportation might  
find such a refusal to be an insurmountable barrier to medication because other options are not  
realistically available to her. She thus may experience loss of control of her reproductive fate and  
quality of life for herself and her children. Refusals that unduly burden the most vulnerable of  
society violate the core commitment to justice in the distribution of health resources.”\

1 increase in unwanted pregnancy has larger ramifications, because “[t]he ability of women to  
 2 participate equally in the economic and social life of the Nation has been facilitated by their  
 3 ability to control their reproductive lives.” *Planned Parenthood v. Casey*, 505 U.S. 833, 856  
 4 (1992) (plurality op.).

5 By dismissing the serious risk of harm, or even death, that patients could suffer in rural  
 6 areas if providers can freely deny them care, Defendants have failed to meaningfully respond to  
 7 this significant issue raised by numerous commenters and conceded by Defendants, thus  
 8 rendering the Rule arbitrary and capricious. *Del. Dep’t of Nat. Res. & Env’tl. Control*, 785 F.3d 1,  
 9 15 (D.C. Cir. 2015); *see also Ctr. for Biological Diversity v. U.S. Bureau of Land Mgmt.*, 698  
 10 F.3d 1101, 1125 (9th Cir. 2012).

11 **b. Defendants’ Dismissal of the Harm to the LGBTQ Community**  
 12 **Does not Withstand Scrutiny**

13 Defendants are equally dismissive of comments raising concerns that the LGBTQ  
 14 community will be harmed by the Rule, minimizing their concerns of being “offended,” “insulted  
 15 or emotionally distressed” by being denied care. 84 Fed. Reg. at 23251. Defendants again claim  
 16 that any potential harm will be mitigated by the unsupported assertion that the Rule will prevent  
 17 providers from leaving the field. *Id.* And while comments stated that some LGBTQ individuals  
 18 are denied care altogether due to prejudices against this community (*see supra* Section I(B)(3)(a)  
 19 at n.31), Defendants conclude that the “burden of not being able to receive any health care clearly  
 20 outweighs the burden of not being able to receive a particular treatment.” 84 Fed. Reg. 23252.  
 21 Summarily disregarding these comments as well as studies cited by commenters that the LGBTQ  
 22 community already faces discrimination and barriers to basic healthcare, Defendants conclude  
 23 that the data is insufficient and unreliable, with “too many confounding variables,” thus  
 24 preventing Defendants from arriving at a “useful estimate” to quantify this harm. *Id.* Even if that  
 25 were true, this Court recently held that “[t]he mere fact that the ... effect[ ] [of a rule] is *uncertain*  
 26 is no justification for *disregarding* the effect entirely.” *California*, 2019 WL 1877392, at \*39,  
 27 *citing Pub. Citizen v. Fed. Motor Carrier Safety Admin.*, 374 F.3d 1209, 1219 (D.C. Cir. 2004)  
 28 (emphases in original). This Court added:

1 HHS cannot simply disregard costs that are uncertain or difficult to quantify. Its  
 2 “Guidelines for Regulatory Impact Analysis” set forth in detail how the agency is  
 3 supposed to “address[ ] outcomes that cannot be quantified but may have important  
 4 implications for decision-making.” HHS Guidelines at 47. Per the Guidelines, “[i]f  
 5 quantification is not possible, analysts must determine how to best provide related  
 6 information.” *Id.* (emphasis added); *see id.* at 47–51 (laying out various approaches  
 7 for incorporating non-quantified effects into regulatory impact analysis). “At  
 8 minimum, analysts should list significant nonquantified effects in a table and discuss  
 9 them qualitatively.” *Id.* at 51.

6 *California*, 2019 WL 1877392, at \*39. But here, Defendants only summarily address access  
 7 issues for the LGBTQ community (and all other patients) by listing the non-quantified cost of  
 8 “seeking of alternative providers of certain objected-to medical services or procedures.” 84 Fed.  
 9 Reg. 23227. Defendants surmise that the impact of such denials is no different than being turned  
 10 away because of an inability to pay for the medical service. *Id.* at 23251. This reasoning fails for  
 11 many of the reasons previously outlined, not the least of which being that EMTALA bars denials  
 12 of care in emergencies due to an inability to pay.

13 In short, the Rule is “arbitrary” or “capricious” and therefore invalid. 5 U.S.C. § 706(2)(A).  
 14 Although the circumstances since the enactment of the 2011 rule are relatively unchanged,  
 15 Defendants have made a significant change in public policy. These changes are not supported by  
 16 *any* new factual developments. Because Defendants have acted arbitrarily and capriciously, the  
 17 Rule should be found unlawful. *See Encino Motorcars*, 136 S. Ct. at 2126.

### 18 **C. The Rule Violates the Spending Clause**

19 Under the Spending Clause, U.S. Const., art. I, § 8, cl. 1, Congress may not impose  
 20 conditions on federal funds that are (1) so coercive so as to compel (rather than merely  
 21 encourage) States to comply, (2) ambiguous, (3) retroactive, or (4) unrelated to the federal interest  
 22 in a particular program. *NFIB*, 567 U.S. at 575–82; *S. Dakota v. Dole*, 483 U.S. 203, 206–08  
 23 (1987). Conditioning California’s receipt of federal funds on compliance with the Rule would  
 24 violate all four of these limitations.

#### 25 **1. The Rule is Unconstitutionally Coercive**

26 Like other threats to strip states of all federal Medicaid funding, the Rule is an  
 27 unconstitutionally coercive “a gun to the head.” *NFIB*, 567 U.S. at 581. Because “Medicaid  
 28 spending accounts for over 20 percent of the average State’s total budget, with federal funds

1 covering 50 to 83 percent of those costs”—and because States “have developed intricate statutory  
 2 and administrative regimes” in reliance on such funding—the threatened loss of federal Medicaid  
 3 funding leaves States “with no real option but to acquiesce.” *Id.* at 581–82. For this reason, the  
 4 Rule violates the Spending Clause: Congress may not “penalize States that choose not to  
 5 participate in [a] new program by taking away their existing Medicaid funding.” *Id.* at 585.

6 Indeed, if anything, the Rule is even more coercive than the threatened loss of Medicaid  
 7 funding in *NFIB*. For one thing, the Rule threatens not only Medicaid funding, but *all* funding  
 8 under a vast array of health, education, and employment programs, and not just all of California’s  
 9 Medicaid. Cantwell Dec. ¶ 7; Ghaly Dec. ¶¶ 8-19; Toche Dec. ¶ 12; Cervinka Dec. ¶¶ 5-16; Price  
 10 Dec. ¶¶ 14-15; Parmelee Dec. ¶¶ 5-9; Nunes Dec. ¶¶ 12-18. Additionally, the unbounded,  
 11 discretionary nature of its enforcement authority, *see* 84 Fed. Reg. at 23272, which impermissibly  
 12 seeks to bootstrap Weldon’s consequences to two dozen now expanded federal conscience laws,  
 13 heightens the coercive effect of the Rule. And whereas the conditions that could result in a loss  
 14 of funding in *NFIB* were clear (failure to expand Medicaid), here, the Rule is not so clear. Given  
 15 the billions of dollars of federal funding at stake, the loss of which would decimate the delivery of  
 16 public services to the country’s most populous state, the Rule constitutes “economic dragooning”  
 17 rather than “relatively mild encouragement” to comply. *See NFIB*, 567 U.S. at 581–82. HHS  
 18 itself appears to have previously recognized the constitutional problem that would arise if, in the  
 19 name of enforcing longstanding and carefully limited federal conscience laws, the federal  
 20 government asserted sweeping new authority to strip states of the funding threatened here.<sup>29</sup> The  
 21 Court should do the same, and therefore should hold that the Rule is unconstitutionally coercive.

## 22 **2. The Rule Is Unconstitutionally Ambiguous**

23 The Rule is also unconstitutionally ambiguous. If Congress desires to condition the States’  
 24 receipt of federal funds, it “must do so unambiguously.” *Pennhurst State School and Hosp. v.*  
 25 *Halderman*, 451 U.S. 1, 17 (1981). “[L]egislation enacted pursuant to the spending power is  
 26 much in the nature of a contract; in return for federal funds, the States agree to comply with  
 27 federally imposed conditions.” *Id.* Because “[t]here can, of course, be no knowing acceptance if

28 <sup>29</sup> Palma Dec. Ex. B, Letter from OCR Director to Complainants (June 21, 2016).

1 a State is unaware of the conditions or is unable to ascertain what is expected of it,” *id.*, courts  
2 deciding whether a condition is ambiguous under the Spending Clause view statutes “from the  
3 perspective of a state official who is engaged in the process of deciding whether the State should  
4 accept [the] funds and the obligations that go with those funds.” *Arlington Cent. Sch. Dist. Bd. of*  
5 *Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

6 Under this standard, the rule is unconstitutionally ambiguous. Contrary to Defendants’  
7 argument that the Rule merely “mirror[s]” existing federal law, 84 Fed. Reg. at 23222, the Rule  
8 creates expansive and apparently unbounded definitions untethered from prior constructions of  
9 the relevant statutes. For example, the Rule allows *any* “health care personnel” to refuse medical  
10 care (or refuse to perform any action that has an “articulable connection” to furthering a  
11 procedure) without providing any information about the patient’s medical condition or treatment  
12 options on the basis of “ethical[] or other reasons.” 84 Fed. Reg. 23263. Given this sweeping  
13 and indefinite language, the State cannot make a knowing choice as to whether it would be a  
14 violation of the Rule if it takes enforcement action against medical providers or programs that  
15 deny care and/or who discriminate against its most vulnerable residents.

16 Additionally, the Rule is so broadly and vaguely written that it is nearly impossible to  
17 ascertain how California should communicate with its sub-recipients (such as cities and counties),  
18 in order to obligate them to comply with the Rule in a manner that effectively protects  
19 California’s own funding. The Rule makes California responsible for policing others’  
20 compliance, including other public entities that have obtained funding. 84 Fed. Reg. at 23180  
21 (“[R]ecipients are responsible for their own compliance with Federal conscience and anti-  
22 discrimination laws and implementing regulations, *as well as for ensuring their sub-recipients*  
23 *comply with these laws.*”) (emphasis added). Thus, the State could be found in violation of the  
24 Rule if a sub-recipient is found in violation, regardless of whether the State was put on notice of  
25 such violation and regardless of whether such violation was condoned by the State. The  
26 Spending Clause does not allow such an outcome. For example, in the Title IX context, a federal  
27 funding recipient cannot be held vicariously liable for harassment perpetrated by an individual  
28 employed by that recipient if the funding recipient was not on notice of the particular harassment.



1 *See Franklin v. Gwinnett Cty. Pub. Sch.*, 503 U.S. 60, 74-75 (1992) (finding school to be  
 2 vicariously liable for teacher’s harassment of student because it was on notice of teacher’s  
 3 discrimination and took no action); *Smith v. Metro. Sch. Dist. Perry Twp.*, 128 F.3d 1014, 1030  
 4 (7th Cir. 1997) (holding that “[t]o impute liability to a program or activity” based on one person’s  
 5 actions, “even if [the government entity] acted without notice” of the person’s actions, “cannot be  
 6 used to support a monetary award in a Spending Clause case”); *Rosa H. v. San Elizario Indep.*  
 7 *Sch. Dist.*, 106 F.3d 648, 654 (5th Cir. 1997) (“As a statute enacted under the Spending Clause,  
 8 Title IX should not generate liability unless the recipient of federal funds agreed to assume the  
 9 liability.”). Terminating California’s funding based on the conduct of third parties that participate  
 10 in the program, including other public entities, such as counties (Cantwell Dec. ¶ 6), as the Rule  
 11 purports to do, would create such an unsure stream of funding that it would be financially  
 12 paralyzing for the State.

13 “[B]road interpretations of ambiguous language” in a funding condition are fundamentally  
 14 unfair and violate the Spending Clause. *Clovis Unified Sch. Dist. v. Cal. Office of Admin. Hr’g*,  
 15 903 F.2d 635, 646 (9th Cir. 1990); *City & Cnty. of San Francisco v. Sessions*, No. 18-cv-05146-  
 16 WHO, 2019 WL 1024404, at \*14 (N.D. Cal. Mar. 4, 2019). Despite the substantial amounts of  
 17 funding and critical programs at risk, the State and its agencies cannot reasonably anticipate what  
 18 actions Defendants might deem a violation and strip California of its funding. The Rule’s vague  
 19 and subjective standards, based on overbroad definitions without regard to statutory definitions  
 20 and ill-reasoned reversals of prior policy and determinations, invite inconsistent and biased  
 21 enforcement by Defendants. For this reason, too, the Rule is unconstitutional.

### 22 **3. The Rule Places Conditions on Funding Already Accepted**

23 The federal government cannot “surpris[e] participating States with post-acceptance or  
 24 ‘retroactive’ conditions.” *NFIB*, 567 U.S. at 582-83. Yet the Rule, as written, does just that. In  
 25 *NFIB*, the Court rejected the government’s argument that the Medicaid expansion was “properly  
 26 viewed merely as a modification of the existing program because the States agreed that Congress  
 27 could change the terms of Medicaid when they signed on in the first place.” *NFIB*, 567 U.S. at  
 28 582–83. Although the statute expressly reserved “[t]he right to alter, amend, or repeal any



1 provision of the Social Security Act, which includes the original Medicaid provisions,” the Court  
2 explained that the Medicaid expansion was a shift not merely in degree, but in kind. *Id.* at 583.  
3 While the prior Medicaid Act was limited to four particular categories of persons (the disabled,  
4 the blind, the elderly, and needy families with dependent children), the expansion transformed  
5 Medicaid into a program to meet the healthcare needs of the entire nonelderly population with  
6 income below 133 percent of the poverty level. *Id.* As such, “[a] State could hardly anticipate  
7 that Congress’s reservation of the right to ‘alter’ or ‘amend’ the Medicaid program included the  
8 power to transform it so dramatically.” *Id.* at 584.

9 Congress conferred no authority to Defendants to “alter, amend, or repeal” the federal  
10 conscience laws. Nevertheless, Defendants seek to override the existing federal conscience  
11 protection framework to broadly expand not only those who are covered under federal conscience  
12 protections, but also what activities are considered protected and how they are enforced. For  
13 example, the Weldon, Church, and Coats-Snowe Amendments refer only to specific  
14 circumstances in which healthcare providers or certain enumerated healthcare entities may not be  
15 required to participate in abortions, sterilizations, or certain health service programs and research  
16 activities. Nevertheless, the Rule seeks to broadly expand the scope of the circumstances under  
17 which the federal conscience laws may be implicated, which constitutes a transformation in kind,  
18 not degree.

19 Moreover, Defendants’ reversal of their interpretation of the Weldon Amendment as it  
20 relates to California’s abortion coverage requirement constitutes retroactive, post-acceptance  
21 conditions. This unsupported reversal creates uncertainties as to what additional state laws and  
22 policies may also now be deemed a violation of the Rule. And the January 18, 2019 “Notice of  
23 Violation” issued against California, although it concluded that further remedial action against  
24 California was not warranted, could, under the Rule, be deemed a “determination” that could  
25 “inform funding decision-making.” 84 Fed. Reg. at 23177, 23262.

26 California state agencies accept and plan for the receipt of federal funding with the  
27 expectation that they will receive the funds under existing agreements and under existing federal  
28 programs and conditions. Ghaly Dec. ¶¶ 9-10; Sturges Dec. ¶¶ 6-7; Price Dec. ¶ 16; Parmelee

1 Dec. ¶ 7; Nunes Dec. ¶ 11. State programs and local programs that depend on pass-through  
 2 funding would be crippled by being unable to expend anticipated funds because they cannot  
 3 absorb such a loss of funding without a reduction in staffing, programs, and services. Ghaly Dec.  
 4 ¶ 8; Sturges Dec. ¶ 5; Ghaly Dec. ¶ 8, 16; Price Dec. ¶¶ 14-15; Parmelee Dec. ¶ 9; Nunes Dec. ¶  
 5 10; Cervinka Dec. ¶¶ 8, 11, 13, 15; Toche Dec. ¶ 12. Thus, a sudden disruption in anticipated  
 6 federal funds would create budgetary and operational chaos for state agencies providing critical  
 7 services for Californians. Ghaly Dec. ¶¶ 8, 10, 12, 14, 15, 17, 18; Sturges Dec. ¶ 6; Nunes Dec. ¶  
 8 10, Cervinka Dec. ¶ 16. Notably, DMHC, which administers California’s Medicaid program,  
 9 known as Medi-Cal, and other federally funded healthcare programs, will receive more than \$63  
 10 billion in federal funding for services and operations in Fiscal Year 2018-2019. But much of the  
 11 Medi-Cal budget is expended up-front by the state in expectation of reimbursement from the  
 12 federal government. Ghaly Dec. ¶ 11. The reconditioning of those existing funding will bring  
 13 harm to the state’s fisc because those funds would not be reimbursed.

#### 14 **4. The Rule Places Conditions on Funding that is Unrelated to** 15 **Protection of Conscience Objections**

16 The Spending Clause requires funding conditions “bear some relationship to the purpose of  
 17 the federal spending,” *New York v. United States*, 505 U.S. 144, 167 (1992), and be “reasonably  
 18 calculated” to address the “particular . . . purpose for which the funds are expended.” *Dole*, 483  
 19 U.S. at 208-09. “Conditions on federal grants might be illegitimate if they are unrelated to the  
 20 federal interest in particular national projects or programs.” *Id.* at 207 (quotations omitted). The  
 21 Rule places various federal grants—such as those for Medicaid, HIV prevention, the prevention  
 22 of child abuse and neglect, foster care placement and adoptions assistance, energy assistance for  
 23 low-income, elderly and disabled individuals, among so many others—at risk even though the  
 24 purposes of those statutes are wholly unrelated to the protection of conscience objections. Ghaly  
 25 Dec. ¶¶ 8-9, 14-15.

26 Worse, the Rule also jeopardizes funding for California’s numerous labor and educational  
 27 programs, Sturges Dec. ¶¶ 7-9; Parmelee Dec. ¶¶ 5-9—programs that lack any nexus or  
 28 relationship whatsoever to the Rule’s healthcare restrictions. For example, there is no

1 “reasonable relationship” between the healthcare condition that the Rule adopts through the  
2 Weldon Amendment and the operation of California’s unemployment insurance program, which  
3 provides weekly payments for unemployed workers who lose their jobs through no fault of their  
4 own. Sturges Dec. ¶ 8. If this Court permits OCR to condition California’s receipt of billions of  
5 dollars for educational and employment programs on the State’s agreement to abide by a  
6 completely unrelated federal healthcare restriction, then *Dole*’s relatedness test is rendered  
7 meaningless and the federal government would be able to regulate all aspects of State government  
8 through the Spending Clause.

9 **D. The Rule Violates the Establishment Clause**

10 The Rule violates the Establishment Clause because it burdens third parties, including  
11 patients, employers, and employees, by purporting to guarantee an unqualified right to opt out of  
12 “procedures encompassed” in the Rule in the name of a religious accommodation. 84 Fed. Reg.  
13 at 23253. Government conduct may not have a primary effect that advances a particular religious  
14 practice. *Catholic League for Religious & Civil Rights v. City & Cty. of S.F.*, 624 F.3d 1043,  
15 1054-55 (9th Cir. 2010) (en banc). Conduct unlawfully advances religion by favoring religion at  
16 the expense of the rights, beliefs, and health of others. *Corp. of Presiding Bishop of Church of*  
17 *Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327, 334-35 (1987) (“At some point,  
18 accommodation may devolve into ‘an unlawful fostering of religion.’”).

19 The Supreme Court has repeatedly held that government conduct that shifts the burden to  
20 accommodate religious exercise to third parties violates the Establishment Clause. The Court  
21 invalidated a Connecticut statute providing employees with the absolute right to a day off on their  
22 chosen Sabbath because the law “imposes on employers and employees an absolute duty to  
23 conform their business practices to the particular religious practices of the employee by enforcing  
24 observance of the Sabbath the employee unilaterally designates.” *Estate of Thornton v. Caldor*,  
25 472 U.S. 703, 709 (1985). The Court explained that the “State thus commands that Sabbath  
26 religious concerns automatically control over all secular interests at the workplace; the statute  
27 takes no account of the convenience or interests of the employer or those of other employees who  
28 do not observe a Sabbath.” *Id.*; *Tex. Monthly, Inc. v. Bullock*, 489 U.S. 1, 18, n.8 (1989)

1 (plurality op.) (tax-exemption for religious periodicals invalid because it substantially burdened  
2 nonbeneficiaries by increasing their tax bills); *see also Cutter v. Wilkinson*, 544 U.S. 709 (2005)  
3 (“courts must take adequate account of the burdens a requested accommodation may impose on  
4 nonbeneficiaries”); *United States v. Lee*, 455 U.S. 252 (1982) (rejecting request for a religious  
5 exemption where granting the exemption would operate to impose the employer’s faith on the  
6 employee).

7 Here, the Rule permits providers, insurers, plan sponsors (i.e., employers) and other  
8 healthcare personnel and entities to exempt themselves from providing a broad range of  
9 healthcare services on the basis of religion, irrespective of the burden on patients, employers, and  
10 other employees whose work will be impacted by the refusals. Like the law invalidated in  
11 *Caldor*, the Rule delegates to individuals and private entities the ability to prefer religious  
12 practice “over all secular interests,” 472 U.S. at 709, including full and equal access to healthcare  
13 in accordance with ACA sections 1554 and 1557, emergency and life-saving medical care in  
14 accordance with EMTALA, and consideration of the “exigencies of the employer’s business”  
15 under Title VII (*Ansonia Bd. of Educ.*, 479 U.S. at 69). And unlike the 2008 rule from which the  
16 Rule borrows, there is no indication that the Rule takes into account federal anti-discrimination  
17 laws as an important secular concern. *See* 73 Fed. Reg. 78072. Yet the Supreme Court has held  
18 that “a[] [religious] accommodation must be measured so that it does not override other  
19 significant interests.” *Wilkinson*, 544 U.S. at 722.

20 The Rule is thus invalid under the Establishment Clause because it “imposes significant  
21 burden[s]” on patients, employers, and employees, at the expense of a religious accommodation.  
22 *Caldor*, 472 U.S. at 710; *see also Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 739 (2014)  
23 (Kennedy, J., concurring) (religious accommodation must not “unduly restrict other persons, such  
24 as employees, in protecting their own interests.”).

## 25 **II. ABSENT AN INJUNCTION, CALIFORNIA WILL SUFFER IRREPARABLE HARM**

26 The Rule will inflict immediate, irreparable harm upon California. A likely constitutional  
27 violation—which is present here—is sufficient to establish irreparable harm for purposes of a  
28

1 preliminary injunction. *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012). But the Rule  
2 also threatens to inflict additional irreparable harm on California, as set forth below.

3 **A. Decreased Access to Healthcare and Disproportionate Impact on**  
4 **Vulnerable Communities**

5 California’s public health and the mission of its public health agencies will be irreparably  
6 harmed by the Rule should it take immediate effect pending judicial review. *See State v. Bureau*  
7 *of Land Mgmt.*, 286 F. Supp. 3d 1054, 1074 (N.D. Cal. 2018) (finding irreparable harm from  
8 agency rule that “will have irreparable consequences for public health”).

9 The Rule will result in decreased access to healthcare services that will disproportionately  
10 harm marginalized groups in California, including individuals in rural communities, LGBTQ  
11 individuals, and women. *See supra* Section I(B)(3); *see also* Aizuss Dec. ¶¶ 11-16; Palma Dec.  
12 Ex. G, Am. Acad. PAs, at 1; Ex. H, Am. Nurses Assoc., at 1-2; Ex. I, Cal. Primary Care Assoc.,  
13 at 1-2; Ex. AA, individual comments. For example, rural communities in California often have  
14 fewer primary care doctors and specialists than may be needed to serve a given community. Lara  
15 Dec. ¶ 27. Insurance coverage options are similarly limited in rural areas, often with only one or  
16 two health insurers that provide coverage. Lara Dec. ¶ 27; Palma Dec. Ex. G, Am. Acad. PAs, at  
17 1; Ex. AA, individual comments. Women in low-income rural areas will encounter barriers  
18 trying to access contraceptive and reproductive services, including maternity care and abortion.  
19 *See Zahn Dec.* ¶¶ 8-10; Lara Dec. ¶¶ 21-22. In fact, this Court recently recognized that the  
20 “consequence of the reduced availability and quality of health services [including contraception]  
21 is worse health outcomes for patients and the public as a whole,” thus supporting preliminary  
22 relief. *California*, 2019 WL 1877392 at \*10.

23 Members of the LGBTQ population will also be disproportionately impacted by the Rule.  
24 *See supra* Section I(B)(3)(b); Palma Dec. Ex. I, Cal. Primary Care Assoc., at 1-2; Ex. J, Cal.  
25 LGBT Health & Human Serv. Network, at 2-3. The Rule can be expected to increase the number  
26 of providers who will not treat someone because they are LGBTQ. Palma Dec. Ex. J, Cal. LGBT  
27 Health & Human Serv. Network at 2-3. The federal government’s own Office of Disease  
28 Prevention and Health Promotion has acknowledged that LGBTQ persons already face health

1 disparities linked to social stigma, discrimination, and the denial of their civil and human rights  
2 leading to higher rates of psychiatric disorders, substance abuse and suicide. Lara Dec. ¶ 28.  
3 This Rule will limit access to mental health care for some populations, resulting in increased  
4 suicide rates and treatment costs for suicide attempts. *Id.* at ¶ 29. The Rule will also limit access  
5 to medical services such as HIV preexposure prophylaxis and postexposure prophylaxis, which  
6 will likely result in an increase in the number of people becoming HIV positive. *Id.* at ¶ 16.

7 The Rule will decrease access to healthcare services by giving not only healthcare  
8 providers, but any healthcare worker the ability to refuse medical care, or the ability to refuse  
9 coverage for medically necessary services, thus making it more difficult for State entities charged  
10 with overseeing Californians' access to health care to accomplish their primary missions.  
11 Cantwell Dec. ¶ 8; Lara Dec. ¶ 6; *Valle del Sol Inc. v. Whiting*, 732 F.3d 1006, 1029 (9th Cir.  
12 2013) (finding irreparable harm where “organizational plaintiffs have shown ongoing harms to  
13 their organizational missions as a result of the statute”); *League of Women Voters of U.S. v.*  
14 *Newby*, 838 F.3d 1, 9 (D.C. Cir. 2016) (holding that obstacles that “make it more difficult for the  
15 [organizations] to accomplish their primary mission ... provide injury for purposes both of  
16 standing and irreparable harm”).

### 17 **B. Consumer Confusion Resulting From Denials**

18 The Rule will result in consumer confusion about which providers will perform what  
19 services and will unduly burden consumers as they try to navigate the Rule's new constraints on  
20 the health care delivery system. Ghaly Dec. ¶ 19; Lara Dec. ¶ 10 (“This rule will cause confusion  
21 for patients as they attempt to exercise their right to access the full range of medically appropriate  
22 care, but encounter new roadblocks.”). For example, if a consumer's primary care provider  
23 refuses to perform certain medically necessary services, such as sterilizations, and the provider  
24 refuses to provide the enrollee with a referral to another provider, the consumer may not be aware  
25 that the health plan must find another provider to perform the services. Ghaly Dec. ¶ 19; *see also*  
26 *Hinze Dec.* ¶¶ 3-4. In such instances, the consumer may simply forgo the service and suffer  
27 serious consequences as a result. Ghaly Dec. ¶ 19. Additionally, health plans may be unaware  
28 that certain providers will refuse to perform certain services, which will add to the difficulties

1 consumers may face as they try to find providers to perform medically necessary services. *Id.*  
 2 And because health plans themselves (now included as “health care entities” under the Rule) can  
 3 cease covering certain medically necessary services, some patients, especially those in rural areas,  
 4 may suddenly find themselves with no coverage options for care, given that some rural areas have  
 5 limited health plans options. Lara Dec. ¶ 27. Those who cannot afford to travel will experience  
 6 illness or even death that could have been prevented with timely access to medical care. *Id.*

### 7 **C. Healthcare Industry Confusion and Unworkability**

8 The Rule will cause mass confusion in the healthcare system and is unworkable. Because  
 9 the Rule purports to create a broad exemption for medical professionals and personnel to opt out  
 10 of healthcare services based on a moral or religious ground in a manner far beyond existing state  
 11 and federal conscience laws, regulated medical providers will need to immediately consider  
 12 programmatic changes to account for refusals and to ensure that patients receive medically  
 13 necessary care. Price Dec. ¶¶ 8-10; Toche Dec. ¶¶ 6-8; Harris-Caldwell Dec. ¶¶ 4-5, 12-15;  
 14 Parmelee Dec. ¶ 10 (Rule will necessitate changes to healthcare centers and training programs).  
 15 As discussed further below, the California Department of State Hospitals (CDSH) would need to  
 16 adopt a Policy Directive that would enforce its patients’ legal right to necessary medical  
 17 treatment. Price Dec. ¶¶ 4-5, 8-10. California Correctional Health Care Services will also need  
 18 to consider changes to ensure that inmates in the custody of CDCR receive, as they are entitled,  
 19 medical, dental and mental healthcare in a nondiscriminatory and timely manner, including its  
 20 transgender inmates, and female inmates in need of reproductive healthcare. Toche Dec. ¶¶ 6-8.

21 But the Rule will be unworkable if it permits a medical provider to refuse medical care  
 22 without notifying a supervisor of the denial of service, or without providing notice or alternative  
 23 options and/or referrals to patients. Price Dec. ¶ 10. California county public safety-net  
 24 healthcare providers, including the Santa Clara Valley Medical Center<sup>30</sup> and the San Francisco  
 25 Department of Public Health,<sup>31</sup> also opposed the NPRM due to its confusing and unnecessary new  
 26 burdens on public healthcare providers.<sup>32</sup> And California Medical Association (CMA) noted that

27 <sup>30</sup> Palma Dec. Ex. X, County of Santa Clara, at 2-8.

28 <sup>31</sup> Palma Dec. Ex. Y, San Francisco Dep’t. Pub. Health, at 2-3.

<sup>32</sup> See also Palma Dec. Ex. K, Nat. Assoc. County and City Health Officials.



1 the Rule will compel California physicians to risk violating the Rule or risk violating state and  
 2 federal antidiscrimination laws, as well as the ethical standards of the CMA and the American  
 3 Medical Association. Aizuss Dec. ¶¶ 22-25; Pines Dec. ¶¶ 10-11.

4 Also, due to the Rule’s discrepancies with Title VII, employers and employees will struggle  
 5 to figure out which system they are supposed to be using should an objection to providing  
 6 medical care arise—the well-established religious accommodation process under Title VII  
 7 (complete with guidance from the statute, EEOC regulations and Compliance Manual,<sup>33</sup> and over  
 8 50 years of case law) or the Rule’s vague and contradictory process. *See supra* Section I(B)(2).

9 The Rule will also create confusion and interfere with California’s regulation of state  
 10 licensed professionals. The State has laws, regulations, and efforts in place to ensure that the  
 11 public health, safety and welfare by establishing minimum qualifications and levels of  
 12 competency, and to provide a means for redress of grievances by investigating allegations of  
 13 unprofessional conduct, incompetence, fraudulent action, or unlawful activity and, as necessary,  
 14 to institute disciplinary action against licensees). Morris Dec. ¶¶ 3-4; Pines Dec. ¶¶ 3-5; Nunes  
 15 Dec. ¶ 12. But the Rule will interfere with and subvert these efforts, on which Californians rely  
 16 for public safety, by broadly defining “discriminate or discrimination” to include the acts of  
 17 making unavailable or denying any license, certification, accreditation, title, or other similar  
 18 interest for refusing to perform a service protected under the Rule. 84 Fed. Reg. at 23263.

#### 19 **D. Public Harms If Federal Funding to Public Programs is Terminated**

20 A loss of federal funding at stake under the Rule would have a devastating impact on  
 21 Californians from all walks of life who depend on services supported by these funds. Ghaly Dec.  
 22 ¶¶ 8-18; *see also supra* Section III. This “budget uncertainty,” and the steps required to mitigate  
 23 it, constitutes irreparable harm. *Cty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 537 (N.D.  
 24 Cal. 2017).

25 In California, county and local partners administer the vast majority of health and human  
 26 services programs, and if the Rule is invoked to withhold federal funding for these programs, it  
 27 will have a devastating effect on local communities. Ghaly Dec. at ¶ 10. State programs and

28 <sup>33</sup> EEOC Compliance Manual available at <https://www.eeoc.gov/laws/guidance/compliance.cfm>.

1 local programs that depend on pass-through funding would be unable to absorb such a loss of  
2 funding without cutting staff and services. *Id.* ¶ 8. State and local governments would be unable  
3 to make up this shortfall in funding, and the critical programs would need to be cut as a  
4 consequence. *Id.*

5 Cutting off federal funding to DHCS alone would bring harm to the millions of  
6 beneficiaries that rely on its programs, including women, children, the elderly, people with  
7 disabilities, and working families. Cantwell Dec. ¶¶ 2, 7; Cervinka Dec. ¶¶ 5-16. DHCS  
8 administers and oversees multiple federally funded health care programs, including Medicaid,  
9 Children's Health Insurance Program, and several health-related federal grants. Cantwell Dec. ¶  
10 2. DHCS funds health care services for approximately 13 million members of Medi-Cal,  
11 California's Medicaid program. *Id.* In fact, about one-third of Californians receive health care  
12 services through programs financed and administered by DHCS, making the department the  
13 largest health care purchaser in California. *Id.*

14 Cutting off federal funding to CDPH would have a devastating impact on state public health  
15 programs as well as local programs that receive money from the state. Nunes Dec. ¶¶ 10, 15.  
16 Both CDPH and local health departments would be unable to absorb such a loss of funding  
17 without reducing staffing, programs, and services. *Id.* For example, without pass-through  
18 funding from CDPH, local health department would struggle to provide immunizations against  
19 measles, polio, and other deadly diseases and to continue their work preventing, diagnosing, and  
20 treating sexually transmitted diseases. Nunes Dec. ¶¶ 16-19.

21 A loss of federal funding, by CDSS would put the health and safety of California's most  
22 vulnerable populations at risk. Cervinka Dec. ¶¶ 5-15. Those harmed would be the eligible aged,  
23 blind, and individuals with disabilities who depend on In-Home Supportive Services and the Deaf  
24 Access program, *id.* at ¶¶ 7-8, 14-15, children who depend on the Child Welfare and Foster Care  
25 Programs, *id.* at ¶¶ 9-11, and refugees and other eligible immigrants who depend on the Refugee  
26 Entrant Assistance program, *id.* at ¶¶ 12-13.

27 ///

28 ///

1 The California Department of State Hospitals, which currently operates under a constrained  
2 budget and has a growing patient population, would have to reduce staffing and services if federal  
3 funding were withdrawn. Price Dec. ¶¶ 14-15.

4 Loss of funding California receives from the U.S. Department of Labor will hamper  
5 workplace safety, stifling economic development, and harming efforts to assist unemployed  
6 individuals. Sturges Dec. ¶ 5. The departments and offices California's Labor and Workforce  
7 Development Agency oversees will be unable to absorb such a tremendous loss of funding  
8 without a reduction in staffing, programs and services. *Id.* at ¶¶ 2, 5.

9 A withdrawal of federal funding would mean that the California Community Colleges, the  
10 largest system of higher education in the nation, would have to reduce staffing, programs, and  
11 services. Parmelee Dec. ¶¶ 2, 8. Moreover, the system's students who rely on CalWORKS  
12 services, the Foster Care Education Program, and its Vocational Education programs, would be  
13 impacted and would be less able to receive a quality education. Parmelee Dec. ¶¶ 6, 9.

14 Loss of funding for the California Department of Education from the U.S. Department of  
15 Education would imperil instruction programs, including Migrant Education, California Indian  
16 Education Centers, Education for Homeless Children, Federal Title I, Adult Education Programs,  
17 Special Education Programs for Exceptional Children, and Vocational Education; Instructional  
18 Support; and Special Programs including child care and development services, the California  
19 State Preschool Program, the After School Education and Safety program and the Early Head  
20 Start-Child Care Partnership. Palma Dec. Ex. A, 2018-19 Cal. Dep't. Educ. budget, at 9-12.

21 In this case, the Rule makes clear that an OCR determination of noncompliance will be  
22 used to inform decisions on whether to approve, renew, or modify funding to a recipient, and the  
23 Rule notes that OCR has already made a determination of noncompliance against California. 84  
24 Fed. Reg. at 23177, 23262. And Defendants' reversal of its interpretation of the Weldon  
25 Amendment as it relates to California's abortion health plan coverage requirement puts California  
26 in an impossible position: either changing its laws to comply with the unconstitutional conditions  
27 in the Rule, or refuse to comply and risk losing billions in federal funds, which is the embodiment  
28 of irreparable harm. *See Am. Trucking Ass'ns, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1058-

1 59 (9th Cir. 2009) (motor carriers who were forced to adhere to unconstitutional provisions or  
 2 give up their businesses were likely to suffer irreparable harm); *Morales v. Trans World Airlines,*  
 3 *Inc.*, 504 U.S. 374, 380-81 (1992) (referring to the injury from obeying an unconstitutional law);  
 4 *City & Cty. of San Francisco v. Trump*, 897 F.3d 1225, 1244 (9th Cir. 2018) (“total loss of federal  
 5 funding would be catastrophic” for California counties and “the public interest cannot be  
 6 disserved by an injunction that brings clarity to parties and citizens dependent on public  
 7 services”).

### 8 **E. Immediate Economic Harm to the State**

9 Absent injunctive relief, California will have to immediately begin implementation of the  
 10 Rule to avoid the crippling and catastrophic loss of funding to California. The Rule’s assurance  
 11 and certification requirements (45 C.F.R. 88.4(a)(3), (5)) obligate recipients to comply with the  
 12 Rule throughout the duration of funding and as a condition of continued receipt of funds. 84 Fed.  
 13 Reg. 23269. Thus, the State must take immediate action to come into compliance upon the Rule’s  
 14 effective date. But the Rule’s onerous assurance and certification, as well as recordkeeping,  
 15 reporting, and “voluntary” notice requirements,<sup>34</sup> will immediately impose administrative burdens  
 16 and implementation costs on the State. Ghaly Dec. ¶ 7; Price Dec. ¶¶ 7, 11-13; Cantwell Dec.  
 17 ¶¶ 4-6; Nunes Dec. ¶¶ 7-8; Toche Dec. ¶¶ 5, 9-11; Harris-Caldwell Dec. ¶¶ 7-11.<sup>35</sup>

18 The Rule will require the State to establish costly bureaucratic structures to ensure  
 19 compliance with the Rule’s expansive provisions, including compliance by any downstream sub-  
 20 recipients (84 Fed. Reg. at 2318). Price Dec. ¶ 13; Toche Dec. ¶ 10. DHCS will need to develop  
 21 and maintain a comprehensive system for monitoring compliance at DHCS, as well as the  
 22 compliance its sub-recipients, including all Medi-Cal sub-recipients, which include independent  
 23 political subdivisions, such as counties. Cantwell Dec. ¶ 6. The Rule also makes CDPH liable  
 24 for the actions of third parties in a manner that is unprecedented in CDPH’s experience. Nunes  
 25 Dec. ¶¶ 9, 13-15. Thus, the Rule imposes an oversight obligation that forces CDPH to expend

26 <sup>34</sup> Although the Rule states that the notice requirement is voluntary, it also states that “OCR will  
 27 consider the posting of notices as “non-dispositive” evidence of compliance. 84 Fed. Reg. at  
 28 23270.

<sup>35</sup> The Rule’s burdens will also be felt by physicians who will be required to divert time and focus  
 from actual care to patients. Aizuss Dec. ¶¶ 30-35.

1 funds for additional staff time to monitor the compliance of its sub-recipients. *Id.* And the  
2 Community Colleges estimate oversight costs of \$7,200,000 annually. Harris-Caldwell Dec. ¶ 9.

3 Moreover, because the Rule will permit providers to decline to offer services within their  
4 scope of practice based on an asserted moral or religious objection, CDI will need to revamp its  
5 regulation and analytics software to ensure network adequacy for California consumers. Hinze  
6 Dec. ¶¶ 5-7. Network adequacy refers to a health plan's ability to deliver benefits by providing  
7 access to a sufficient number of in-network primary care and specialty physicians, as well as all  
8 healthcare services included under the terms of the plan. CDI is the largest consumer protection  
9 agency in California and is responsible for regulating California's insurance market, which is the  
10 largest in the country. Lara Dec. ¶ 4. CDI implements and enforces consumer protection laws  
11 related to health insurance, including but not limited to, essential health benefits requirements,  
12 anti-discrimination protections and laws pertaining to timely access to medical care. *Id.* Federal  
13 law requires that health plans participating in the ACA marketplaces meet network adequacy  
14 standards. 42 U.S.C. § 300gg-1(c); 42 U.S.C. § 13031(c); 45 CFR § 156.230(a). Thus, CDI  
15 would incur costs for changes necessary to ensure network adequacy under the Rule. CDI  
16 estimates that it will be required to expend \$256,000 in the first year and \$29,700 every year  
17 thereafter. Hinze Dec. ¶¶ 5-7.

18 The Department of State Hospitals (DSH) must provide its patients with medically  
19 necessary care. Civil Rights of Institutional Persons Act, 42 USC §1997, *et seq.*; Cal. Code Regs.  
20 tit. 22 § 71203(a)(2)(A). Thus, it will need to adopt a new Policy Directive that would enforce  
21 the legal right of its 12,000 patients to necessary medical treatment. Price Dec. ¶¶ 4, 9. That  
22 policy would state that any legally and medically required service with patient consent or a court  
23 order, shall be provided by DSH staff or DSH contractors. *Id.* Adoption of this policy and legal  
24 staff time will require DSH to expend \$6,000 in the first year following the Rule's effective date.  
25 *Id.* at ¶ 12.

26 Other state agencies will also be harmed by this Rule as they seek to implement California  
27 laws relating to nondiscrimination, including laws protecting LGBTQ individuals from  
28 discrimination, and access to healthcare, including law ensuring that patients receive timely,

1 accurate, and complete information to make informed decisions about their healthcare. Kish Dec.  
 2 ¶¶ 2-15; Pines Dec. ¶¶ 2-7; Cantwell Dec. ¶ 6; Morris Dec. ¶¶ 2-4, 7-9. If, as a result of the  
 3 Rule’s requirements, patients file complaints against medical professionals who deny care or fail  
 4 to provide them with timely, accurate, and complete information, or if there is a complaint of  
 5 denial of care due to an allegation of discrimination, then California’s licensing boards will have  
 6 to investigate such complaints. Pines Dec. ¶¶ 12-14; Morris Dec. ¶ 9. As the largest consumer  
 7 protection agency in the state, CDI also anticipates that it will receive consumer inquiries and  
 8 complaints under the Rule. Lara Dec. Dec. ¶ 10.

9 **IV. THE BALANCE OF EQUITIES AND THE PUBLIC INTEREST FAVOR ISSUING AN**  
 10 **INJUNCTION TO PRESERVE THE STATUS QUO**

11 Given the “potentially dire public health and fiscal consequences” of the Rule (discussed  
 12 above), *California*, 911 F.3d at 582, the public interest and the balance of the equities favor of  
 13 injunctive relief. Indeed, for the reasons given above, the balance of hardships sharply favors  
 14 California—which means that injunctive relief would be appropriate even if California had  
 15 merely raised “serious questions going to the merits” of this litigation, *Arc of California*, 757 F.3d  
 16 at 983—though of course California has done more than that.

17 And in upholding a recent preliminary injunction prohibiting other federal regulations that  
 18 would have reduced access to contraception, the Ninth Circuit found that an injunction was  
 19 appropriate given the “potentially dire public health and fiscal consequences” and highlighted the  
 20 public interest in access to contraceptive care. *California v. Azar*, 911 F.3d 558, 582 (9th Cir.  
 21 2018). A preliminary injunction is also merited here for the same reasons.

22 **III. THE COURT SHOULD POSTPONE THE EFFECTIVE DATE OF THE REGULATION**  
 23 **PENDING JUDICIAL REVIEW OR ISSUE A NATIONWIDE INJUNCTION**

24 Given the equities at issue, the Court should stay the effective date of this regulation until a  
 25 determination on the merits, pursuant to 5 U.S.C. § 705, or issue a preliminary injunction  
 26 enjoining the regulation from taking effect. This Court cannot simply draw a line around  
 27 California and impose an injunction here to ensure complete relief. In this case, the harm to the  
 28 healthcare industry, consumers, and employers due to the illegal rule extends beyond state lines.

1 See e.g., Aizuss Dec. ¶¶ 30-35. There is no bar against nationwide relief in the district courts,  
2 even if the case was not certified as a class action, if such broad relief is necessary to give  
3 prevailing parties the relief to which they are entitled, as is the case here. See *Bresgal v. Brock*,  
4 843 F.2d 1163, 1171 (9th Cir. 1987) (“Class-wide relief may be appropriate even in an individual  
5 action.”); *Oregon v. Azar*, No. 6:19-CV-00317-MC, 2019 WL 1897475, at \*16 (D. Or. Apr. 29,  
6 2019) (granting nationwide injunction); *Washington v. Azar*, No. 1:19-CV-03040-SAB, 2019 WL  
7 1868362, at \*3 (E.D. Wash. Apr. 25, 2019) (granting nationwide injunction); see generally  
8 *California*, 911 F.3d at 584 (nationwide relief required to address “nationwide impact”).

9 **CONCLUSION**

10 The Court should enjoin implementation of the Rule.

11 Dated: June 4, 2019

Respectfully Submitted,

12 XAVIER BECERRA  
13 Attorney General of California  
14 MICHAEL NEWMAN  
15 Senior Assistant Attorney General  
16 KATHLEEN BOERGERS  
17 Supervising Deputy Attorney General

*/s/ Neli N. Palma*

18 NELI PALMA  
19 KARLI EISENBERG  
20 STEPHANIE YU  
21 Deputy Attorneys General  
22 *Attorneys for Plaintiff State of California, by*  
23 *and through Attorney General Xavier*  
24 *Becerra*

25 SA2018100335/13788977.docx



## CERTIFICATE OF SERVICE

Case Name: State of California v. Alex M. Azar No. 4:19-cv-02769-HSG

---

I hereby certify that on June 4, 2019, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

CALIFORNIA'S NOTICE OF MOTION AND MOTION FOR PRELIMINARY INJUNCTION, WITH MEMORANDUM OF POINTS AND AUTHORITIES;

DECLARATION OF JAY STURGES IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF CHRISTOPHER M. ZAHN, MD IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF MARI CANTWELL IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF KEVIN KISH IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF BRUCE HINZE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF RICARDO LARA IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF MARK GHALY IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF STIRLING PRICE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF DR. JOSEPH MORRIS IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF FRANCES PARMELEE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF BRANDON NUNES IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF DAVID H. AIZUSS IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF DENISE PINES IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF PETE CERVINKA IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF DIANA TOCHE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF NELI N. PALMA IN SUPPORT OF PLAINTIFF'S MOTION FOR  
PRELIMINARY INJUNCTION

DECLARATION OF DR. JEANNE HARRIS-CALDWELL IN SUPPORT OF PLAINTIFF'S  
MOTION FOR PRELIMINARY INJUNCTION

[PROPOSED] ORDER GRANTING PLAINTIFF'S MOTION FOR A PRELIMINARY  
INJUNCTION

I certify that **all** participants in the case are registered CM/ECF users and that service will be  
accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true  
and correct and that this declaration was executed on June 4, 2019, at Sacramento, California.

Ashley Harrison  
\_\_\_\_\_  
Declarant

*/s/ Ashley Harrison*  
\_\_\_\_\_  
Signature

SA2019501805  
13794191.docx

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
 Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra

8  
 9 IN THE UNITED STATES DISTRICT COURT  
 10 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 11

12 **STATE OF CALIFORNIA, BY AND**  
 13 **THROUGH ATTORNEY GENERAL XAVIER**  
 14 **BECERRA,**  
 Plaintiff,  
 15  
 16 **v.**  
 17 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
**CAPACITY AS SECRETARY OF THE U.S.**  
**DEPARTMENT OF HEALTH & HUMAN**  
**SERVICES; U.S. DEPARTMENT OF**  
**HEALTH AND HUMAN SERVICES;**  
 18 **DOES 1-100,**  
 19  
 20 Defendants,  
 21

4:19-cv-02769-HSG  
**DECLARATION OF DAVID H. AIZUSS,**  
**M.D. IN SUPPORT OF PLAINTIFF'S**  
**MOTION FOR PRELIMINARY**  
**INJUNCTION**  
 Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S.  
 Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

22 I, DAVID H. AIZUSS, M.D., declare as follows:

23 1. I am currently the President of the California Medical Association (CMA) and  
 24 previously served as the Chair of CMA's Board of Trustees for 3 years. CMA's Board of Trustees  
 25 review, debate, and set health care policy that governs CMA's advocacy in the Legislature,  
 26 regulatory agencies, and the courts.

27 2. The California Medical Association (CMA) is a nonprofit, incorporated  
 28 professional association of more than 44,000 members throughout the State of California. For

1 more than 150 years, CMA has promoted the science and art of medicine, the care and well-being  
2 of patients, the protection of public health, and the betterment of the medical profession. CMA’s  
3 physician members practice medicine in all specialties and settings.

4 3. I am a licensed physician practicing in the State of California. I have been  
5 practicing medicine for 34 years as an ophthalmologist. I currently practice in Los Angeles,  
6 California.

7 4. I received my undergraduate degree from Northwestern University. I received my  
8 medical degree from Northwestern University Medical School. I completed my residency at the  
9 Jules Stein Eye Institute at the University of California, Los Angeles. I am board certified in  
10 ophthalmology by the American Board of Ophthalmology.

11 5. I am familiar with the rule “Protecting Statutory Conscience Rights in Health  
12 Care; Delegations of Authority” (the Rule), published in the Federal Register on May 21, 2019.

13 6. CMA submitted comments to the United States Department of Health and Human  
14 Services (HHS) on March 27, 2018 on the Notice of Proposed Rulemaking, published in the  
15 Federal Register on January 28, 2018, that preceded the Rule.

16 7. The Rule purports to “protect the rights of individuals, entities, and health care  
17 entities to refuse to perform, assist in the performance of, or undergo certain health care services  
18 or research activities to which they may object for religious, moral, ethical, or other reasons” and  
19 further states that the provisions are to be “interpreted and implemented broadly to effectuate  
20 their protective purpose.”

21 8. In 2018, HHS received 25,912 health information privacy complaints compared to  
22 343 complaints alleging conscience violations. This was an increase from a total of 10 complaints  
23 filed with HHS under the conscience protection laws between 2005 and 2015.

24 9. HHS estimates that implementation of the Rule will, on average, cost \$312.3  
25 million in year one and \$125.5 million annually in years two through five.

26 10. By issuing the Rule and creating a new division within the Office of Civil Rights  
27 (“OCR”)—the new “Conscience and Religious Freedom Division”—HHS is inappropriately  
28

1 using OCR’s limited resources to encourage discrimination in health care and undermine the  
2 ability of states to enforce their own conscience and anti-discrimination laws.

3  
4 **The Rule Will Negatively Impact Access to Care**

5 11. The Rule expands the application of existing conscience protections laws in a way  
6 that is likely to create serious barriers to patients accessing care, particularly patients seeking  
7 comprehensive reproductive health care and end-of-life care as well as patient populations that  
8 have been most vulnerable to insidious discrimination, including lesbian, gay, bisexual, and  
9 transgender individuals.

10 12. The Rule would allow any “entity” involved in a patient’s care—from a hospital  
11 and the hospital board of directors to individuals such as the receptionist that schedules  
12 procedures and the person preparing a room for a procedure—to use their personal beliefs to  
13 disrupt a patient’s access to care.

14 13. The Rule’s definition of “assist in the performance” greatly expands the types of  
15 services that can be refused to include “an action that has a specific, reasonable, and articulable  
16 connection to furthering a procedure or a part of a health service program or research activity  
17 undertaken by or with another person or entity.” In fact, merely “making arrangements for the  
18 procedure,” is included in the reach of the Rule. This means individuals such as the office  
19 scheduler, the technician charged with cleaning surgical instruments, and other medical office and  
20 hospital employees, can now assert a new right to refuse care based on their religious and moral  
21 convictions. Such an interpretation is potentially disruptive to the normal operations of a medical  
22 office or other health care facility and impedes the provision of necessary care to patients.

23 14. The Rule also defines “referral” or “refer” to mean providing any information, “in  
24 oral, written, or electronic form ... where the purpose or reasonably foreseeable outcome of the  
25 provision of the information is to assist a person in receiving funding or financing for, training in,  
26 obtaining, or performing a particular health care service, program, activity, or procedure.” This  
27 includes information related to contact information, directions, instructions, descriptions, or other  
28 information resources that could help an individual to get the health care service they need.

1           15.     Such an expansive definition could prevent patients from getting information  
2 about the availability of comprehensive health care options in their state.

3           16.     CMA believes that these overly broad definitions will result in denial of care and  
4 miscommunication to patients without meaningfully advancing physicians’ rights of conscience.

5  
6                           **The Rule Undermines Anti-Discrimination Protections in Healthcare**

7           17.     The Rule undercuts California laws that have been put into place to ensure that  
8 patients in the state have access to comprehensive health care. The Rule interferes with existing  
9 state laws and accreditation requirements and will create needless legal confusion for California  
10 physicians.

11           18.     California law explicitly prohibits discrimination based on sex, sexual orientation,  
12 or gender identity, among other factors. California law provides that persons holding licenses  
13 under the provisions of the Business & Professions Code, such as physicians, are subject to  
14 disciplinary action for refusing, in whole or in part, or aiding or inciting another licensee to refuse  
15 to perform the licensed services to an “applicant” (patient) because of any characteristics under  
16 the Unruh Civil Rights Act, that is, the applicant’s race, color, sex, religion, ancestry, disability,  
17 marital status, national origin, medical condition, sexual orientation, or genetic information.

18           19.     The California Supreme Court has held that physicians’ religious freedom and free  
19 speech rights do not exempt physicians from complying with the Unruh Act’s prohibition against  
20 discrimination based on a person’s sexual orientation.

21           20.     California law prohibits discrimination by any person under any program that  
22 receives any financial assistance from the state. Additionally, the California Insurance Gender  
23 Nondiscrimination Act prohibits a health plan and insurer from “refusing to enter into, cancel or  
24 decline to renew or reinstate a contract because of race, color, national origin, ancestry, religion,  
25 sex, marital status, sexual orientation, or age.” Sex includes both gender identity and gender  
26 expression.

27           21.     In addition, the Rule may conflict with policies of agencies that accredit health  
28 care institutions. For example, the Joint Commission, which accredits and certifies nearly 21,000

1 facilities in the U.S., has required since 2011 that the nondiscrimination policy of every  
2 accredited facility protect transgender patients.

3 22. The Rule will compel California physicians to risk violating the Rule or risk  
4 violating state and federal antidiscrimination laws that are in place to ensure that patient  
5 populations vulnerable to discrimination have equal access to health care and health care  
6 coverage.

7  
8 **CMA Policy is to Balance Patients’ Rights with Physicians’ Conscience Rights**

9 23. CMA advocates for conscience protections for physicians that promote the rights  
10 of physicians to exercise their conscience while ensuring that such rights do not negatively impact  
11 patient care.

12 24. The Rule conflicts with policy adopted by medical professional associations  
13 including CMA and the American Medical Association which assert that physicians have an  
14 “ethical responsibility to place patients’ welfare above the physicians’ own self-interest or  
15 obligations to others, to use sound medical judgment on patients’ behalf, and to advocate for their  
16 welfare.”

17 25. According to the policy, physicians acting or refraining from acting in accordance  
18 with their conscience cannot be at the expense of their professional obligations to patients.

19  
20 **Existing Laws Protect Patients’ and Physicians’ Rights**

21 26. Existing federal and state laws protect the rights of physicians by allowing states to  
22 take nuanced positions on protecting the conscience rights of health care workers, particularly  
23 with regard to abortion, sterilization, and aid-in-dying. The Rule’s provisions are not only  
24 redundant but will have a chilling effect on the enforcement of and passage of state laws that  
25 protect access to health care.

26 27. California law already properly balances the rights of physicians and their patients.  
27 California has extensive protections for health care providers that do not want to participate in  
28 abortion for moral, ethical, or religious reasons, while protecting patients who need emergency



1 care. While religiously affiliated hospitals can also exercise their rights under this provision, they  
2 must post a notice of their refusal policy so that patients are properly informed about the care they  
3 will receive.

4 28. Current California law ensures that even when a patient cannot receive the services  
5 they seek at a certain facility, the patient would at least be afforded the resources, information,  
6 and options to receive treatments at an alternative site. The Rule would now “protect” the  
7 facility’s moral and ethical rights to such an extent that the patient would not even receive the  
8 information they need to receive necessary medical care.

9 29. The Rule would impede the ability of states to craft nuanced solutions that protect  
10 the rights of providers and patients in accordance with states’ own values.

11  
12 **The Rule’s Burden on Physicians**

13 30. Finally, the Rule puts into place new administrative requirements, imposing a  
14 significant burden on many physicians who already face an increasing number of administrative  
15 burdens under state and federal law.

16 31. According the Rule, physicians must submit certifications and assurances to HHS,  
17 maintain detailed records to establish compliance, cooperate with HHS’s enforcement activities,  
18 and generally ensure compliance with the new Rule. It also incentivizes physicians to post  
19 lengthy required notices on their websites and in conspicuous physical locations and inform  
20 patients and employees about the federal health care conscience rights.

21 32. HHS conducted an analysis of the estimated burdens for the Rule in which it looks  
22 at the implementation costs for providers. The estimate includes time for providers to familiarize  
23 themselves with the Rule and the cost to hire an attorney to review it. It includes: staff time to  
24 review the assurance and certification language and underlying laws amounting to a labor cost of  
25 \$93.8 million each year for the first five years; review of policies and procedures or other actions  
26 to self-assess compliance amounting to a labor cost of \$46.9 million each year for the first five  
27 years; and actions to improve compliance taken by some companies such as taking remedial  
28 action, updating policies and procedures, and implementing staffing and scheduling practices

1 amounting to \$14.8 million for the first year and \$1.5 million annually for years two through five.  
2 In addition, HHS estimates that the burden on providers will amount to \$93.4 million in the first  
3 year and \$14.1 million annually in years two through five in costs related to the voluntary posting  
4 and distribution of notices.

5 33. These costs are burdensome enough in themselves; this analysis fails to fully  
6 consider, moreover, the significant time and resources it takes to continuously implement and  
7 enforce such a Rule, cooperate with any HHS enforcement actions, as well as the numerous other  
8 administrative and regulatory burdens physicians already face and the degree to which each  
9 additional burden detracts from a physician's clinical practice.

10 34. Excessive administrative tasks imposed on physicians divert time and focus from  
11 providing actual care to patients and improving quality and may prevent patients from receiving  
12 timely and appropriate care.

13 35. CMA opposes adding additional burdens to physicians that do nothing to improve  
14 the quality of patient care and create yet more regulatory hurdles for the practice of medicine.

15  
16 I declare under penalty of perjury under the laws of the United States and the State of  
17 California that the foregoing is true and correct to the best of my knowledge.

18  
19 Executed on May 31, 2019 in Los Angeles, California.

20  
21 

22 \_\_\_\_\_  
23 David H. Aizuss, M.D.  
24 President  
25 California Medical Association  
26  
27  
28

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov

7 *Attorneys for Plaintiff the State of California, by and*  
*through Attorney General Xavier Becerra*  
 8  
 9  
 10

11 IN THE UNITED STATES DISTRICT COURT  
 12 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 13  
 14

15 **STATE OF CALIFORNIA, BY AND**  
 16 **THROUGH ATTORNEY GENERAL XAVIER**  
**BECERRA,**

17 Plaintiff,

18 v.

19 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
 20 **CAPACITY AS SECRETARY OF THE U.S.**  
 21 **DEPARTMENT OF HEALTH & HUMAN**  
 22 **SERVICES; U.S. DEPARTMENT OF**  
**HEALTH AND HUMAN SERVICES;**  
**DOES 1-100,**

23 Defendants,  
 24

Case No. 4:19-cv-02769-HSG

**DECLARATION OF PETE CERVINKA**  
**IN SUPPORT OF PLAINTIFF'S**  
**MOTION FOR PRELIMINARY**  
**INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S.  
 Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

1 I, Pete Cervinka, declare:

2 1. I am a resident of the State of California. I am over the age of 18 and have personal  
3 knowledge of all the facts stated herein. If called as a witness, I could and would testify  
4 competently to the matters set forth below.

5 2. I am currently employed by the California Department of Social Services (CDSS)  
6 and have served CDSS for ten years. I have served as the Chief Deputy Director since 2016 and  
7 previously served as the Program Deputy Director for Benefits and Services beginning in 2009.  
8

9 3. CDSS is one of twelve departments and five offices within the California Health and  
10 Human Services Agency and is responsible for overseeing the administration of public social  
11 service benefit programs serving 6.3 million of California's most vulnerable residents. Our  
12 mission is to serve, aid, and protect needy and vulnerable children and adults in ways that  
13 strengthen and preserve families, encourage personal responsibility, and foster independence.  
14 CDSS has a total annual budget of \$32.5 billion of federal, state and county funding to support its  
15 programs. Of this amount, approximately \$13 billion are directed to child welfare programs and  
16 the In-Home Supportive Services Program, as described further below.

17 4. As Chief Deputy Director, I oversee programs including, but not limited to, child  
18 welfare, cash and food assistance, housing and civil rights, and Medicaid home- and community-  
19 based care. My responsibilities include policy development, program implementation and  
20 oversight, federal compliance, and associated fiscal and budgetary matters.

21 5. CDSS has identified specific programs that receive federal funding and would be  
22 subject to the requirements of the regulations set forth in the final rule, Protecting Statutory  
23 Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, published on May  
24 21, 2019 by the U.S. Department of Health and Human Services (HHS) (Rule). These programs  
25 include: In-Home Supportive Services (IHSS), Refugee and Entrant Assistance, Deaf Access  
26 Program, Title IV-B (Child Welfare) and Title IV-E (Foster Care) of the Social Security Act.  
27

1           6. If CDSS were determined to be non-compliant with the above-noted federal rule, the  
2 loss of federal funding, as identified for each program described below, would be significant and  
3 would put the health and safety of California's most vulnerable populations at risk.

4           **In-Home Supportive Services**

5           7. The IHSS program is a Medicaid benefit program that provides in-home assistance to  
6 eligible aged, blind, and individuals with disabilities as an alternative to out-of-home care and  
7 enables recipients to remain safely in their own homes. The purpose of the program is to allow  
8 vulnerable elderly and disabled Californians to avoid costly and unnecessary institutionalized care  
9 and to receive necessary services in their homes and communities. IHSS services include:  
10 paramedical services; accompaniment to medical appointments; personal care such as bowel and  
11 bladder care, bathing, and certain medical services under the direction of a physician; domestic  
12 and related services such as meal preparation, housecleaning, laundry, and grocery shopping; and  
13 protective supervision. Over 502,000 IHSS providers are employed to provide services to more  
14 than 594,000 IHSS recipients. More than 98 percent of the IHSS recipient population receives  
15 IHSS as a Medi-Cal (Medicaid) benefit, for which CDSS will receive approximately \$6 billion in  
16 federal funding for Fiscal Year 2019.

17  
18           8. A reduction in federal funding would place IHSS recipients at serious risk of  
19 institutionalization, resulting in both violations of their *Olmstead* rights and increased costs to the  
20 State, counties and federal government.

21           **Child Welfare and Foster Care Programs**

22           9. Titles IV-B and IV-E of the Social Security Act provide significant funding to  
23 California's child welfare system. The federal Foster Care Program, authorized by Title IV-E of  
24 the Social Security Act, helps to provide safe and stable out-of-home care for children who have  
25 been abused or neglected, until they are safely returned home, placed permanently with adoptive  
26 families, exit foster care to a guardianship with a relative, or age out of California's foster care  
27 system. Title IV-E funds, in conjunction with state and local funds, are used to provide monthly  
28 maintenance payments for the daily care and supervision of children in foster care; adoption

1 assistance payments; kinship guardianship assistance payments; administrative costs of activities  
2 necessary to implement the program; training of staff and foster care providers; recruitment of  
3 foster parents; and costs related to the design, implementation and operation of a state-wide data  
4 collection system. CDSS received approximately \$2.2 billion in federal funding for  
5 administrative and assistance payments in Fiscal Year 2019.

6 10. Title IV-B provides funding for child welfare services that focus on the prevention of,  
7 and response to, child abuse and neglect. This funding supports services and programs which: 1)  
8 prevent the neglect, abuse, or exploitation of children [through the Child Abuse Prevention and  
9 Treatment Act program and the Community-Based Child Abuse Prevention program, for which  
10 CDSS received a combined \$14.5 million for Fiscal Year 2019)]; 2) promote the safety,  
11 permanence and well-being of children in foster care and adoptive families, as well as to provide  
12 training, professional development and support to ensure a well-qualified workforce (for which  
13 CDSS received \$29.2 million for Title IV-B Part I in Fiscal Year 2019); and 3) provides funding  
14 for states to operate coordinated child/family support and preservation services, and seeks to  
15 promote adoption and support services that prevent child maltreatment among at-risk families  
16 [(through the Promoting Safe and Stable Families program, for which CDSS received \$33.4  
17 million for administrative and assistance payments in Fiscal Year 2019)]. Thus, CDSS received a  
18 total of 77.1 million dollars in federal funding for these programs.

19 11. Losing Title IV-E and IV-B federal funding would be devastating to children and  
20 families served by California's child welfare system. Necessary services and supports would be  
21 substantially reduced or eliminated, placing children at further risk of abuse or neglect.

### 22 **Refugee and Entrant Assistance**

23  
24 CDSS administers the Refugee Entrant Assistance program on behalf of the federal  
25 government. This program serves refugees and other eligible immigrants who do not qualify for  
26 Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid programs  
27 and meet the income and resource eligibility standards of the program. The purpose of this  
28 program is to assist refugees and other eligible immigrants, such as asylees, Cuban and Haitian

1 entrants, Special Immigrant Visa arrivals, and trafficking victims, to become employed and self-  
2 sufficient as quickly as possible and to integrate successfully into their receiving communities.  
3 Under the program, refugees and eligible individuals can receive refugee cash assistance and  
4 refugee medical assistance during their first eight months in the US, as well as a broad range of  
5 social services intended to help refugees obtain employment, achieve economic self-sufficiency,  
6 and further their social integration. The refugee social services programs include programs for  
7 elder care, school impact services, youth mentoring programs, employment training and English  
8 language acquisition services. Service providers offer a range of support to eligible recipients to  
9 further their social integration, including counseling focused on communication, stress  
10 management, and conflict resolution; employment case management; interpretation and  
11 translation; assistance with citizenship and naturalization; and assistance in connecting with  
12 health care providers.

13 13. CDSS received approximately \$21.6 million from the federal Refugee Entrant  
14 Assistance Grant for Fiscal Year 2019. The loss of this federal funding would have an  
15 immediate negative impact on newly arrived refugees and other eligible individuals and their  
16 families, who receive support and services during the first eight months in the United States.  
17 These initial few months are critical to vulnerable individuals, who are experiencing cultural  
18 acclimation and learning to navigate a new society. The loss of federal funding would impact  
19 supports that include cash aid, employment, medical, and language services that provide critical  
20 pathways to self-sufficiency and prevent increased poverty for this already vulnerable  
21 population.

### 22 **Deaf Access Program**

23  
24 14. The Deaf Access Program was created in 1980 to ensure that California's public  
25 social service programs are able to meet the communication needs of deaf and hard of hearing  
26 children, adults, and families. Meeting the communication needs of this population assists them  
27 in achieving economic independence to fully participate in mainstream society. The services  
28



1 provided by the Deaf Access Program include sign language interpretation, advocacy, job  
2 development and placement, counseling, information and referral and community education.

3 15. CDSS received approximately \$3 million for Fiscal Year 2019 and the loss of this  
4 federal funding would greatly reduce or eliminate the above-noted services barring access to  
5 public social service benefits.

6 **CDSS Potential Budgetary Consequences**  
7

8 16. It is unclear, based on the regulatory language of the Rule, how OCR will interpret,  
9 implement, and enforce monetary consequences for noncompliance with the Rule and underlying  
10 conscience laws. The Rule specifies that OCR has authority to terminate federal financial  
11 assistance or other federal funds, in whole or in part. The potential total loss of federal funding  
12 for the above-described programs administered by CDSS would be approximately \$8.3 billion. A  
13 sudden disruption in the receipt of these federal funds would create budgetary chaos and have  
14 damaging effect on the State of California, its citizens, and other residents within the State's  
15 borders.

16 I declare under penalty of perjury under the laws of the United States and the State of  
17 California that the foregoing is true and correct to the best of my knowledge.

18 Executed on June 3, 2019 in Sacramento, California.  
19

20  
21 

22 Pete Cervinka  
23 Chief Deputy Director  
24 California Department of Social Services  
25

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra*

8  
 9 IN THE UNITED STATES DISTRICT COURT  
 10 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 11

12 **STATE OF CALIFORNIA, BY AND**  
 13 **THROUGH ATTORNEY GENERAL XAVIER**  
 14 **BECERRA,**  
 Plaintiff,  
 15  
 16 v.  
 17 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
**CAPACITY AS SECRETARY OF THE U.S.**  
**DEPARTMENT OF HEALTH & HUMAN**  
 18 **SERVICES; U.S. DEPARTMENT OF**  
**HEALTH AND HUMAN SERVICES;**  
 19 **DOES 1-100,**  
 20 Defendants,  
 21

Case No. 4:19-cv-02769-HSG

**DECLARATION OF MARK GHALY IN  
 SUPPORT OF PLAINTIFF'S MOTION  
 FOR PRELIMINARY INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S.  
 Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

22 I, Mark Ghaly, declare:

23 1. I am a resident of the State of California. I am over the age of 18 and have  
 24 personal knowledge of all the facts stated herein. If called as a witness, I could and would testify  
 25 competently to all the matters set forth below.

26 2. I am the Secretary of the California Health & Human Services Agency (CHHS).  
 27 The California Health & Human Services Agency (CHHS) is the state's largest agency. The  
 28 Secretary of CHHS is a member of the Governor's Cabinet. CHHS oversees twelve departments

1 and five offices that provide a range of health care services, social services, mental health  
2 services, alcohol and drug services, income assistance, and public health services to Californians  
3 from all walks of life. More than 33,000 people work for departments in CHHS at state  
4 headquarters in Sacramento, regional offices throughout the state, state institutions and residential  
5 facilities serving the mentally ill and people with developmental disabilities.

6 3. I was appointed Secretary of CHHS by Governor Newsom in April 2019. I am a  
7 Secretary in Governor Newsom's cabinet. My duties as Secretary of CHHS include supervising  
8 the CHHS departments and offices in administering and overseeing state programs for health care  
9 and social services. CHHS departments are instrumental in implementing Governor Newsom's  
10 goal of achieving universal coverage in the state and expanding access to care. In addition to my  
11 official duties, I am a licensed pediatrician, and I treat high-needs patients on a volunteer basis.

12 4. Before my appointment as Secretary of CHHS, I served for over a decade in  
13 various health care programmatic and policy leadership roles in county government. Most  
14 recently, since April 2018, I served as the Director for Health & Social Impact at the Los Angeles  
15 County Chief Executive Office, where I spearheaded and supported a number of health care,  
16 housing, and employment initiatives for the County. From 2011 until April 2018, I was the  
17 Deputy Director for Community Health and Integrated Programs for the Los Angeles County  
18 Department of Health Services. In that role, I directed clinical services for county correctional  
19 facilities; the Los Angeles County Whole Person Care Pilot Program; and created and developed  
20 a program for individuals facing chronic illnesses and homelessness to obtain permanent housing  
21 and appropriate treatment. Before my appointment in Los Angeles County, I served for five years  
22 in the City and County of San Francisco as the Medical Director for Southeast Health Center, a  
23 public health clinic located in the Bayview-Hunters Point community. As Medical Director, I  
24 supervised clinic operations and promoted community-based initiatives to improve population  
25 health. In 1996, I earned a Bachelor of Arts degree in Biology and Biomedical Ethics from Brown  
26 University. In 2002, I earned a Doctorate of Medicine from Harvard Medical School, as well as a  
27 Masters in Public Health from the Harvard School of Public Health. And in 2006, I completed my  
28 residency training in Pediatrics at the University of California, San Francisco.



1           5. CHHS oversees the Department of Aging, the Department of Child Support  
2 Services, the Department of Community Services & Development, the Department of  
3 Developmental Services, the California Emergency Medical Services Authority, the Department  
4 of Health Care Services, the Department of Managed Health Care, the Department of Public  
5 Health, the Department of Rehabilitation, the Department of Social Services, the Department of  
6 State Hospitals, the Office of Health Information Integrity, the Office of Law Enforcement  
7 Support, the Office of Statewide Health Planning and Development, the Office of Systems  
8 Integration, and the Office of the Patient Advocate.

9           6. I am familiar with the rule Protecting Statutory Conscience Rights in Health Care;  
10 Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human  
11 Services (HHS) on May 2, 2019, and published in the Federal Register on May 21, 2019 (Rule).

12           7. The Rule will impose an immediate cost on CHHS and the departments and offices  
13 it oversees due to its notice, assurance and certification, recordkeeping, and reporting  
14 requirements. Although the final rule indicates that the notice requirements are voluntary, the  
15 Rule also states that adherence to the notice requirements will be taken into consideration when  
16 assessing whether an agency is in compliance.

17           8. The Rule potentially places at risk all federal funds CHHS receives from the U.S.  
18 Department of Health and Human Services. For fiscal year 2019-2020, CHHS expects \$77.6  
19 billion in total federal funds in a total budget of \$162.3 billion. Federal funds make up much of  
20 CHHS's budget, and a substantial portion of those federal funds come from appropriations  
21 subject to the Rule. Loss of this funding would have a devastating impact on California. State  
22 programs and local programs that depend on pass-through funding would be unable to absorb  
23 such a loss of funding without cutting staff and services. The state and local governments would  
24 be unable to make up this shortfall in funding, and the programs would need to be cut as a  
25 consequence.

26           9. Federal funding comes to the departments CHHS oversees from appropriations acts  
27 approved by Congress and signed by the president. The Department of Defense and Labor, Health  
28 and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations

1 Act, 2019, Public Law 115-245, which was enacted September 28, 2019, makes appropriations  
2 for the following programs (among others), which provide funding to CHHS and the departments  
3 and offices it oversees:

- 4 • Title XIX of the Social Security Act, to operate and make payments for Medicaid  
5 which provides healthcare coverage for low-income adults, families and children,  
6 pregnant women, the elderly, and people with disabilities;
- 7 • The Child Support Enforcement and Family Support Programs for child support  
8 enforcement and family support programs;
- 9 • The Social Security Block Grant Program to assist states in delivering social services  
10 by helping reduce dependency, increase self-sufficiency, prevent abuse and neglect,  
11 and limit institutional care, if possible;
- 12 • The Older Americans Act of 1965 for programs that serve older adults, adults with  
13 disabilities, family caregivers, and residents in long-term care facilities; ;
- 14 • The 21st Century Cures Act, section 1003(c), and the State Opioid Response Grants  
15 Program to assist state response to the opioid crisis;
- 16 • The Ryan White HIV/AIDS Program to provide primary medical care and essential  
17 support for people with HIV/AIDS; and
- 18 • The Rehabilitation Act of 1973 to ensure that individuals with disabilities have access  
19 to programs and activities that are funded by federal agencies and to federal  
20 employment.

21 10. In developing its annual budget, CHHS did so with the expectation that it would  
22 receive the federal funds to which it is entitled to under its existing agreements under the  
23 aforementioned federal programs—these funds are now being placed at risk under the Rule. A  
24 sudden disruption in anticipated federal funds would create budgetary chaos for CHHS, the  
25 departments and offices it oversees, and the many entities that receive pass-through federal  
26 funding. In California, county and local partners administer the vast majority of health and  
27 human services programs. If the Rule is invoked to withhold federal funding for these programs,  
28 it will have a devastating effect on local communities.

1           11. It is estimated that the Department of Health Care Services, which administers  
2 California's Medicaid program, known as Medi-Cal, and other federally funded health care  
3 programs, will receive more than \$63 billion in federal funding for services and operations in  
4 Fiscal Year 2018-2019. Much of the Medi-Cal budget is expended up-front by the state in  
5 expectation of reimbursement from the federal government.

6           12. The loss of federal Medicaid or Children's Health Insurance Program funding in  
7 California would largely end the delivery of basic health care services to more than 13 million  
8 low income, elderly and pregnant individuals, as well as individuals with disabilities. Numerous  
9 studies have shown that not having access to coverage leads individuals to postpone or forgo  
10 needed medical treatment, including both preventive treatment as well as treatments for major  
11 acute or chronic conditions. Lack of access to timely treatment leads to increased emergency  
12 room use and hospitalizations, and a decline in health. Additionally, when uninsured individuals  
13 ultimately undergo medical treatment, as everyone eventually must, they often receive  
14 unaffordable medical bills, causing serious financial harms. These can include medical debt and  
15 bankruptcy.

16           13. The Department of Social Services estimates that it will receive nearly \$2.5 billion  
17 in federal funding for various child welfare and refugee assistance programs and over \$6 billion  
18 in federal funding for the In-Home Supportive Services program during Fiscal Year 2018-19.

19           14. If federal dollars are reduced or eliminated pursuant to implementation of the Rule,  
20 additional social services programs would be impacted, resulting in significant reductions or  
21 potentially termination of crucial supports and services that include, but are not limited to:  
22 programs for foster care placements and the prevention of child abuse awarded under Titles IV-E  
23 and IV-B; the Adoption Assistance Program, which provides financial and medical support to  
24 promote the adoption of children who otherwise would remain in long-term foster care; the  
25 Kinship Guardianship Program, which promotes permanency for foster children living with an  
26 approved relative caregiver; the In-Home Supportive Services Program, which provides services  
27 to the elderly and individuals with disabilities to remain safely within in community settings as  
28



1 opposed to institutional placement; and the Refugee and Entrant Assistance Program, which  
2 coordinates the delivery of benefits and services to refugees and entrants in the state.

3 15. Approximately 218,000 households are served in California under the Low-  
4 Income Home Energy Assistance Program (LIHEAP). Of the households served, 162,000 are  
5 considered a vulnerable population such as elderly, individuals with disabilities, or households  
6 with children under five. LIHEAP is the primary source of financial assistance for the eligible  
7 low-income households in California to manage and meet their immediate home heating and/or  
8 cooling needs. LIHEAP also provides emergency assistance to help low-income households  
9 avoid the loss of home energy services and those facing life-threatening energy-related  
10 emergencies created by a natural disaster. The weatherization component of LIHEAP provides  
11 energy efficiency upgrades for low-income households, helping to reduce utility costs, while  
12 improving the health and safety of the occupants. The heating, cooling, and weatherization  
13 services LIHEAP helps to provide can mean the difference between life and death for recipients.  
14 Loss of federal funding for this program would deprive thousands vulnerable Californians of the  
15 support they need to keep their homes safe for habitation.

16 16. The California Department of Public Health's (CDPH) Immunization Branch  
17 receives substantial annual funding and support under the federal Health and Human Services  
18 appropriation, totaling almost \$581 million annually. Approximately \$537 million supports the  
19 Vaccines for Children program, an entitlement program allocated through the Centers for  
20 Medicare and Medicaid (CMS) which supplies vaccines for all children in the Medi-Cal  
21 program. About \$8.7 million in direct assistance provides vaccines for uninsured and  
22 underinsured adults being immunized in local health departments and 500 federally qualified  
23 health center sites, as well as for outbreak containment. Of the remaining \$35.4 million, half of  
24 this funding is CDPH support and half is provided through CDPH to all 61 local health  
25 departments around the state. If this \$581 million in federal support is jeopardized or lost, the  
26 local health departments and federally qualified health clinics would be severely limited in their  
27 ability to provide immunizations to protect California communities against dangerous diseases,  
28



1 and the state Medicaid program would need to make up a \$537 million shortfall in vaccine  
2 funding for its pediatric members.

3 17. CDPH's STD Control Branch receives approximately \$6.8 million in annual  
4 federal funding. This funding is critical for STD control programs, and enables CDPH to monitor  
5 STDs, provide information about STD trends to the public and policy makers, identify effective  
6 strategies to control STDs based on the groups and regions most at risk, provide expert  
7 consultation and training to front line local disease prevention staff, and leverage partnerships  
8 with health care systems and others to prevent disease. Losing this funding would increase the  
9 likelihood of further accelerating the rate of STD transmission at a time when STD rates,  
10 particularly syphilis and gonorrhea rates, are already rising in the state.

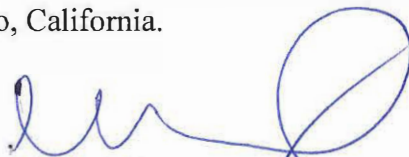
11 18. The Public Health Emergency Preparedness Program at CDPH coordinates  
12 preparedness and response activities for public health emergencies and supports surge capacity in  
13 health care and public health systems during emergencies. This program receives approximately  
14 \$65 million in federal HHS funding annually, without which the state's emergency health care  
15 system could be unequipped to handle a public health crisis. These funds provide a whole  
16 community approach to emergency response for events ranging from communicable disease  
17 outbreaks like the current national measles outbreak to the catastrophic wildfires faced by  
18 California over the last few years. The funds provide for advanced planning and preparedness at  
19 the state and local level to handle the laboratory and epidemiology skills necessary to stop a  
20 communicable disease outbreak. The funds also provide for the safe evacuation of healthcare  
21 facilities and emergency medical transport, medical care in evacuation shelters, and the safe  
22 repopulation and return to normal operations of the medical and health infrastructure following an  
23 event.

24 19. In addition to the individual and public health harms that would occur if federal  
25 funding to these programs is terminated, the Rule will result in health care consumer confusion  
26 about which providers will perform what services and will unduly burden consumers as they try  
27 to navigate the health care delivery system. For example, if a consumer's primary care provider  
28 refuses to perform certain medically necessary services, such as sterilizations, and the provider

1 refuses to provide the enrollee with a referral to another provider, the consumer may not be aware  
2 that the health plan must find another provider to perform the services. In such instances, the  
3 consumer may simply forgo the service and suffer serious consequences as a result. Additionally,  
4 health plans may be unaware that certain providers will refuse to perform certain services, which  
5 will add to the difficulties consumers may face as they try to find providers to perform medically  
6 necessary services.

7  
8 I declare under penalty of perjury under the laws of the United States and the State of  
9 California that the foregoing is true and correct to the best of my knowledge.

10  
11 Executed on May 28, 2019 in Sacramento, California.

12   
13 \_\_\_\_\_  
14 Mark Ghaly, MD, MPH  
15 Secretary  
16 California Health & Human Services Agency

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
 Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra

8 IN THE UNITED STATES DISTRICT COURT  
 9 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 10

11  
 12 **STATE OF CALIFORNIA, BY AND**  
 13 **THROUGH ATTORNEY GENERAL XAVIER**  
 14 **BECCERRA,**

Plaintiff,

15 v.

16  
 17 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
**CAPACITY AS SECRETARY OF THE U.S.**  
 18 **DEPARTMENT OF HEALTH & HUMAN**  
**SERVICES; U.S. DEPARTMENT OF**  
 19 **HEALTH AND HUMAN SERVICES;**  
**DOES 1-100,**

20 Defendants,  
 21

4:19-cv-02769-HSG

**DECLARATION OF DR. JEANNE**  
**HARRIS-CALDWELL IN SUPPORT OF**  
**PLAINTIFF'S MOTION FOR**  
**PRELIMINARY INJUNCTION**

22 I, Dr. Jeanne Harris-Caldwell, declare:

- 23 • I am the president of the Health Services Association, California Community Colleges  
 24 (HSACCC) and the Dean of Wellness, Social Services, and Child Development at Saddleback  
 25 College, as the Dean I oversees all operations of health services. Over the last 26 years I have  
 26 held several progressive leadership and management roles in healthcare, and education  
 27 in both California Community College, and private college systems.

28 1. Additionally, I have presented nationally on several occasions on health related  
 topics and most recently for the American College Health Association. HSACCC is a



1 membership organization of CCC healthcare professionals and community partners. HSACCC's  
2 mission is to support and foster student access to quality health service programs within the  
3 California Community Colleges.

4 2. The California Community Colleges (CCC) are the largest system of higher  
5 education in the nation, with 2.1 million students attending 115 colleges. With a wide range of  
6 educational offerings, the colleges provide workforce training, basic courses in English and math,  
7 certificate and degree programs and preparation for transfer to four-year institutions. CCCs offer  
8 training for students who are pursuing careers as registered nurses, paramedics, emergency  
9 medical technicians, phlebotomists, and other health care professionals. Saddleback College  
10 offers more than 300 certificate or degree programs from architecture to oceanography. The  
11 colleges play a critical role in California's public education system and healthcare workforce  
12 training.

13 3. The CCCs are organized in 72 districts. Each district's Board of Trustees  
14 determines how to provide health services to students. A minority of districts outsource services  
15 to a third party; most districts run an on-campus health center. These health centers vary in size  
16 from a single practitioner to a team of dozens of medical professionals.

17 4. Currently, 90 community colleges have a health center. Health centers have the  
18 primary purpose of providing a scope of services to meet the student's physical, social, and  
19 mental health needs necessary to facilitate a successful completion of their academic goals and  
20 objectives. This is accomplished through provision of first aid, urgent care services, health  
21 assessment and treatment, psychological counseling & crisis intervention, health education, and  
22 community partnerships.

23 5. Many of the 90 health centers across within the CCC system offer robust health  
24 centers which include medical doctors, registered nurses, nurse practitioners, physician assistants,  
25 clinical psychologists, clinical psychiatrists and mental health therapists. These services provide  
26 primary care for many of the 2.1 million students within the CCC system.

1           6. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care;  
2 Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human  
3 Services (HHS) on May 2, 2019 (Rule), and published in the Federal Register on May 21, 2019.

4           7. The Rule will impose an immediate cost on CCC health centers due to its notice,  
5 assurance and certification, recordkeeping, and reporting requirements.

6           8. The notification provision of the Rule will impose costs on CCC health centers.

7 Although the Rule indicates that the notice provisions are now voluntary (unlike in the proposed  
8 rule), the Rule also states that adherence to the notice provisions will be taken into consideration  
9 when assessing whether an agency is in compliance. To provide notice, CCC health centers will  
10 need to: (1) post the notice in Appendix A (or similar text) at each CCC health center  
11 establishment where notices to the public and workforce are customarily posted, and thereafter  
12 continuously take steps to ensure that the notice is not altered, defaced, or covered by other  
13 materials, (2) include the notice on each of its websites, and (3) include the notice in its personnel  
14 manuals, applications, and benefits and training materials, as inclusion in these materials will be a  
15 factor in determining whether a CCC health center is in compliance. The estimated costs of  
16 compliance with these notification provisions is \$1,350,000, due to the necessary changes to  
17 websites, physical postings, as well as costs associated with updates to training manuals, new  
18 employee documentation, internship materials, and updates to benefits handbooks.

19           9. The Rule also includes an assurance and certification requirement that should be  
20 included with all applications, reapplications, and amendments and modifications. The provision  
21 also places an obligation on CCC to take actions to come into compliance. Notably and under the  
22 compliance provision, if a sub-recipient (as defined by the Rule) is found in violation, CCC will  
23 be subject to remedial action. This Rule thus places some oversight obligation on CCC which  
24 could cost CCC \$7,200,000 annually for additional staff time (1 staff member for monitoring and  
25 compliance, web page maintenance, form revisions, etc. at 78,000 per year with benefits at 90  
26 health care centers) necessary to engage in this sub-recipient monitoring component as some of  
27 the health centers are operated by local hospitals. Outsourcing of health centers through MOU is  
28

1 utilized within the CCC system in areas where resources are limited in order to provide access and  
2 care for all students within the CCC system.

3 10. The compliance provision also includes a recordkeeping and reporting requirement  
4 applicable to all recipients and sub-recipients which obligates CCC to include information  
5 concerning any compliance reviews or complaints to the Office of Civil Rights within the last  
6 three years as part of the application process. The costs of the record keeping and reporting  
7 requirements are reported in the above figures for compliance.

8 11. As with any compliance reporting, the HSACCC is additionally estimating another  
9 \$ 135,000.00 annually for any periodic compliance reviews and/or investigations.

10 12. The Rule creates a broad exemption for medical professionals and personnel to opt  
11 out of healthcare services based on a moral or religious ground. Specifically, personnel may opt  
12 out of healthcare services involving abortion, sterilization, and euthanasia. Further, the rule  
13 appears to enable objections to providing a broad range of healthcare services, including certain  
14 vaccinations if there is an "aborted fetal tissue" connection (rubella, polio, Hepatitis A,  
15 chickenpox, small pox), contraception, gender transition/gender dysphoria (counseling,  
16 administering hormone prescriptions, etc.), tubal ligations, hysterectomies, and assisted suicide.  
17 There does not appear to be any exception provided for emergency situations under the Rule.

18 13. Many CCC health centers provide services such as immunization/vaccinations,  
19 HIV testing and counseling, contraception, STD/STI screening, gynecological services, and  
20 referrals for these and follow-up services where appropriate. The Rule appears to target many of  
21 these services for potential refusal which could hinder the provision of these services to students.  
22 The Rule could also hinder the provision of services to LGBTQ students, including counseling  
23 services that members of this community could seek out.

24 14. In addition, HSACCC is concerned that the rule will impact access or create  
25 barriers to care or services including contraception, including emergency contraception,  
26 medication abortion, family planning, etc.

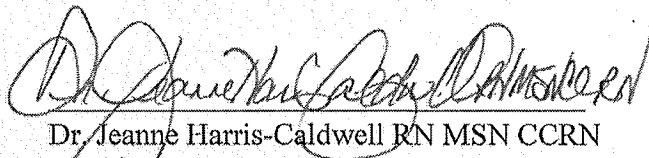
27 15. Currently, if CCC health center staff refuse to provide a service due to a religious  
28 or moral objection, substitute staff is found to perform the objected-to service. But the Rule



1 expands the scope of objections that can be made to include objections on the basis of  
2 “conscience, religious beliefs, or moral convictions” to not just services such as abortion,  
3 sterilization, and euthanasia, but also “other health services.” The Rule will be unworkable if it  
4 permits a medical provider to refuse “other health services” without notifying a supervisor of the  
5 denial of service, or without providing notice or alternative options and/or referrals to patients.  
6 Additionally, it would be difficult if not impossible to find a substitute provider at a health center  
7 that employs only a single health professional.

8  
9 I declare under penalty of perjury under the laws of the United States and the State of  
10 California that the foregoing is true and correct to the best of my knowledge.

11 Executed on the 4th of June 2019 in Mission Viejo, California.

12  
13 

14 Dr. Jeanne Harris-Caldwell RN MSN CCRN  
15 President  
16 Health Services Association  
17 California Community Colleges



1 XAVIER BECERRA, State Bar No. 118517  
Attorney General of California  
2 KATHLEEN BOERGERS, State Bar No. 213530  
Supervising Deputy Attorney General  
3 NELI N. PALMA, State Bar No. 203374  
Deputy Attorney General  
4 1300 I Street, Suite 125  
Sacramento, CA 94244-2550  
5 Telephone: (916) 210-7913  
Fax: (916) 324-5567  
6 E-mail: Neli.Palma@doj.ca.gov  
Attorneys for Plaintiff the State of California, by and  
7 through Attorney General Xavier Becerra

8  
9 IN THE UNITED STATES DISTRICT COURT  
10 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
11

12 **STATE OF CALIFORNIA, BY AND**  
13 **THROUGH ATTORNEY GENERAL XAVIER**  
14 **BECERRA,**  
15  
16  
17 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
18 **CAPACITY AS SECRETARY OF THE U.S.**  
19 **DEPARTMENT OF HEALTH & HUMAN**  
20 **SERVICES; U.S. DEPARTMENT OF**  
21 **HEALTH AND HUMAN SERVICES;**  
22 **DOES 1-100,**  
23  
24  
25  
26  
27  
28

Plaintiff,

v.

Defendants,

Case No.: 4:19-cv-02769-HSG

**DECLARATION OF BRUCE HINZE IN  
SUPPORT OF PLAINTIFF’S MOTION  
FOR PRELIMINARY INJUNCTION**

Date: October 10, 2019  
Time: 2:00 P.M.  
Dept: 2, 4<sup>th</sup> Floor  
Judge: The Honorable Haywood S.  
Gilliam, Jr.  
Trial Date: Not set  
Action Filed: May 21, 2019

I, Bruce Hinze, declare:

1. I am an attorney in good standing licensed to practice before all courts of the State of California. I am employed in an Attorney IV classification with the California Department of Insurance (“CDI” or “the Department”), and am the senior attorney in the CDI Health Policy Approval Bureau (HPAB), which monitors health insurer legal compliance, and provide the Insurance Commissioner with legal advice regarding health insurance. My duties include estimating the anticipated workload and costs that may result from proposed legislation. If

1 called upon to do so, I could and would testify competently about the contents of this  
2 declaration.

3 2. My duties include the review and analysis of proposed federal rules relating to  
4 health coverage for their impacts on the California health insurance market. I am familiar with the  
5 final rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN  
6 0945-AA10, published in volume 84, number 98 of the Federal Register on May 21, 2019,  
7 beginning at page 23170.

8 3. In accordance with regulations promulgated by CDI, under California Code of  
9 Regulations title 10, § 2240.5, health insurers are required to annually submit reports through the  
10 System for Electronic Rate and Form Filing (“SERFF”) demonstrating compliance with the  
11 network adequacy requirements of §2240.1. I was the lead attorney when the most recent  
12 revisions of these regulations were adopted in 2008, 2015, and 2016. I was also the lead in  
13 subsequent implementation of a network analytic software suite, and am the lead trainer and  
14 resource for all staff regarding network analysis.

15 4. The CDI network adequacy regulation requires, at California Code of Regulations  
16 title 10, § 2240.1(b)(1), that insurer networks include sufficient providers in-network to provide  
17 covered services, and, if a network provider does not provide a service that is otherwise within  
18 the scope of their practice, that the insurer must ensure there are sufficient providers within the  
19 network to provide that service.

20 5. The final federal rule, “Protecting Statutory Conscience Rights in Health Care;  
21 Delegations of Authority” would permit providers to decline to provide services within their  
22 scope of practice based on an asserted moral or religious objection. However, CDI’s current  
23 network adequacy regulation does not require identification of objecting network providers and  
24 the objected services, nor does CDI’s network adequacy analytics software provide the  
25 Department with the capability to excise objecting providers from an insurer’s data set within the  
26 software suite in order to audit the adequacy of the insurers’ network for services to which some  
27 providers may object to providing on conscience grounds. CDI will have to add to its network  
28 analysis procedures, in the short term, an inquiry to selected insurers regarding: (1) the number

1 and location of objecting providers, (2) identification of procedures not provided by these  
2 objecting providers otherwise within providers' scope of practice, and (3) identification of the  
3 network providers, if any, who provide the objected service[s] whose presence in the network  
4 backfills for the objecting providers in terms of assuring network adequacy. However, the  
5 Department will not be able to independently verify that the network is adequate. This spot  
6 inquiry will involve the expenditure of additional staff time by CDI, and by insurers. I estimate  
7 that this additional spot inquiry would involve at least 10 hours of additional time in the Attorney  
8 III category for each inquiry, analysis of insurer response, and rectification of compliance  
9 deficiencies, involving at least ten health insurers. This will represent an additional personnel  
10 cost of \$11,000 per year. Insurers are charged a single fee for each network submission, and so  
11 this additional compliance review will result in no offsetting revenue to CDI.

12           6. In the first full calendar year after the final rule, CDI will undertake a rulemaking  
13 process to develop a revised network adequacy regulation to reflect additional insurer data  
14 submission requirements to determine adequacy of networks where providers decline to provide  
15 services within the scope of their license based on the provisions of the proposed rule.  
16 Promulgation of a revised regulation under the California Administrative Procedures Act involves  
17 at least one year of staff time in developing the proposed regulation text, soliciting public  
18 comment, and revising the text after public comments. Promulgation of such a regulation would  
19 involve approximately 1,160 hours of Attorney IV time at a cost of \$157,000, as well as  
20 approximately 1,130 hours of time for staff in a variety of classifications, at a cost of \$99,000, for  
21 a total personnel cost to CDI for the regulation of \$256,000. Subsequent to the effective date of  
22 this regulation, review of insurer submissions would involve approximately 10 additional hours of  
23 Attorney III time per submission, involving approximately 27 annual network filings, for an  
24 additional annual personnel cost of approximately \$29,700 per year.

25           7. I am also the Department's lead counsel in the promulgation of guidance and  
26 regulations regarding uniform provider directory standards, pursuant to California Insurance Code  
27 section 10133.15(k). The Department is already in the early phase of the rulemaking process  
28 described in that section. However, the final rule will add additional complexity to the

1 rulemaking regarding provider directory standards, as the Department will consider requirements  
2 regarding consumer disclosure of procedures and services not covered by a provider exercising  
3 the options described in the final rule. Consideration of these additional provider directory  
4 requirements related to the final rule will require approximately 80 additional hours of Attorney  
5 IV time during the rulemaking process, representing a cost of \$10,828.

6  
7 I declare under penalty of perjury under the laws of the United States and the State of California  
8 that the foregoing is true and correct to the best of my knowledge.

9  
10 Executed on May 24, 2019 in San Francisco, California.

11  
12 

13 Bruce Hinze  
14 Attorney IV  
15 California Department of Insurance  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra*

8  
 9 IN THE UNITED STATES DISTRICT COURT  
 10 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 11

12 **STATE OF CALIFORNIA, BY AND**  
 13 **THROUGH ATTORNEY GENERAL XAVIER**  
 14 **BECERRA,**  
 15  
 16 **v.**  
 17 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
 18 **CAPACITY AS SECRETARY OF THE U.S.**  
 19 **DEPARTMENT OF HEALTH & HUMAN**  
 20 **SERVICES; U.S. DEPARTMENT OF**  
 21 **HEALTH AND HUMAN SERVICES;**  
 22 **DOES 1-100,**  
 23  
 24  
 25  
 26  
 27  
 28

Plaintiff,

Defendants,

Case No. 4:19-cv-02769-HSG

**DECLARATION OF KEVIN KISH IN  
 SUPPORT OF PLAINTIFF'S MOTION  
 FOR PRELIMINARY INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S. Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

I, Kevin Kish, declare:

1. I am the Director of the California Department of Fair Employment and Housing (DFEH). I was appointed in December 2014 to lead DFEH.
2. DFEH is the state agency charged by the California Legislature with enforcing California's civil rights laws. The mission of DFEH is to protect the people of California from unlawful discrimination in employment, housing, and public accommodations and from hate violence and human trafficking. Cal. Gov't Code § 12930.



1           3.       DFEH is responsible for enforcing state laws that make it illegal to discriminate  
2 against an employee because of certain protected categories that include religion, sex and gender  
3 (e.g. pregnancy, childbirth, breastfeeding, or related medical conditions), gender identity and  
4 gender expression, and sexual orientation, among many other bases. Among other laws, DFEH  
5 enforces the California Fair Employment and Housing Act (FEHA) (Cal. Gov't Code § 12900 et  
6 seq.), the Unruh Civil Rights Act (Cal. Civil Code § 51), and Cal. Gov't Code § 11135.

7           4.       FEHA applies to public and private employers, labor organizations, and  
8 employment agencies. Under FEHA, it is illegal for employers of five or more employees to  
9 discriminate against employees because of a protected category, or to retaliate against them  
10 because they have asserted their rights under the law.

11           5.       The Unruh Civil Rights Act prohibits discrimination by business establishments  
12 and is incorporated into the FEHA. Cal. Gov't Code § 12948. Unruh is violated by denying the  
13 full and equal accommodations, advantages, facilities, privileges, or services of a business  
14 establishment.

15           6.       Under Cal. Gov't Code § 11135, no person in the State of California shall be  
16 denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under,  
17 any program or activity that is conducted, operated, or administered by the state or by any state  
18 agency, is funded directly by the state, or receives any financial assistance from the state.

19           7.       To carry out its responsibilities, DFEH facilitates a complaint process, whereby  
20 individuals who believe that they were the victim of discrimination, may file a complaint with  
21 DFEH, which is called an intake form. The submission of the intake form initiates an intake  
22 interview with a department representative to determine whether a formal complaint will be  
23 accepted for investigation. The DFEH investigator contacts the individual complainant and the  
24 investigator seeks specific facts and any records about the incident(s) and copies of any  
25 documents supporting the complaint. DFEH then evaluates the facts and decides whether the case  
26 alleges facts within DFEH's jurisdiction. DFEH does not have discretion to decline to investigate  
27 cases within its jurisdiction. If a case is within its jurisdiction, DFEH will prepare a complaint  
28 form for the individual's signature under penalty of perjury and when the individual returns the

1 complaint, it is delivered to the person or entity that the person believes discriminated against  
2 him/her/them, who is the respondent.

3 8. After a complaint is signed and issued, the respondent is required to answer the  
4 complaint. DFEH reviews the answer with the complainant. It conducts an investigation by  
5 obtaining documents and interviewing witnesses. Cases are evaluated for complexity and merit at  
6 every stage of the investigation.

7 9. DFEH offers free dispute resolution services to encourage parties to resolve the  
8 complaint, when appropriate. For many less complex cases, a voluntary resolution can be  
9 negotiated at any time during the complaint process. When parties cannot resolve a complaint or  
10 DFEH determines that a case is not appropriate for voluntary resolution, DFEH continues an  
11 investigation to determine if a violation of California law occurred. If it did not, the case is  
12 closed. If DFEH finds there were probable violations of the law, there is a cause finding and the  
13 case moves into DFEH's Legal Division. At that time, the parties are required to go to mediation.  
14 DFEH represents the interests of the State, and the complainant is a witness to the discrimination.  
15 At mediation, the parties have the opportunity to reach an agreement to resolve the dispute and  
16 close the case. If mediation fails, DFEH may file a lawsuit in court.

17 10. If an individual prefers not to use the DFEH investigation process, the individual  
18 may instead file their own lawsuit. In the context of employment discrimination, a complainant  
19 must first obtain a Right-to-Sue notice from DFEH before filing a lawsuit in court.

20 11. DFEH conducts an independent investigation when a complaint is filed. DFEH  
21 investigates the facts and encourages the parties to resolve the dispute in appropriate cases. DFEH  
22 considers taking legal action if evidence supports a finding of discrimination and the dispute is  
23 not resolved.

24 12. In addition to individual complaints, the Director may also initiate a Director's  
25 Complaint pursuant to 2 C.C.R. § 10012 on behalf of a group or class of persons adversely  
26 affected in a similar manner by an unlawful practice under FEHA.

27  
28



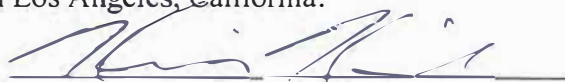
1           13. I have reviewed and am familiar with the content of the final rule Protecting  
2 Statutory Conscience Rights in Health Care; Delegations of Authority that the U.S. Health and  
3 Human Services Department published on May 21, 2019 (the Rule).

4           14. Under state laws, DFEH has jurisdiction over complaints filed by employees  
5 alleging that their employers have not reasonably accommodated their religious beliefs or that  
6 their employers have otherwise discriminated against or harassed them on a protected basis.  
7 DFEH also has jurisdiction over complaints filed by patients, consumers, and contractors alleging  
8 that they have been denied full and equal accommodations, advantages, facilities, privileges, or  
9 services. DFEH similarly has jurisdiction over complaints of discrimination under – and unequal  
10 access to – government-funded programs and activities.

11           15. After considering the rule, I believe that it will impact the analysis that DFEH  
12 must engage in to carry out its required responsibilities under these laws, including analysis of the  
13 scope and application of California’s own religion-based exemptions from anti-discrimination  
14 principles of general applicability, See, e.g., Cal. Gov’t Code § 12926.2. It will impact the  
15 analysis that DFEH must engage in to enforce the Unruh Civil Rights Act and Cal. Gov’t Code §  
16 11135.

17           I declare under penalty of perjury under the laws of the United States and the State of  
18 California that the foregoing is true and correct to the best of my knowledge.

19  
20 Executed on May 23, 2019 in Los Angeles, California.

21 

22 Kevin Kish  
23 Director  
24 Department of Fair Employment and Housing  
25  
26  
27  
28

1 XAVIER BECERRA, State Bar No. 118517  
Attorney General of California  
2 KATHLEEN BOERGER, State Bar No. 213530  
Supervising Deputy Attorney General  
3 NELI N. PALMA, State Bar No. 203374  
Deputy Attorney General  
4 1300 I Street, Suite 125  
Sacramento, CA 94244-2550  
5 Telephone: (916) 210-7913  
Fax: (916) 324-5567  
6 E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
7 through Attorney General Xavier Becerra*

8  
9 IN THE UNITED STATES DISTRICT COURT  
10 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
11

12 **STATE OF CALIFORNIA, BY AND**  
13 **THROUGH ATTORNEY GENERAL XAVIER**  
14 **BECCERRA,**  
  
15 v.  
  
16 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
17 **CAPACITY AS SECRETARY OF THE U.S.**  
18 **DEPARTMENT OF HEALTH & HUMAN**  
19 **SERVICES; U.S. DEPARTMENT OF**  
20 **HEALTH AND HUMAN SERVICES;**  
21 **DOES 1-100,**  
22  
23  
24  
25  
26  
27  
28

Plaintiff,

Defendants,

Case No.: 4:19-cv-02769-HSG

**DECLARATION OF RICARDO LARA  
IN SUPPORT OF PLAINTIFF'S  
MOTION FOR PRELIMINARY  
INJUNCTION**

Date: October 10, 2019  
Time: 2:00 P.M.  
Dept: 2, 4<sup>th</sup> Floor  
Judge: The Honorable Haywood S.  
Gilliam, Jr.  
Trial Date: Not set  
Action Filed: May 21, 2019

I, Ricardo Lara, declare:

1. I am the elected Insurance Commissioner of the State of California. I was elected to this position in November 2018 and was sworn into office on January 7, 2019. I am the first openly LGBTQ person to be elected to statewide office in California. As Insurance Commissioner, I oversee the California Department of Insurance (CDI). Prior to being elected California's Insurance Commissioner, I was elected to and served in the California State Legislature from 2010-2018.

1           2.       I am familiar with the final Rule, Protecting Statutory Conscience Rights in Health  
2 Care; Delegations of Authority, RIN 0945-AA10, published in volume 84, number 98 of the  
3 Federal Register on May 21, 2019, beginning at page 23170.

4           3.       If called upon to do so, I could and would testify competently about the contents of  
5 this declaration.

6           4.       CDI is the largest consumer protection agency in the state and is responsible for  
7 regulating California's insurance market, which is the largest in the country. CDI implements and  
8 enforces consumer protection laws related to health insurance, including but not limited to,  
9 essential health benefits requirements, anti-discrimination protections and laws pertaining to  
10 timely access to medical care.

11          5.       Based upon my knowledge and experience, I believe the Rule will harm patients  
12 by delaying timely access to medical care, result in denial of access to medically necessary health  
13 care services, and increase discrimination against patients. This Rule invites discrimination and  
14 threatens the health of Californians, particularly women, members of the lesbian, gay, bisexual,  
15 transgender, queer or questioning (LGBTQ) community, people of color, and persons living in  
16 communities with limited medical treatment options.

17          6.       This Rule flies in the face of decades of civil rights laws, court rulings, and our  
18 progress as a nation. This Rule allows a broad range of individuals and entities (such as medical  
19 providers, medical facilities, insurers, third-party administrators, employers, and their employees  
20 such as medical personnel, call center staff, receptionists, scheduling staff and others) to impose  
21 their personal bias against a particular medical service or patient. By giving these individuals and  
22 entities free rein to put their biases above the needs of patients, this Rule allows these individuals  
23 and entities to interfere with patient care, to refuse to provide care, or to refuse to provide health  
24 insurance coverage for medically necessary health care services. This Rule will therefore have a  
25 chilling effect on the practice of medicine, hospital operations, and insurance coverage for  
26 medically necessary services. This Rule threatens a fundamental right, the freedom from  
27 discrimination, which state and federal laws guarantee to all people.

28          7.       The Rule interferes with enforcement of state laws that prohibit discrimination on

1 the basis of race, color, ancestry, marital status, sex, sexual orientation, gender, and gender  
2 identity.

3 8. With this Rule, the federal government threatens to withhold billions of dollars  
4 from California unless we deny Californians the privacy and anti-discrimination protections  
5 enshrined in state law and our state constitution.

6 9. CDI enforces laws that require that health insurers provide timely access to  
7 medical care. Health insurers submit their medical provider network data to CDI, which includes  
8 information about medical providers who are available to provide medical care to policyholders  
9 of that insurer. CDI receives consumer calls, requests for information, and complaints concerning  
10 patients who encounter difficulty receiving timely access to medical care.

11 10. This rule will make it more difficult for patients to access the care they need in a  
12 timely manner. When care is delayed or denied, it often results in more costly care being  
13 necessary at a later date, which can result in adverse medical outcomes. This rule will cause  
14 confusion for patients as they attempt to exercise their right to access the full range of medically  
15 appropriate care, but encounter new roadblocks. The Rule will also create confusion for health  
16 facilities, providers and insurers, given that they are bound by state laws that protect patient  
17 access to medically necessary health care, while these rules may interfere with the provision of  
18 timely access to care.

19 11. If providers exercise the discriminatory refusals of care invited by this Rule,  
20 insurers may find that their medical provider networks are now insufficient to provide timely  
21 access to specific necessary services. As a result, these insurers will be required to arrange for  
22 care for their policyholders with out-of-network providers. This would likely result in increased  
23 costs to the insurer that would then be passed on to policyholders. Also, given the overbroad  
24 scope of the Rule, an insurer's employee, who has no medical background or involvement in the  
25 actual treatment of the insured patient, might nonetheless object on the basis of this Rule to  
26 participating in arranging this out-of-network care, further delaying or preventing the patient from  
27 accessing care. Similarly, this Rule also increases the likelihood that a patient who goes to an in-  
28 network medical facility will be forced to see an out-of-network medical provider to get the care

1 they need, which in some situations will result in the patient having to pay higher, out-of-network  
2 cost-sharing.

3 12. Throughout my career in public service, I have heard from people who have  
4 experienced difficulty getting access to medical care because they are transgender.

5 13. A 2015 national transgender survey shared with CDI found that 33% of  
6 respondents who had seen a health care provider in the past year reported having at least one  
7 negative experience related to being transgender such as verbal harassment, refusal of treatment,  
8 or having to educate the medical provider about transgender people to receive appropriate care.

9 14. Progress has been made in terms of increasing access to needed medical care for  
10 transgender Californians. In 2012, CDI issued regulations clarifying that insurers are prohibited  
11 from denying, canceling, and limiting or refusing insurance coverage based on gender identity,  
12 expression or transgender status. Health insurance coverage in California is prohibited from  
13 arbitrarily excluding coverage for gender affirmation services including (but not limited to)  
14 hormone therapy, mental health services and surgical services. However, this Rule seeks to  
15 reverse that progress, and may embolden those who might engage in such harassment or refusal  
16 to provide care.

17 15. As some providers use this Rule to express their biases while practicing their  
18 profession, this Rule will increase discrimination against LGBTQ Californians. This Rule can be  
19 expected to increase the number of providers who will not treat someone because they are  
20 LGBTQ. Some pediatricians or other primary care providers may decline to treat certain patients.  
21 In some areas of California, this will make it very difficult for LGBTQ Californians to access the  
22 care they need. This type of discrimination will have devastating impacts on the health and well-  
23 being of patients, both those who are denied care and those who worry they will not be able to get  
24 care due to this Rule.

25 16. This Rule will limit access to medical services such as human immunodeficiency  
26 virus (HIV) preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP), which will  
27 likely result in an increase in the number of people becoming HIV positive. This Rule threatens  
28 public health. 4



1           17.     The Federal Bureau of Investigation (FBI) reported that hate crimes have been on  
2 the rise three years in a row, but this Rule gives medical providers and others permission to  
3 discriminate against even those who need medical attention because they have just been victims  
4 of violent hate crimes.

5           18.     The federal government should not be encouraging unlawful discrimination by  
6 adopting this regulation, which runs counter to existing state and federal privacy and anti-  
7 discrimination laws, particularly when the result will be harm to the health and well-being of  
8 already vulnerable populations.

9           19.     Californians have a constitutionally guaranteed right to privacy. This Rule  
10 threatens the ability of Californians to exercise their right to privacy and impedes access to basic  
11 health care services.

12           20.     As Insurance Commissioner, I enforce the Affordable Care Act (ACA) and state  
13 laws that require health insurance policies to cover preventive health care. This Rule will  
14 interfere with the ability of women to get access to and even information about the full range of  
15 reproductive health services that the law requires be covered by health insurance.

16           21.     Prior to the passage of the ACA, CDI heard from some women who had, at times,  
17 experienced difficulty filling their prescriptions for contraceptives each month, resulting in their  
18 skipping needed pills. Some of those women became pregnant, despite having a prescription for  
19 contraceptives. A Rule that allows more pharmacists or others to interfere with a woman's access  
20 to contraceptives will result in undue hardships for women, some of whom will then face  
21 unintended pregnancies and abortions that would otherwise not have occurred.

22           22.     This Rule will limit access to medical services for victims of sexual assault  
23 seeking treatment to prevent pregnancy. Delaying such treatment will result in unintended  
24 pregnancies. Under this Rule, we can expect that a patient who is brought to the nearest  
25 emergency room for treatment may need to later transport themselves to a different medical  
26 facility where they can receive the treatment they need. By then, it may be too late to prevent an  
27 unintended pregnancy.

28           23.     This Rule also seeks to make it more difficult for women in many communities to

1 access abortion services. To the extent that a woman's access is delayed, the type of procedure  
2 that will be medically appropriate may change and the cost of that procedure will be higher than if  
3 she was able to access abortion services earlier in her pregnancy.

4 24. In a circumstance where sterilization is being used for preventive purposes, such as  
5 a preventive oophorectomy (removal of ovaries) to reduce the risk of future cancers for women  
6 with the high-risk BRCA genetic mutation, this Rule could make it possible for providers to delay  
7 or prevent this treatment.

8 25. This Rule will limit access to medical services in rural communities and other  
9 geographic areas with limited numbers of health care providers, which will endanger patients.

10 26. The Rule acknowledges that "...patients in rural areas are more likely than patients  
11 in urban areas to suffer adverse health outcomes as a result of being denied care" (84 Fed. Reg. at  
12 23253) and yet astoundingly the Rule creates a situation in which an overly broad range of people  
13 and entities will have the ability to interfere with the ability of a patient who needs medical to  
14 care to receive that care.

15 27. Rural communities in California often have fewer primary care doctors and  
16 specialists than may be needed to serve a given community. Additionally, in some communities,  
17 an individual or employer may only have a choice of one or two health insurers in particular  
18 geographic areas when buying coverage. This Rule will be particularly harmful in areas where  
19 the small number of medical providers and/or insurers serving the area already presents  
20 challenges to timely access to medical care. Some people will have to drive long distances to  
21 access care. Others will not be able to afford to travel to receive the medical care they need,  
22 which may result in illness or even death that could have been prevented with timely access to  
23 medical care.

24 28. The Federal Office of Disease Prevention and Health Promotion has  
25 acknowledged that LGBTQ persons already face health disparities linked to social stigma,  
26 discrimination, and denial of their civil and human rights leading to higher rates of psychiatric  
27 disorders, substance abuse and suicide. By allowing health care providers to discriminate against  
28 LGBTQ persons, this Rule poses a direct threat to the health of LGBTQ patients.



1           29.    This Rule will limit access to mental health care for some populations, resulting in  
2 increased suicide rates and treatment costs for suicide attempts, and substance abuse and  
3 treatment costs for substance abuse.

4           30.    This Rule will interfere with serving the needs of a diverse community. The Rule  
5 threatens the health and safety of Californians.

6  
7 I declare under penalty of perjury under the laws of the United States and the State of California  
8 that the foregoing is true and correct to the best of my knowledge.

9

10           Executed on May 24, 2019 in San Francisco, California.

11

12

13

14



15

---

Ricardo Lara  
Insurance Commissioner  
State of California

16

17

18

19

20

21

22

23

24

25

26

27

28

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra*

8  
 9 IN THE UNITED STATES DISTRICT COURT  
 10 FOR THE NORTHERN DISTRICT OF CALIFORNIA

11 **STATE OF CALIFORNIA, BY AND**  
 12 **THROUGH ATTORNEY GENERAL XAVIER**  
 13 **BECERRA,**  
 Plaintiff,  
 14 v.  
 15 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
 16 **CAPACITY AS SECRETARY OF THE U.S.**  
 17 **DEPARTMENT OF HEALTH & HUMAN**  
 18 **SERVICES; U.S. DEPARTMENT OF**  
 19 **HEALTH AND HUMAN SERVICES;**  
 20 **DOES 1-100,**  
 Defendants,

4:19-cv-02769-HSG

**DECLARATION OF DR. JOSEPH MORRIS IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S. Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

21 I, Joseph Morris, PhD, MSN, RN, declare:

22 1. I am the Executive Officer of the Board of Registered Nursing (Board) and an  
 23 active licensed Registered Nurse in the State of California. I make this declaration in my official  
 24 capacity as the Executive Officer of the Board and make this declaration of my own personal  
 25 knowledge.

26 2. The California Board of Registered Nursing (the Board) is a state governmental  
 27 agency established to protect the public by regulating the practice of registered nurses; it is  
 28

1 organized under the California Department of Consumer Affairs. Cal. Bus. & Prof. Code §§ 101,  
2 2701. The Board is responsible for implementing and enforcing the Nursing Practice Act. The  
3 Board's authorizing statutes designate protection of the public as its highest priority. Cal. Bus. &  
4 Prof. Code § 2708.1.

5 3. To carry out its mission to protect the public, the Board performs a number of  
6 functions, including but not limited to:

- 7 • Establishing educational standards for nursing programs which prepare individuals to  
8 become licensed as registered nurses;
- 9 • Evaluating licensure applications to determine whether the applicant meets the criteria  
10 for licensure;
- 11 • Enforcing state law by taking appropriate disciplinary action against nurses who  
12 violate the Nursing Practice Act and relevant provisions of the Business & Professions  
13 Code;
- 14 • Adopting regulations to clarify the performance, practice, and disciplinary standards  
15 for its licensees.

16 4. The Board's Enforcement Division protects consumers from licensees who  
17 practice in a manner that may be unsafe or unprofessional. The Board has authority to revoke,  
18 suspend, or place on probation any license if the licensee has violated a provision of the law  
19 governing the profession. Cal. Bus. & Prof. Code § 2759.

20 5. I am familiar with the rule Protecting Statutory Conscience Rights in Health Care;  
21 Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human  
22 Services (HHS) on May 2, 2019, and published in the Federal Register on May 21, 2019 (the  
23 Rule).

24 6. The Rule creates a broad exemption for medical professionals and personnel to opt  
25 out of any healthcare service based on a moral or religious ground. Specific scenarios are  
26 included in the Rule, including abortion, sterilization, euthanasia, certain vaccinations if there is  
27 an "aborted fetal tissue" connection (rubella, polio, Hep A, chickenpox, small pox),  
28 contraception, gender transition/gender dysphoria (counseling, administering hormone

1 prescriptions, etc.), tubal ligations, hysterectomies, assisted suicide, and referrals for advanced  
2 directives, and there does not appear to be any exception provided for emergency situations.

3 7. Under the Rule, nurses can refuse medical care without any information about the  
4 patient's medical condition or treatment options, not just on the basis of federally protected  
5 conscience protections, but also on the basis of "ethical or other reasons." A provider can do this  
6 without any supporting evidence, without notifying a supervisor of the denial of service, and  
7 without providing notice or alternative options and/or referrals to patients in need

8 8. The Rule if implemented may thus impact the work and mission of the Board.

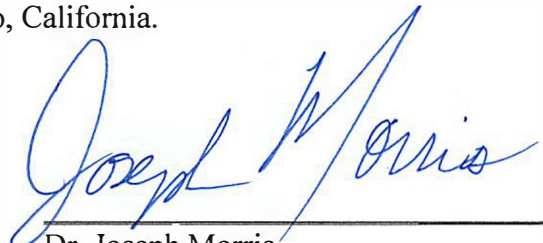
9 9. If, as a result of the Rule's requirements, patients file complaints against nurses  
10 who deny care or fail to provide them with timely, accurate, and complete information, then the  
11 Board will have to investigate such complaints.

12 10. Furthermore, the Board is responsible for enforcing California law through  
13 disciplinary proceedings. Thus, the Board may face an increase in disciplinary matters for nurses  
14 that fail to abide by the Nursing Practice Act, including standards of care.

15 11. Notably, the standards of competent performance that nurses must abide by  
16 include acting as the patient's advocate which includes giving the patient the opportunity to make  
17 informed decisions about healthcare. Cal. Code Regs. tit. 16, § 1443.5(6) (2019). Failing to act  
18 in an emergency thereby jeopardizing a patient's health or life could also result in a charge of  
19 "gross negligence." Cal. Code Regs. tit. 16, § 1442.

20 I declare under penalty of perjury under the laws of the United States and the State of  
21 California that the foregoing is true and correct to the best of my knowledge.

22 Executed on May 29, 2019 in Sacramento, California.

23  
24  
25 

26 Dr. Joseph Morris  
27 Executive Officer  
28 California Board of Registered Nursing

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra*

8  
 9 IN THE UNITED STATES DISTRICT COURT  
 10 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 11

12 **STATE OF CALIFORNIA, BY AND**  
 13 **THROUGH ATTORNEY GENERAL XAVIER**  
 14 **BECERRA,**

Plaintiff,

15 v.

16 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
 17 **CAPACITY AS SECRETARY OF THE U.S.**  
 18 **DEPARTMENT OF HEALTH & HUMAN**  
 19 **SERVICES; U.S. DEPARTMENT OF**  
 20 **HEALTH AND HUMAN SERVICES;**  
 21 **DOES 1-100,**

Defendants,

Case No. 4:19-CV-02769-HSG

**DECLARATION OF BRANDON NUNES  
 IN SUPPORT OF PLAINTIFF'S  
 MOTION FOR PRELIMINARY  
 INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S.  
 Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

22 I, Brandon Nunes, declare:

23 1. I am a resident of the State of California. I am over the age of 18 and have  
 24 personal knowledge of all the facts stated herein. If called as a witness, I could and would testify  
 25 competently to all the matters set forth below.

26 2. I am the Chief Deputy Director of Operations for the California Department of  
 27 Public Health (CDPH). CDPH has nearly 3,800 employees working in over 200 program areas to  
 28 serve the people of California.



1           3.       I was appointed Chief Deputy Director of Operations in May 2015. In this  
2 capacity, and as a member of the CDPH directorate, I have responsibility in overseeing and  
3 supporting our department's programs to ensure they have the resources they need to successfully  
4 implement their mission and the mission of CDPH.

5           4.       Prior to my appointment as Chief Deputy Director of Operations, I worked for  
6 over 16 years at the California Department of Finance (DOF) in various roles. The first eight  
7 years of my time with DOF was spent in the Office of State Audits and Evaluations (OSAE).  
8 OSAE is responsible for all Executive Branch audit functions, including financial audits,  
9 performance audits, and compliance audits. During my time at OSAE, I lead and supervised a  
10 number of audit teams responsible for evaluating and advising on the programmatic,  
11 administrative, and fiscal policies of a wide variety of state and local entities. The second half of  
12 my career with DOF was spent in the Health and Human Services Budget Unit. During this time,  
13 I was responsible for developing, overseeing, and defending the budgets of a number of  
14 departments under the California Health and Human Services Agency, including the Department  
15 of Public Health and the Department of Social Services.

16           5.       CDPH works to optimize and protect the health and wellbeing of the people in  
17 California. Our fundamental responsibilities include infectious disease control and prevention,  
18 food safety, environmental health, laboratory services, patient safety, emergency preparedness,  
19 chronic disease prevention and health promotion, family health, health equity, and vital records  
20 and statistics. Our key activities include protecting people in California from the threat of  
21 preventable infectious diseases like Zika virus, HIV/AIDS, tuberculosis, and viral hepatitis, and  
22 providing reliable and accurate public health laboratory services and information about health  
23 threats. CDPH also protects patient safety in hospitals and skilled nursing facilities, maintains  
24 birth and death certificates, and prepares for and responds to public health emergencies. CDPH  
25 works continuously to reduce health and mental health disparities affecting vulnerable and  
26 underserved communities to achieve health equity throughout California. Indeed, CDPH  
27 programs and services touch the lives of every Californian and visitor to the state 24 hours a day,  
28 seven days a week.



1           6. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care;  
2 Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human  
3 Services (HHS) on May 2, 2019 (Rule), and published in the Federal Register on May 21, 2019.

4           7. The Rule has already imposed costs on California. CDPH has spent more than 30  
5 hours of program staff and attorney time reading and analyzing the Rule in order to determine its  
6 potential impacts on our programs, workforce, and partnerships with local health departments.

7           8. The Rule will impose immediate costs on CDPH. Although the final rule indicates  
8 that notice requirements are now voluntary, the Rule also states that adherence to the notice  
9 requirements will be taken into consideration when assessing whether an agency is in compliance.  
10 In accordance with section 88.5 of the Rule, CDPH will incur costs developing easy-to-  
11 understand, accessible materials for CDPH staff and others, including written policies and  
12 procedures, electronic notices, and updates to CDPH's internal and external websites. CDPH will  
13 also incur costs creating and operationalizing new training modules.

14           9. Currently, CDPH has nearly 670 contracts that involve federal funding. These  
15 contracts help fund public health efforts throughout the state. For fiscal year 2018-2019, CDPH's  
16 budget was approximately \$3.2 billion, which included approximately \$1.5 billion from the  
17 federal government.

18           10. The Rule jeopardizes all federal funds CDPH receives from the U.S. Department  
19 of Health and Human Services, including the Centers for Disease Control and Prevention, as well  
20 as from the U.S. Department of Education and the U.S. Department of Labor. Loss of this federal  
21 funding will have a devastating impact on California, the nation's most populous state, both by  
22 impacting state public health programs and by having a cascading impact on local health  
23 departments dependent on federal funding that flows through the state. CDPH—and, in all  
24 likelihood, the local health departments—will be unable to absorb such a tremendous loss of  
25 funding without a reduction in staffing, programs, and services.

26           11. In developing its annual budget, CDPH did so with the expectation that it would  
27 receive the federal funds to which it is entitled to under its existing agreements with the  
28 aforementioned federal agencies—these funds are now being placed at risk under the Rule. A

1 sudden disruption in anticipated federal funds would create budgetary chaos for both state and  
2 local public health programs and undermine their ability to deliver vital public health programs  
3 and services.

4 12. Federal funding supports numerous programs within CDPH, including through  
5 dollars that support state operations or are passed through to local health departments. With  
6 regard to CDPH's 2018-2019 budget, the Rule jeopardizes the following public health programs,  
7 and corresponding federal funding dollars (among others):

- 8 • Public Health Emergency Preparedness Program, which coordinates preparedness  
9 and response activities for all public health emergencies, including natural disasters,  
10 acts of terrorism, and pandemic diseases and plans and supports surge capacity in  
11 the medical care and public health systems to meet needs during emergencies (\$31.4  
12 million for state operations and \$59.1 million for local assistance in 2018-2019);
- 13 • Chronic Disease Prevention and Health Promotion, which works to prevent and  
14 control chronic diseases, injuries, and violence, including reducing the prevalence of  
15 obesity, reducing and preventing tobacco use, promoting safe and healthy  
16 environments, and treating problem gambling (\$23.7 million for state operations and  
17 \$12.2 million for local assistance in 2018-2019);
- 18 • Infectious Diseases Program, which works to prevent and control infectious diseases  
19 such as: HIV/AIDS, viral hepatitis, influenza and other vaccine-preventable  
20 illnesses, sexually transmitted diseases, tuberculosis, emerging infections, and  
21 foodborne illnesses (\$66.0 million for state operations and \$215.6 million for local  
22 assistance in 2018-2019);
- 23 • Health Statistics and Informatics Program, which develops data systems and  
24 facilitates the collection, validation, analysis, and dissemination of health  
25 information (\$913,000 for state operations in 2018-2019);
- 26 • County Health Services Program, which supports county-based public health  
27 information and services (\$3.9 million for local assistance in 2018-2019);

- 1           • Programs within the Center for Environmental Health, which work to protect and  
2           improve the health of all California residents by providing for the safety of food,  
3           drugs, and medical devices; conducting underage tobacco enforcement; conduct  
4           environmental management programs; and oversee the use of radiation through  
5           investigation, inspection, laboratory testing, and regulatory activities (\$1.4 million  
6           for state operations in 2018-2019);
- 7           • Health Facilities Licensing Program, which regulates the quality of care in over  
8           10,000 public and private health facilities, clinics, and agencies throughout the state;  
9           licenses nursing home administrators; certifies nurse assistants, home health aides,  
10          and hemodialysis technicians; and oversees the prevention, surveillance, and  
11          reporting of healthcare-associated infections in California’s general acute care  
12          hospitals (\$102.1 million for state operations in 2018-2019); and
- 13          • Laboratory Field Services Program, which regulates quality standards in  
14          approximately 22,000 clinical laboratories, public health laboratories, blood banks,  
15          and tissue banks in California; and licenses approximately 60,000 scientific  
16          classifications that include 30 different categories of laboratory personnel including  
17          laboratory scientists, phlebotomists, genetic scientists, clinical chemists, and public  
18          health microbiologists (\$1.7 million for state operations in 2018-2019).

19           13.     The Rule makes CDPH liable for the actions of third parties in a manner that is  
20           unprecedented in CDPH’s experience and unworkable in practice. This is because the Rule  
21           dictates that if a sub-recipient violates the Rule, the sub-recipient’s violation jeopardizes CDPH’s  
22           funding as a recipient. Specifically, the Rule includes an assurance and certification requirement  
23           that should be included with all applications, reapplications, and amendments and modifications.  
24           The provision also places an obligation on CDPH to take actions to come into compliance. But if  
25           a sub-recipient (as defined by the Rule) is found in violation, CDPH will be subject to remedial  
26           action, including the loss of some or all of the federal funding described above.

27           14.     By making CDPH responsible for the compliance of sub-recipients, the Rule  
28           appears to impose an oversight obligation that requires CDPH to expend funds for additional staff

1 time to monitor the compliance of sub-recipients. Even if monitoring is not required under the  
2 Rule, the Rule is so broadly and vaguely written that it is nearly impossible to ascertain how  
3 CDPH should communicate with its sub-recipients, including through the re-drafting of its  
4 contracts, in order to obligate its sub-recipients to comply with the Rule in a manner that  
5 effectively protects CDPH's own federal funding.

6 15. Terminating CDPH's funding based on the conduct of third parties that CDPH  
7 neither controls nor operates would hobble the state's ability to protect the public health. For  
8 example, federal funding for CDPH and for all counties could be placed at risk based on the  
9 alleged violation of a single county, a separate legal entity from the state (Cal. Gov. Code  
10 § 23000, et seq.).

11 16. As one example, CDPH's Immunization Branch receives substantial annual  
12 funding and support under the federal Health and Human Services appropriation, totaling almost  
13 \$581 million annually. Approximately \$537 million supports routine childhood vaccines, \$8.7  
14 million covers routine vaccines for uninsured and underinsured adults, and \$35.4 million provides  
15 financial assistance for state and local operations each year. Of this \$35.4 million in operations  
16 funding, approximately half (\$17 million) is provided to 61 local health departments throughout  
17 California. Under the Rule, even if CDPH contractually obligates all local health departments to  
18 comply with the Rule, and a single violation is committed without CDPH's knowledge, this  
19 violation would put CDPH's funding and pass-through funding at risk. And, as a result of the loss  
20 of federal funding, local health departments would struggle to provide immunizations against  
21 deadly diseases such as measles, polio, and tetanus.

22 17. As another example, CDPH's Sexually Transmitted Diseases (STD) Control  
23 Branch provides support, guidance, coordination and safety-net services to local STD control  
24 programs. CDPH receives \$6.8 million in federal funding, including \$1.5 million that is passed  
25 through to local STD control programs throughout California. Under the Rule, even if CDPH  
26 contractually obligates all local health departments to comply with the Rule, and a single  
27 violation is committed without CDPH's knowledge, this violation would put CDPH's funding at  
28 risk. STD rates are currently on the rise in California: In 2017 compared to 2016, the rate of

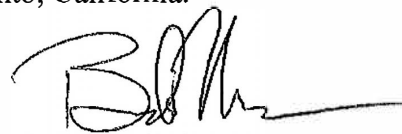
1 syphilis increased 9%, the rate of gonorrhea increased 16%, and the rate of early syphilis  
2 increased 21%. If CDPH lost federal funding due to one local health department's  
3 non-compliance with the Rule, many local health departments could struggle to continue their  
4 work preventing, diagnosing, and treating STDs.

5 18. In addition to the potential decimation of public health programs in the state due to  
6 the potential loss of federal funding, CDPH is also concerned that the Rule's position on  
7 vaccinations, and its potential to encourage doctors opposed to the state's efforts to ensure that all  
8 families follow the recommended childhood vaccination schedule, will adversely affect  
9 California's public health efforts to control the spread of preventable diseases such as measles.

10 19. As of April 24, 2019, 38 confirmed measles cases, including 28 outbreak-  
11 associated cases, have been reported in California. The outbreak of measles has an impact beyond  
12 state lines. The last large outbreak of measles in California was associated with Disneyland and  
13 occurred from December 2014 to April 2015, when at least 131 California residents were infected  
14 with measles, and also infected residents of six other states, Mexico, and Canada.

15 I declare under penalty of perjury under the laws of the United States and the State of  
16 California that the foregoing is true and correct to the best of my knowledge.

17  
18 Executed on May 31, 2019, in Sacramento, California.

19  
20 

21 Brandon Nunes  
22 Chief Deputy Director of Operations  
23 California Department of Public Health



XAVIER BECERRA, State Bar No. 118517  
Attorney General of California  
KATHLEEN BOERGERS, State Bar No. 213530  
Supervising Deputy Attorney General  
NELI N. PALMA, State Bar No. 203374  
Deputy Attorney General  
1300 I Street, Suite 125  
Sacramento, CA 94244-2550  
Telephone: (916) 210-7913  
Fax: (916) 324-5567  
E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
through Attorney General Xavier Becerra*

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF CALIFORNIA

**STATE OF CALIFORNIA, BY AND  
THROUGH ATTORNEY GENERAL XAVIER  
BECERRA,**  
  
Plaintiff,  
  
v.  
  
**ALEX M. AZAR, II, IN HIS OFFICIAL  
CAPACITY AS SECRETARY OF THE U.S.  
DEPARTMENT OF HEALTH & HUMAN  
SERVICES; U.S. DEPARTMENT OF  
HEALTH AND HUMAN SERVICES;  
DOES 1-100,**  
  
Defendants,

4: 19-cv-02769-HSG

**DECLARATION OF NELI N. PALMA IN  
SUPPORT OF PLAINTIFF'S MOTION  
FOR PRELIMINARY INJUNCTION**

Date: October 10, 2019  
Time: 2:00 P.M.  
Dept: 2, 4<sup>th</sup> Floor  
Judge: The Honorable Haywood S.  
Gilliam, Jr.  
Trial Date: Not set  
Action Filed: May 21, 2019

I, Neli N. Palma, declare:

1. I am a member of the California State Bar, admitted to practice before this Court, employed by the Office of the California Attorney General as a Deputy Attorney General, and counsel to Plaintiffs in this action. I have personal knowledge of the facts set forth herein, and if called upon as a witness, I could testify to them competently under oath.

2. Attached hereto as Exhibit A is a true and correct copy of the 2018-19 budget for the California Department of Education, available online via ebudget.ca.gov.



1           3.       Attached hereto as Exhibit B is a true and correct copy of the letter from the OCR  
2 director to complainants, dated June 21, 2016.

3           4.       Attached hereto as Exhibit C is a true and correct copy of the HHS notice of  
4 violation, dated January 18, 2019.

5           5.       Attached hereto as Exhibit D is a true and correct copy of the white paper, Wendy  
6 Chavkin, et al., "Conscientious Objection and Refusal to Provide Reproductive Healthcare: A  
7 White Paper Examining Prevalence, Health Consequences' and Policy Responses." 123 Int'l J.  
8 Gynecol. & Obstet. 3 (2013).

9           6.       Attached hereto as Exhibit E is a true and correct copy of an undated 2011  
10 memorandum, summarizing polling done on behalf of the Christian Medical Association and the  
11 Freedom2Care Foundation.

12           7.       Attached hereto as Exhibit F is a true and correct copy of a memorandum, dated  
13 April 8, 2009, summarizing polling done on behalf of the Christian Medical & Dental  
14 Association.

15           8.       Attached hereto as Exhibit G is a true and correct copy of a comment letter  
16 submitted by the American Academy of PAs, dated March 26, 2018, available online via  
17 regulations.gov.

18           9.       Attached hereto as Exhibit H is a true and correct copy of a comment letter  
19 submitted by the American Nursing Association and the American Academy of Nursing, dated  
20 March 23, 2018, available online via regulations.gov.

21           10.      Attached hereto as Exhibit I is a true and correct copy of a comment letter  
22 submitted by the California Primary Care Association, dated March 27, 2018, available online via  
23 regulations.gov.

24           11.      Attached hereto as Exhibit J is a true and correct copy of a comment letter  
25 submitted by the California LGBT Health & Human Services Network, dated March 27, 2018,  
26 available online via regulations.gov.

27

28

1           12. Attached hereto as Exhibit K is a true and correct copy of a comment letter  
2 submitted by the National Association of County and City Health Officials, dated March 27,  
3 2018, available online via regulations.gov.

4           13. Attached hereto as Exhibit L is a true and correct copy of a comment letter  
5 submitted by Physicians for Reproductive Health, dated March 27, 2018, available online via  
6 regulations.gov.

7           14. Attached hereto as Exhibit M is a true and correct copy of a comment letter  
8 submitted by the Association of American Medical Colleges, dated March 26, 2018, available  
9 online via regulations.gov.

10           15. Attached hereto as Exhibit N is a true and correct copy of a comment letter  
11 submitted by the National Association of Councils on Developmental Disabilities, dated March  
12 22, 2018, available online via regulations.gov.

13           16. Attached hereto as Exhibit O is a true and correct copy of a comment letter  
14 submitted by the Oregon Foundation for Reproductive Health, dated March 27, 2018, available  
15 online via regulations.gov.

16           17. Attached hereto as Exhibit P is a true and correct copy of a comment letter  
17 submitted by the North Carolina Justice Center, dated March 27, 2018, available online via  
18 regulations.gov.

19           18. Attached hereto as Exhibit Q is a true and correct copy of a comment letter  
20 submitted by the National Center for Lesbian Rights, dated March 26, 2018, available online via  
21 regulations.gov.

22           19. Attached hereto as Exhibit R is a true and correct copy of a comment letter  
23 submitted by the Anti-Defamation League, dated March 26, 2018, available online via  
24 regulations.gov.

25           20. Attached hereto as Exhibit S is a true and correct copy of a comment letter  
26 submitted by Justice in Aging, dated March 27, 2018, available online via regulations.gov.  
27  
28

1           21. Attached hereto as Exhibit T is a true and correct copy of a comment letter  
2 submitted by the Consortium for Citizens with Disabilities, dated March 27, 2018, available  
3 online via regulations.gov.

4           22. Attached hereto as Exhibit U is a true and correct copy of a comment letter  
5 submitted by Disabilities Rights Education & Defense Fund, dated March 27, 2018, available  
6 online via regulations.gov.

7           23. Attached hereto as Exhibit V is a true and correct copy of a comment letter  
8 submitted by the Disability Coalition of New Mexico, dated March 27, 2018, available online via  
9 regulations.gov.

10          24. Attached hereto as Exhibit W is a true and correct copy of a comment letter  
11 submitted by the National Organization for Women, dated March 27, 2018, available online via  
12 regulations.gov.

13          25. Attached hereto as Exhibit X is a true and correct copy of a comment letter  
14 submitted by the County of Santa Clara, dated March 27, 2018, available online via  
15 regulations.gov.

16          26. Attached hereto as Exhibit Y is a true and correct copy of a comment letter  
17 submitted by the San Francisco Department of Public Health, available online via  
18 regulations.gov.

19          27. Attached hereto as Exhibit Z is a true and correct copy of a comment letter  
20 submitted by Family Voices, dated March 27, 2018, available online via regulations.gov.

21          28. Attached hereto as Exhibit AA are true and correct copies of individual comments,  
22 available online via regulations.gov.

23           I declare under penalty of perjury under the laws of the United States and the State of  
24 California that the foregoing is true and correct.

25           Executed on the 4th of June in Sacramento, California.

26   
27 \_\_\_\_\_  
28 Neli N. Palma  
Deputy Attorney General

# **EXHIBIT A**

### 6100 Department of Education

California's public education system is administered at the state level by the Department of Education, under the direction of the State Board of Education and the Superintendent of Public Instruction, for the education of approximately 6.2 million students. Administrative branches of the Department include the Executive Branch; the Systems Support Branch; the Teaching and Learning Support Branch; the Performance, Planning, and Technology Branch; and the Legal and Audits Branch.

The primary duties of the Superintendent and the Department are to provide technical assistance to local school districts and to work with the educational community to improve academic performance. Major goals of the Department include: (a) holding local agencies accountable for student achievement in all programs and for all groups of students, (b) building local capacity to enable all students to achieve to state standards, (c) expanding and improving a system of recruiting, developing, and supporting teachers that instills excellence in every classroom, preschool through adult, (d) providing statewide leadership that promotes effective use of technology to improve teaching and learning, (e) increasing efficiency and effectiveness in the administration of K-12 education, including student record keeping and good financial management practices, (f) providing broader and more effective communication among the home, school, district, county, and state, (g) establishing and fostering systems of school, home, and community resources that provide the physical, emotional, and intellectual support to help students succeed, (h) advocating for additional resources and additional flexibility, (i) providing statewide leadership that promotes good business practices so that California schools can target their resources to serve students, and (j) improving the effectiveness and efficiency of the Department.

Because the Department of Education's programs drive a need for infrastructure investment, the Department has a capital outlay program to support this need. For the specifics on the Department's capital outlay program see "Infrastructure Overview."

#### 3-YEAR EXPENDITURES AND POSITIONS

		Positions			Expenditures		
		2016-17	2017-18	2018-19	2016-17*	2017-18*	2018-19*
5200	Instruction	867.4	874.6	874.6	\$65,974,174	\$68,587,951	\$72,557,395
5205	Instructional Support	694.0	662.6	662.6	1,231,509	1,166,114	1,061,287
5210	Special Programs	414.2	394.7	394.7	5,939,415	6,730,706	7,135,034
5220	State Board of Education	10.4	9.8	9.8	2,017	2,680	2,681
5240	State-Mandated Local Programs	-	-	-	462,897	1,401,547	841,972
9900100	Administration	229.8	275.5	275.5	30,401	39,264	54,291
9900200	Administration - Distributed	-	-	-	-30,401	-39,264	-54,291
9990	Unscheduled Items of Appropriation	-	-	-	391,228	392,185	7,700
<b>TOTALS, POSITIONS AND EXPENDITURES (All Programs)</b>		<b>2,215.8</b>	<b>2,217.2</b>	<b>2,217.2</b>	<b>\$74,001,240</b>	<b>\$78,281,183</b>	<b>\$81,606,069</b>
<b>FUNDING</b>					<b>2016-17*</b>	<b>2017-18*</b>	<b>2018-19*</b>
0001	General Fund				\$1,204,665	\$1,456,162	\$1,758,691
0001	General Fund, Proposition 98				44,567,257	47,297,643	48,632,348
0044	Motor Vehicle Account, State Transportation Fund				-	-	896
0140	California Environmental License Plate Fund				391	405	405
0178	Driver Training Penalty Assessment Fund				1,515	-	-
0231	Health Education Account, Cigarette and Tobacco Products Surtax Fund				18,237	15,253	13,998
0342	State School Fund				18,841	19,168	19,168
0349	Educational Telecommunication Fund				-	-	716
0687	Donated Food Revolving Fund				3,825	6,590	6,591
0814	California State Lottery Education Fund				1,201,552	1,201,767	1,200,858
0890	Federal Trust Fund				7,324,591	7,702,721	8,247,630
0903	State Penalty Fund				-	895	-
0942	Special Deposit Fund				2,261	2,193	2,193
0986	Local Property Tax Revenues				19,237,722	20,075,802	21,218,845
0995	Reimbursements				425,149	464,849	461,521
3085	Mental Health Services Fund				131	156	156
3170	Heritage Enrichment Resource Fund				-	40	40
3286	Safe Neighborhoods and Schools Fund				9,465	11,296	16,066
3309	Tobacco Prevention and Control Programs Account, California Healthcare,				-	31,963	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

Research and Prevention Tobacco Tax Act of 2016 Fund			
3321	Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD	-	22,847
6036	2002 State School Facilities Fund	15	1,901
6044	2004 State School Facilities Fund	553	1,162
6057	2006 State School Facilities Fund	1,552	35
8080	Clean Energy Job Creation Fund	-16,482	-8,818
<b>TOTALS, EXPENDITURES, ALL FUNDS</b>		<b>\$74,001,240</b>	<b>\$78,281,183</b>

**LEGAL CITATIONS AND AUTHORITY**

DEPARTMENT AUTHORITY

Education Code, Section 33300

PROGRAM AUTHORITY

California Education Code, and select federal laws including, but not limited to, Every Student Succeeds Act, Carl D. Perkins Career and Technical Education Improvement Act, Workforce Investment Act, Individuals with Disabilities Education Act, Child Care and Development Fund and Healthy Hunger Free Kids Act.

**MAJOR PROGRAM CHANGES**

- An increase of \$3.7 billion Proposition 98 General Fund to fully implement the Local Control Funding Formula, which includes a 2.71 cost-of-living adjustment and \$570 million above the cost-of-living adjustment as an ongoing increase to the formula.
- An increase of \$1.1 billion Proposition 98 General Fund on a one-time basis for discretionary grants that support local needs and priorities while offsetting outstanding K-12 mandate debt.
- An increase of \$300 million Proposition 98 General Fund on a one-time basis for the Low-Performing Students Block Grant to assist pupils performing at the lowest levels on the state's academic assessments.
- An increase of \$167.2 million Proposition 98 General Fund on a one-time basis to increase the availability of inclusive early education and care for children aged zero to five years old.
- An increase of \$164 million Proposition 98 General Fund to establish a K-12 specific component of the Strong Workforce Program to encourage local educational agencies to offer high-quality career technical education programs that are aligned with needed industry skills and regional workforce development efforts.
- An increase of \$150 million Proposition 98 General Fund to establish the Career Technical Education Incentive Grant Program as an ongoing program.
- An increase of \$109.2 million non-Proposition 98 General Fund to reflect an increase in CalWORKS child care cases.
- An increase of \$57.8 million Proposition 98 General Fund for county offices of education to provide technical assistance to school districts, of which \$4 million will go towards geographical regional leads.
- An increase of \$50 million Proposition 98 General Fund on a one-time basis for the Classified School Employee Summer Assistance Program to provide a state match to classified school employees who elect to have a portion of their monthly pay withheld and repaid during the summer recess period.
- An increase of \$50 million Proposition 98 General Fund on a one-time basis for the Classified School Employee Professional Development Program to provide professional development opportunities for classified school employees.
- An increase of \$39.7 million non-Proposition 98 General Fund to increase the reimbursement rate adjustment factors for child care providers serving infants, toddlers, and children with exceptional needs.
- An increase of \$34.2 million non-Proposition 98 General Fund beginning in 2019-20 to make permanent the existing limited-term Regional Market Reimbursement Rate hold harmless provision.
- An increase of \$32.3 million non-Proposition 98 General Fund and \$28.4 million Proposition 98 General Fund to reflect costs associated with new child care policies implemented part-way through the 2017-18 fiscal year, including an update of the Regional Market Reimbursement Rate to the 75th percentile of the 2016 regional market rate survey and 2,959 new slots for full-day State Preschool.
- An increase of \$31.6 million Proposition 98 General Fund and \$16.1 million non-Proposition 98 General Fund to increase

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.



**6100 Department of Education - Continued**

- child care provider reimbursements by approximately 2.8 percent.
- An increase of \$27.1 million Proposition 98 General Fund on a one-time basis to convert the paper-based English Language Proficiency Assessment for California (ELPAC) to a computer-based assessment and to develop an ELPAC assessment specific to students with exceptional needs.
  - An increase of \$26.4 million federal Child Care and Development Fund to increase inspections of licensed child care providers from once every three years to annual inspections.
  - An increase of \$21.1 million Proposition 98 General Fund on a one-time basis and \$24.8 million Proposition 98 General Fund ongoing to reflect increased programmatic costs in the Charter School Facility Grant Program.
  - An increase of \$20 million Child Care and Development Fund on a one-time basis for licensed child care teacher professional development.
  - An increase of \$15.8 million non-Proposition 98 General Fund and \$204.6 million federal Child Care and Development Fund for the Alternative Payment Program to provide 13,407 new voucher slots, of which 11,307 are available until June 30, 2020.
  - An increase of \$15 million Proposition 98 General Fund on a one-time basis for the Kids Code After School Program to increase opportunities for students in after-school programs to access computer coding education.
  - An increase of \$15 million Proposition 98 General Fund on a one-time basis to expand the state’s Multi-Tiered Systems of Support framework to foster positive school climate in both academic and behavioral areas.
  - An increase of \$13.3 million Proposition 98 General Fund on a one-time basis for the California Collaborative for Educational Excellence and a co-lead county office of education to help school districts build capacity for community engagement in the Local Control Accountability Plan process.
  - An increase of \$11.5 million Proposition 98 General Fund to support the California Collaborative for Educational Excellence in its role within the statewide system of support.
  - An increase of \$10 million Proposition 98 General Fund for Special Education Local Plan Areas to assist county offices of education in providing technical assistance to school districts serving students with exceptional needs within the statewide system of support.
  - An increase of \$4.4 million Proposition 98 General Fund over two years for property tax relief for schools impacted by the fires of 2017 and an additional \$25 million Proposition 98 General Fund relief through the Local Control Funding Formula.
  - An increase of \$1 million Proposition 98 General Fund on a one-time basis for the California-Grown Fresh School Meals Grant Program to encourage the purchase of California-grown food by schools.
  - An increase of \$972,000 Proposition 98 General Fund to allow the Fiscal Crisis and Management Assistance Team (FCMAT) to coordinate with county offices of education to offer more proactive and preventive services to fiscally distressed school districts.
  - An increase of \$144.1 million Proposition 98 General Fund to provide a 2.71 percent cost-of-living adjustment for categorical programs that remain outside the Local Control Funding Formula, including Special Education, Child Nutrition, Foster Youth, American Indian Centers, American Indian Early Childhood Education, and the Mandate Block Grant.

**DETAILED BUDGET ADJUSTMENTS**

	2017-18*			2018-19*		
	General Fund	Other Funds	Positions	General Fund	Other Funds	Positions
<b>Workload Budget Adjustments</b>						
<b>Workload Budget Change Proposals</b>						
• District LCFF 2018-19 Transition Funding	\$-	\$-	-	\$3,556,177	\$-	-
• One-Time Funding for Discretionary Grants and Mandate Reimbursement	294,756	-	-	300,000	-	-
• Proposition 98 Reappropriation for Discretionary Grants and Mandate Reimbursement	-	-	-	225,331	-	-
• Add Funding for the Career Technical Education Incentive Grant	-	-	-	150,000	-	-
• LCFF Transition Funding for Basic Aid Districts	-	-	-	109,623	-	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

• Proposition 98 Reversion Account for Discretionary Grants and Mandate Reimbursement	-	-	-	80,331	-	-
• County Office of Education Augmentation for Statewide System of Support	-	-	-	55,200	-	-
• Increase Child Care Reimbursement Rate Adjustment Factors	-	-	-	39,668	-	-
• Increase the Standard Reimbursement Rate: State Preschool	-	-	-	31,629	-	-
• K-14 Education Fire-Related Property Tax Loss Backfill	12,339	-	-	19,181	-	-
• Increase the Standard Reimbursement Rate: Child Care	-	-	-	16,104	-	-
• Add Alternative Payment Program Slots	-	-	-	15,833	204,590	-
• Funding for the California Collaborative for Educational Excellence	-	-	-	11,534	-	-
• Special Education Local Plan Areas Augmentation for Statewide System of Support	-	-	-	10,000	-	-
• Proposition 98 Reappropriation for California School Information Services	-	-	-	6,508	-	-
• One-Time Funding for Facility Improvements	-	-	-	6,000	-	-
• Proposition 98 Reappropriation for the California Collaborative for Education Excellence	-	-	-	5,600	-	-
• Regional County Office of Education Leads	-	-	-	4,000	-	-
• SoCal ROC Transition Funding	-	-	-	3,000	-	-
• Add funding for Special Olympics Unified Champion Schools Program	-	-	-	2,000	-	-
• Base Child Care Development Fund Grant Adjustment	-	-	-	1,998	-	-
• One-Time Funding for Suicide Prevention Training	-	-	-	1,700	-	-
• Fire-Related Property Tax Loss Backfill for Basic Aid School Districts	2,399	-	-	1,292	-	-
• California College Guidance Initiative Augmentation	-	-	-	1,000	-	-
• Increase FCMAT Oversight Funding	-	-	-	972	-	-
• Add One-Time Funding for the Instructional Quality Commission	-	-	-	938	-	-
• One-Time Carryover for the Career Technical Education Pathways Program	-	-	-	680	-	-
• Personnel Funding to Support Subsidized County Child Care Pilot Programs	-	-	-	624	-	-
• Sexual Health Education Backfill	-	-	-	600	-	-
• One-Time Funding for Ella T. v California Legal Costs	-	-	-	595	-	-
• Proposition 98 Reappropriation for the History Social Science Framework-Genocide Awareness Resources	-	-	-	500	-	-
• One-Time Funding for Teacher Dismissal Hearing Costs	-	-	-	339	-	-
• Adjust State Assessments Funding to Offset Reduction in Federal Grant	-	-	-	304	-	-
• K-12 Accountability: Dashboard Improvements	-	-	-	300	-	-
• One-Time Funding for Employment Lawsuit Legal Costs	-	-	-	297	-	-
• Personnel Funding for State Preschool Expansion	-	-	-	293	-	-
• Personnel Funding to Support a Centralized Uniform Complaint Procedures Process and Database	-	-	-	257	-	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

• Personnel Funding for Computer-Based ELPAC and Alternative ELPAC Assessments	-	-	-	252	-	-
• Personnel Funding for High School Equivalency Exam Fee Waiver Backfill	-	-	-	197	-	-
• One-Time Funding for Education Commission of the States Dues	-	-	-	150	-	-
• Personnel Funding for the Information Security and Privacy Office	-	-	-	143	-	-
• Personnel Funding to Support District Reorganization Workload	-	-	-	131	-	-
• Personnel Funding for Educational Equity Compliance Reviews (AB 699)	-	-	-	128	-	-
• Personnel Funding for Data Collection and Reporting Requirements for the District of Choice Program	-	-	-	119	-	-
• Personnel Funding for Universal Meal Service Support (SB 138)	-	-	-	108	-	-
• Ongoing Funding for Teacher Dismissal Hearing Costs	-	-	-	60	-	-
• Title IV Student Support and Academic Enrichment Grant	-	-	-	-	165,005	-
• Adjust Federal Funds for the Title I Program	-	-	-	-	160,574	-
• One-Time Federal Funds Carryover for the Title I Program	-	-	-	-	123,756	-
• TANF Stage 2 Child Care Adjustment	-	-	-	-	70,636	-
• Adjust Federal Funds for the Federal Individuals with Disabilities Education Act	-	-	-	-	34,391	-
• Annual Licensed Child Care Provider Inspections	-	-	-	-	26,400	-
• One-Time Federal Immediate Aid to Restart School Operations Funds (Local Assistance)	-	-	-	-	13,864	-
• One-Time Federal Funds Carryover for the Vocational Education Program	-	-	-	-	13,714	-
• One-Time Federal Funds Carryover for the Migrant Education Program	-	-	-	-	13,000	-
• One-Time Federal Funds for the Early Math Initiative	-	-	-	-	11,122	-
• Child Care Development Fund Quality Adjustment (2017 BA)	-	8,822	-	-	8,822	-
• One-Time Federal Funds Carryover for the Adult Education Program	-	-	-	-	7,500	-
• Adjust Federal Funds for the Adult Education Program	-	1,567	-	-	7,126	-
• One-Time Federal Funds Carryover for the 21st Century Community Learning Centers Program	-	-	-	-	5,000	-
• 21st Century Community Learning Centers Base Grant Adjustment (2017 BA)	-	3,921	-	-	3,921	-
• One-Time Funding for Special Education Dispute Resolution Costs	-	-	-	-	3,050	-
• Align Federal Student Assessment Funding to Estimated Costs	-	2,133	-	-	2,133	-
• One-Time Federal Funds Carryover for Migrant Education Program State Level Activities	-	-	-	-	2,000	-
• One-Time Federal Funds Carryover for the Individuals with Disabilities Education Act	-	-	-	-	2,000	-
• One-Time Federal Project School Emergency Response to Violence Funds	-	-	-	-	2,000	-
• Adjust State Special Schools Reimbursement for the Education Technology Voucher Program	-	-	-	-	1,897	-
• Add One-Time Federal Carryover for Assessments	-	-	-	-	1,148	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

• One-Time Federal Funds Carryover for the Federal Individuals with Disabilities Education Act Preschool Grant Program	-	-	-	-	1,020	-
• One-Time Federal Funds Carryover for the English Language Acquisition Program	-	-	-	-	1,000	-
• One-Time Federal Funds Carryover for the Neglected and Delinquent Children Program	-	-	-	-	965	-
• Adjust Federal Funds for the Neglected and Delinquent Children Program	-	447	-	-	932	-
• One-Time Federal Funds Carryover for Charter Schools Grant Program	-	-	-	-	923	-
• One-Time Federal Funds to Support Equitable Services for Eligible Private Schools	-	-	-	-	733	-
• One-Time Funding for the Standardized Account Code Structure System Replacement Project	-	-	-	-	716	-
• One-Time Federal Funds to Supplement 2017-18 Equitable Services for Eligible Private Schools	-	-	-	-	670	-
• Increase Title II State Administrative Funding for the Workforce Innovation and Opportunity Act (WIOA)	-	-	-	-	645	-
• Personnel Funding for Special Education Litigation Unit	-	-	-	-	625	-
• One-Time Federal Funds Carryover for the Early Head Start-Child Care Partnership Program	-	-	-	-	602	-
• One-Time Federal Immediate Aid to Restart School Operations Funds (State Operations)	-	-	-	-	533	-
• Reimbursement Funding for the Collaborative to Provide Technical Assistance	-	-	-	-	500	-
• One-Time Federal Funds Carryover for the State Improvement Grant Program	-	-	-	-	491	-
• One-Time English Learner Reclassification Support	-	-	-	-	437	-
• Cross-Agency Work to Support the Statewide System of Support (State Operations)	-	-	-	-	381	-
• Adjust Early Head Start-Child Care Partnership Program Grant Funding	-	-	-	-	323	-
• One-Time Federal Funds Carryover for the Mathematics and Science Partnerships Program	-	-	-	-	323	-
• One-Time Federal Funds Carryover for the McKinney-Vento Homeless Children Education Program	-	-	-	-	298	-
• One-Time Federal Funds Carryover for the Rural and Low Income Schools Program	-	-	-	-	231	-
• Personnel Funding for Child Care Slot Expansion	-	-	-	-	135	-
• One-Time Federal Funds Carryover for the Project AWARE Grant Program	-	-	-	-	131	-
• One-Time Federal Funds to Support the Early Math Initiative	-	-	-	-	100	-
• One-Time Federal Funds for the Newborn Hearing Screening Program	-	-	-	-	50	-
• Inclusive Early Education Expansion Program (Local Educational Agencies)	167,242	-	-	-	-	-
• One-Time Funding for the Classified School Employees Professional Development Block Grant Program	50,000	-	-	-	-	-
• Provide Funding for Lowest-Performing Students Block Grant	300,000	-	-	-	-	-
• Adjust Federal Funds for the Public Charter Schools Grant Program	-	-	-	-	-14	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

• Adjust Federal Funds for the Rural and Low Income Schools Program	-	-	-	-	-63	-
• Adjust Federal Funds for State Assessments	-	-	-	-	-304	-
• Redirect Title I Federal Funds to Support Cross-Agency Work Related to the Statewide System of Support (Local Assistance)	-	-	-	-	-381	-
• Adjust Federal Funds for the McKinney-Vento Homeless Children Education Program	-	-	-	-	-435	-
• Adjust Federal Funds for Individuals with Disabilities Act State Level Activities	-	-	-	-	-625	-
• Adjust Federal Funds for Individuals with Disabilities Act State Operations	-	-	-	-	-811	-
• Adjust Federal Funds for the 21st Century Community Learning Centers Program	-	-	-	-	-839	-
• Adjust Federal Funds for Migrant Education Program State Level Activities	-	-	-	-	-925	-
• Adjust Federal Funds for the Migrant Education Program	-	-	-	-	-1,070	-
• Reflect Base Child Care Development Fund Grant Adjustment Offset	-	-	-	-	-1,998	-
• Adjust Federal Funds for the Federal Individuals with Disabilities Education Act Preschool Grant Program	-	-	-	-	-2,660	-
• Redirect Federal Individuals with Disabilities Education Act Funding for Special Education Dispute Resolution Costs	-	-	-	-	-3,050	-
• Adjust Federal Funds for the Vocational Education Program	-	-	-	-	-6,165	-
• Remove One-Time Funding for the California Educator Development (CalED) Program	-	-	-	-	-11,327	-
• Adjust Federal Funds for the Supporting Effective Instruction Local Grants	-	-	-	-	-13,316	-
• Adjust Federal Funds for the Title I Basic Grant Program	-	29,728	-	-	-15,411	-
• Adjust Federal Funds for the English Language Acquisition Program	-	-	-	-	-17,390	-
• Decrease Mandate Reimbursement Program Funding to Reflect the Repeal of the California High School Exit Exam	-	-	-	-1	-	-
• Align K-12 School Dashboard Funding with Contract Amount	-	-	-	-120	-	-
• County Office of Education System of Support Funding Alignment	-	-	-	-1,400	-	-
• Align Student Assessment Funding to Estimated Costs	-2,133	-	-	-2,133	-	-
• Base Child Care Development Fund Grant Adjustment (2017 BA)	-	9,008	-	-9,008	9,008	-
• Technical Offset Adjustment to K-14 Fire-Related Property Tax Loss Backfill	-12,339	-	-	-19,181	-	-
• Reflect TANF Stage 2 Child Care Adjustment Offset	-	-	-	-70,636	-	-
<b>Totals, Workload Budget Change Proposals</b>	<b>\$812,264</b>	<b>\$55,626</b>	<b>-</b>	<b>\$4,559,217</b>	<b>\$828,637</b>	<b>-</b>
<b>Other Workload Budget Adjustments</b>						
• Education Protection Account Revenue Adjustment	372,408	372,409	-	841,583	841,583	-
• CalWORKs Stage 2 and Stage 3 Child Care Caseload Adjustments	-	-	-	109,233	-	-
• Special Education Program for Individuals with Exceptional Needs Cost-of-Living Adjustment	-	-	-	100,127	-	-
• Backfill One-Time Special Education Fund Swap	-	-	-	64,243	-	-
• LCFF Floor Growth Adjustment	51,585	-	-	61,040	-	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

• State Preschool Cost-of-Living Adjustment	-	-	-	29,916	-	-
• County Office of Education Minimum State Aid Adjustment	25,854	-	-	25,854	-	-
• Child Care Programs Cost-of-Living Adjustment	-	-	-	23,972	-	-
• Full Year Costs of Prior Year Preschool Slots	-	-	-	19,130	-	-
• Full Year Costs of Prior Year Child Care Rate Adjustments	-	-	-	18,997	-	-
• Align Student Assessment Funding to Estimated Costs	-	-	-	18,160	-	-
• Full Year Costs of Prior Year Child Care Hold Harmless	-	-	-	13,272	-	-
• LCFF Additional Funding Adjustment	5,794	-	-	13,195	-	-
• District LCFF Minimum State Aid Adjustment	9,355	-	-	9,355	-	-
• Add 2,959 Full-Day State Preschool Slots	-	-	-	8,457	-	-
• Backfill Prior Year One-Time Federal Carryover for Child Care	-	-	-	7,641	-	-
• Mandate Block Grant Cost-of-Living Adjustment	-	-	-	6,234	-	-
• Child Nutrition Program Cost-of-Living Adjustment	-	-	-	4,333	-	-
• Adjust General Fund to Reflect Removal of Federal Carryover for Assessments Costs	-	-	-	2,785	-	-
• Early Education Program for Individuals with Exceptional Needs Cost-of-Living Adjustment	-	-	-	2,429	-	-
• Foster Youth Program Cost-of-Living Adjustment	-	-	-	699	-	-
• Adults in Correctional Facilities Cost-of-Living Adjustment	-	-	-	235	-	-
• American Indian Education Centers Cost-of-Living Adjustment	-	-	-	112	-	-
• Allocation for Other Post-Employment Benefits	81	69	-	81	69	-
• American Indian Early Childhood Education Program Cost-of-Living Adjustment	-	-	-	15	-	-
• K-12 District Local Property Tax Revenue Offset Adjustment	-	560,665	-	-	1,766,167	-
• County Office of Education Local Property Tax Revenue Offset Adjustment	-	7,771	-	-	93,633	-
• One-Time Child Care Development Fund Quality Adjustment	-	-	-	-	25,955	-
• Reflect Proposition 56 Local Assistance Funding	-	-	-	-	21,114	-
• K-12 Lottery Adjustment	-	17,373	-	-	16,464	-
• One-Time Federal Child Care and Development Carryover	-	-	-	-	4,877	-
• Reflect Proposition 56 State Operations Funding	-	-	-	-	1,111	-
• Motor Vehicle Account Allocation for the Bus Driver Instructor Training Program	-	-	-	-	896	7.8
• Adjust Proposition 56 Tobacco Tax Initiative Funding	-	-	-	-	622	-
• State School Fund Adjustment	-	249	-	-	249	-
• Lottery Revenue Adjustment for State Special Schools	-	3	-	-	3	-
• Special Education Local Property Tax Revenue-Fire Related Backfill	267	-	-	-	-	-
• Adjust Proposition 47 State Operations Funding	-	-	-	-	-72	-
• Adjust County Office of Education Funding for Health and Physical Education Drug-Free Schools Program	-	-214	-	-	-601	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.



**6100 Department of Education - Continued**

• Shift the Bus Driver Instructor Training Program to the Motor Vehicle Account	-	-	-	-	-896	-7.8
• Adjust School District Funding for Health and Physical Education Drug-Free Schools Program	-	-420	-	-	-1,063	-
• Adjust Proposition 47 Local Assistance Funding	-	-	-	-	-1,356	-
• Remove Federal Carryover for Assessments Costs	-	-	-	-	-2,785	-
• Remove Prior Year One-Time Child Care Development Fund Carryover	-	-	-	-	-7,641	-
• Education Protection Account Offset Adjustment	-	-372,409	-	-	-841,583	-
• Adjust Mandate Block Grant to Reflect Revised Average Daily Attendance	-	-	-	-133	-	-
• ASES Local Assistance Workload Adjustments	-138	-	-	-141	-	-
• Early Education Program for Individuals with Exceptional Needs Growth Adjustment	-	-	-	-242	-	-
• Expenditure by Category Redistribution	2,427	2,428	-	-975	-975	-
• Align Student Assessment Funding to One-Time Federal Carryover	-	-	-	-1,148	-	-
• Child Nutrition Program Growth Adjustment	-	-	-	-2,607	-	-
• Reflect Base Adjustments for Special Education Programs	-	-	-	-3,793	-	-
• Child Care Programs Growth Adjustment	-	-	-	-4,157	-	-
• Reflect One-Time Federal Child Care and Development Carryover Offset	-	-	-	-4,877	-	-
• State Preschool Growth Adjustment	-	-	-	-5,325	-	-
• County Office Education Protection Account Offset Adjustment	-3,499	-	-	-7,892	-	-
• Special Education Program for Individuals with Exceptional Needs Growth Adjustment	-	-	-	-10,003	-	-
• County Office of Education LCFF Growth Adjustment	-23,733	-	-	-17,424	-	-
• County Office of Education Local Revenue Adjustment	3,664	-	-	-27,348	-	-
• Special Education Local Property Tax Revenue Offset Adjustment	-	3,596	-	-31,558	36,571	-
• District LCFF Education Protection Account Offset Adjustment	-369,193	-	-	-833,974	-	-
• District LCFF Property Tax Adjustment	-361,178	-	-	-1,421,646	-	-
• Miscellaneous Baseline Adjustments	-25,952	-150,158	-	1,346,450	-248,718	-
• Salary Adjustments	3,649	3,140	-	3,649	3,140	-
• Benefit Adjustments	1,506	1,295	-	1,648	1,417	-
• Retirement Rate Adjustments	1,429	1,228	-	1,429	1,228	-
• Budget Position Transparency	-2,427	-2,428	-28.0	975	975	-26.0
• SWCAP	-	-	-	-	2,468	-
• Carryover/Reappropriation	1,474	226	-	-	-	-
• Lease Revenue Debt Service Adjustment	-964	-	-	-1,471	-	-
<b>Totals, Other Workload Budget Adjustments</b>	<b>\$-307,591</b>	<b>\$444,823</b>	<b>-28.0</b>	<b>\$360,535</b>	<b>\$1,712,852</b>	<b>-26.0</b>
<b>Totals, Workload Budget Adjustments</b>	<b>\$504,673</b>	<b>\$500,449</b>	<b>-28.0</b>	<b>\$4,919,752</b>	<b>\$2,541,489</b>	<b>-26.0</b>
<b>Totals, Budget Adjustments</b>	<b>\$504,673</b>	<b>\$500,449</b>	<b>-28.0</b>	<b>\$4,919,752</b>	<b>\$2,541,489</b>	<b>-26.0</b>

**PROGRAM DESCRIPTIONS**

5200 - INSTRUCTION

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

## 6100 Department of Education - Continued

This program provides direct educational services to children and adults in the state's public elementary and secondary school system. The following elements are included in this program:

### School Apportionments:

Supplements local resources to fund general education programs.

### Other Compensatory Programs:

Includes Migrant Education, California Indian Education Centers, Education for Homeless Children, and Federal Title I.

### Adult Education Programs:

Provides citizenship training and education to improve literacy skills, employability, and parenting abilities to adults served by public high school and unified districts. Adult education programs also meet the special needs of the disabled, older persons, and non- or limited-English speaking adults.

### Special Education Programs for Exceptional Children:

Provides special education services. Under state law and the federal Individuals with Disabilities Education Act (20 USC 1400 et seq.), individuals with exceptional needs are entitled to a free, appropriate public education. Students requiring special education are served either by local educational agencies using state, federal, and local property tax funds or by the State Special Schools operated by the Department. The Special Schools (three centers for diagnostic services, two residential schools for the deaf and one residential school for the blind) provide highly specialized services including educational assessments and individual educational recommendations and a comprehensive residential and nonresidential educational program composed of academic, nonacademic and extracurricular activities.

### Vocational Education:

Offers a sequence of courses that provide the academic knowledge and skills needed to prepare for further education and careers in current or emerging employment sectors. Programs include Partnership Academies, Agricultural Education, and Regional Occupational Centers and Programs, and the federal Career and Technical Education Program.

## 5205 - INSTRUCTIONAL SUPPORT

Instructional Support provides resources to complement the Instruction Program. The following elements are included in this program:

### Curriculum Services:

Provides materials and resources for curriculum planning and development in language arts, mathematics, science, history-social science, foreign language, visual and performing arts, health, nutrition, safety, physical education, and environmental/energy education. Provides funding for the K-12 High Speed Network and Rural and Low Income Schools Grants.

### "Now is the Time" Advancing Wellness and Resilience in Education:

Provides federal funding to develop a comprehensive, coordinated, and integrated partnership with multiple service systems to help address critical mental health needs of California's kindergarten through grade twelve students.

### Administrative Services to Local Educational Agencies:

Provides leadership, guidance, and technical expertise to schools to manage and improve operations, more efficiently use scarce resources, and publish specified documents.

### Supplementary Program Services:

Identifies, develops, and disseminates innovative and exemplary programs and practices to schools and aids in the development of alternative educational options. Examples include Foster Youth Services, Career Technical Education Incentive Programs, English Language Acquisition, and Specialized Secondary Programs.

### Public Charter Schools:

Public charter schools are created or organized by a group of teachers, parents, community leaders or a community-based organization, and provide instruction in any combination of grades, kindergarten through grade twelve.

### Assessments:

Includes the California Assessment of Student Performance and Progress Program, which provides funding to districts for assessments, the English Language Proficiency Assessments for California, and California High School Proficiency Exams.

## 5210 - SPECIAL PROGRAMS

**6100 Department of Education - Continued**

**Child Development:**

Provides a full range of child care and development services, including part- and full-time child care and development and supportive services to children from low-income families and families with special needs. Several different programs exist to target resources to specific populations or to address specific needs. The California State Preschool Program provides a wide range of educational services in part-day settings for pre-kindergarten (three and four year old) children from low-income families and parent education for the parents of eligible children. The After School Education and Safety program provides students in grades K-9 with academic support, homework assistance, and enrichment programs, in a safe after-school environment. Child care services for families participating in the California Work Opportunity and Responsibility to Kids (CalWORKs) program help public assistance recipients achieve and maintain self-sufficiency. The Department administers child care for CalWORKs Stages 2 and 3.

**Early Head Start-Child Care Partnership:**

Provides federal funding for high quality infant and toddler child care to low income families enrolled in subsidized programs administered by county offices, family child care home education networks, center-based homes, and tribal governments receiving federal Child Care and Development funds in selected northern California counties.

**Child Nutrition:**

Assists participating public and private schools, county offices of education, public and private residential child care institutions, camps, family day care homes, and non-residential adult day care centers in serving nutritious meals by providing educational and technical assistance, and federal and state subsidies. Subsidies are received from the United States Department of Agriculture (USDA) to fund the National School Lunch Program (NSLP), School Breakfast Program, Special Milk Program, Child and Adult Care Food Program, Summer Food Service Program, After School Meals Supplements Program under the NSLP, and Seamless Summer Feeding Option, Fresh Fruits and Vegetable Program, and nutrition education and training. Subsidies also are provided by the state through the state-mandated Child Nutrition Programs and the School Breakfast and Summer Food Start-Up and Expansion Grants Program.

**Food Distribution:**

Makes USDA Foods available to certain California public, private, and nonprofit agencies. The Department is designated as the California state agency for USDA Foods surplus distribution.

**5220 - STATE BOARD OF EDUCATION**

The State Board of Education sets K-12 education policy in the areas of standards, instructional materials, assessment, and accountability.

**5240 - STATE-MANDATED LOCAL PROGRAMS**

This program provides funding, pursuant to Section 6 of Article XIII B of the California Constitution, to reimburse local entities for costs they incur in complying with certain state-mandated education programs.

**DETAILED EXPENDITURES BY PROGRAM**

		<u>2016-17*</u>	<u>2017-18*</u>	<u>2018-19*</u>
	<b>PROGRAM REQUIREMENTS</b>			
<b>5200</b>	<b>INSTRUCTION</b>			
	<b>State Operations:</b>			
0001	General Fund	\$109,775	\$111,278	\$109,388
0814	California State Lottery Education Fund	-	162	162
0942	Special Deposit Fund	1,117	1,049	1,049
0995	Reimbursements	10,363	16,220	12,392
	<b>Totals, State Operations</b>	<u>\$121,255</u>	<u>\$128,709</u>	<u>\$122,991</u>
	<b>Local Assistance:</b>			
0001	General Fund	\$41,588,433	\$43,287,715	\$45,713,574
0342	State School Fund	18,841	19,168	19,168
0814	California State Lottery Education Fund	1,201,552	1,201,605	1,200,696
0890	Federal Trust Fund	3,413,906	3,440,700	3,847,869
0986	Local Property Tax Revenues	19,237,722	20,075,802	21,218,845

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

0995	Reimbursements	392,465	434,252	434,252
	<b>Totals, Local Assistance</b>	<b>\$65,852,919</b>	<b>\$68,459,242</b>	<b>\$72,434,404</b>
	<b>PROGRAM REQUIREMENTS</b>			
<b>5205</b>	<b>INSTRUCTIONAL SUPPORT</b>			
	<b>State Operations:</b>			
0001	General Fund	\$43,867	\$45,238	\$49,127
0044	Motor Vehicle Account, State Transportation Fund	-	-	896
0140	California Environmental License Plate Fund	31	45	45
0178	Driver Training Penalty Assessment Fund	1,515	-	-
0231	Health Education Account, Cigarette and Tobacco Products Surtax Fund	964	1,036	1,037
0890	Federal Trust Fund	92,799	119,194	111,928
0903	State Penalty Fund	-	895	-
0942	Special Deposit Fund	1,144	1,144	1,144
0995	Reimbursements	5,470	10,074	10,074
3170	Heritage Enrichment Resource Fund	-	40	40
3286	Safe Neighborhoods and Schools Fund	96	565	803
3309	Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund	-	1,574	-
3321	Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD	-	-	1,111
6036	2002 State School Facilities Fund	15	1,901	-
6044	2004 State School Facilities Fund	553	1,162	2,636
6057	2006 State School Facilities Fund	1,552	35	464
	<b>Totals, State Operations</b>	<b>\$148,006</b>	<b>\$182,903</b>	<b>\$179,305</b>
	<b>Local Assistance:</b>			
0001	General Fund	\$556,137	\$427,434	\$356,565
0140	California Environmental License Plate Fund	360	360	360
0231	Health Education Account, Cigarette and Tobacco Products Surtax Fund	17,273	14,217	12,961
0349	Educational Telecommunication Fund	-	-	716
0890	Federal Trust Fund	483,837	498,648	472,449
0995	Reimbursements	16,527	1,432	1,932
3286	Safe Neighborhoods and Schools Fund	9,369	10,731	15,263
3309	Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund	-	30,389	-
3321	Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD	-	-	21,736
	<b>Totals, Local Assistance</b>	<b>\$1,083,503</b>	<b>\$983,211</b>	<b>\$881,982</b>
	<b>PROGRAM REQUIREMENTS</b>			
<b>5210</b>	<b>SPECIAL PROGRAMS</b>			
	<b>State Operations:</b>			
0001	General Fund	\$6,511	\$9,021	\$7,979
0687	Donated Food Revolving Fund	3,825	6,590	6,591
0890	Federal Trust Fund	58,938	61,956	63,190
0995	Reimbursements	324	2,815	2,815
3085	Mental Health Services Fund	131	156	156
	<b>Totals, State Operations</b>	<b>\$69,729</b>	<b>\$80,538</b>	<b>\$80,731</b>
	<b>Local Assistance:</b>			
0001	General Fund	\$2,594,575	\$3,067,945	\$3,302,109
0890	Federal Trust Fund	3,275,111	3,582,223	3,752,194
	<b>Totals, Local Assistance</b>	<b>\$5,869,686</b>	<b>\$6,650,168</b>	<b>\$7,054,303</b>
	<b>PROGRAM REQUIREMENTS</b>			
<b>5220</b>	<b>STATE BOARD OF EDUCATION</b>			
	<b>State Operations:</b>			

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

0001	General Fund	\$2,017	\$2,624	\$2,625
0995	Reimbursements	-	56	56
	<b>Totals, State Operations</b>	<b>\$2,017</b>	<b>\$2,680</b>	<b>\$2,681</b>
	<b>PROGRAM REQUIREMENTS</b>			
<b>5240</b>	<b>STATE-MANDATED LOCAL PROGRAMS</b>			
	<b>Local Assistance:</b>			
0001	General Fund	\$462,897	\$1,401,547	\$841,972
	<b>Totals, Local Assistance</b>	<b>\$462,897</b>	<b>\$1,401,547</b>	<b>\$841,972</b>
	<b>PROGRAM REQUIREMENTS</b>			
<b>9990</b>	<b>UNSCHEDULED ITEMS OF APPROPRIATION</b>			
	<b>Local Assistance:</b>			
0001	General Fund	\$407,710	\$401,003	\$7,700
8080	Clean Energy Job Creation Fund	-16,482	-8,818	-
	<b>Totals, Local Assistance</b>	<b>\$391,228</b>	<b>\$392,185</b>	<b>\$7,700</b>
	<b>SUBPROGRAM REQUIREMENTS</b>			
<b>9900100</b>	<b>Administration</b>			
	<b>State Operations:</b>			
0001	General Fund	\$30,401	\$39,264	\$54,291
	<b>Totals, State Operations</b>	<b>\$30,401</b>	<b>\$39,264</b>	<b>\$54,291</b>
	<b>SUBPROGRAM REQUIREMENTS</b>			
<b>9900200</b>	<b>Administration - Distributed</b>			
	<b>State Operations:</b>			
0001	General Fund	-\$30,401	-\$39,264	-\$54,291
	<b>Totals, State Operations</b>	<b>-\$30,401</b>	<b>-\$39,264</b>	<b>-\$54,291</b>
	<b>TOTALS, EXPENDITURES</b>			
	State Operations	341,007	394,830	385,708
	Local Assistance	73,660,233	77,886,353	81,220,361
	<b>Totals, Expenditures</b>	<b>\$74,001,240</b>	<b>\$78,281,183</b>	<b>\$81,606,069</b>

**EXPENDITURES BY CATEGORY**

1 State Operations	Positions			Expenditures		
	2016-17	2017-18	2018-19	2016-17*	2017-18*	2018-19*
PERSONAL SERVICES						
Baseline Positions	2,249.7	2,245.2	2,243.2	\$159,340	\$155,230	\$154,420
Budget Position Transparency	-	-28.0	-26.0	-	-4,855	1,950
Other Adjustments	-33.9	-	-	113	6,789	9,331
<b>Net Totals, Salaries and Wages</b>	<b>2,215.8</b>	<b>2,217.2</b>	<b>2,217.2</b>	<b>\$159,453</b>	<b>\$157,164</b>	<b>\$165,701</b>
Staff Benefits	-	-	-	80,253	91,969	90,729
<b>Totals, Personal Services</b>	<b>2,215.8</b>	<b>2,217.2</b>	<b>2,217.2</b>	<b>\$239,706</b>	<b>\$249,133</b>	<b>\$256,430</b>
OPERATING EXPENSES AND EQUIPMENT				\$72,335	\$122,279	\$111,349
SPECIAL ITEMS OF EXPENSES				28,966	23,418	17,929
<b>TOTALS, POSITIONS AND EXPENDITURES, ALL FUNDS (State Operations)</b>				<b>\$341,007</b>	<b>\$394,830</b>	<b>\$385,708</b>

2 Local Assistance	Expenditures		
	2016-17*	2017-18*	2018-19*
Grants and Subventions - Governmental	\$73,660,233	\$77,886,353	\$81,220,361
<b>TOTALS, EXPENDITURES, ALL FUNDS (Local Assistance)</b>	<b>\$73,660,233</b>	<b>\$77,886,353</b>	<b>\$81,220,361</b>

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

**DETAIL OF APPROPRIATIONS AND ADJUSTMENTS**

<b>1 STATE OPERATIONS</b>		<b>2016-17*</b>	<b>2017-18*</b>
<b>0001 General Fund, Proposition 98</b>			<b>2018-19*</b>
APPROPRIATIONS			
006 Budget Act appropriation (State Special Schools)		\$56,137	\$55,298
Allocation for Employee Compensation		-	1,405
Allocation for Other Post-Employment Benefits		-	18
Allocation for Staff Benefits		-	580
Section 3.60 Pension Contribution Adjustment		-	550
<b>Totals Available</b>		<b>\$56,137</b>	<b>\$57,851</b>
Unexpended balance, estimated savings		-237	-
<b>TOTALS, EXPENDITURES</b>		<b>\$55,900</b>	<b>\$57,851</b>
<b>0001 General Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation (Department State Operations)		\$46,494	\$47,391
Allocation for Employee Compensation		-	1,164
Allocation for Other Post-Employment Benefits		-	25
Allocation for Staff Benefits		-	481
Budget Position Transparency		-	-2,427
Expenditure by Category Redistribution		-	2,427
Section 3.60 Pension Contribution Adjustment		-	456
002 Budget Act appropriation (State Special Schools Lease Revenue Debt Service)		12,757	13,075
Lease Revenue Debt Service Adjustment		-	-962
Lease Revenue and Tenant Adjustments		-	-2
003 Budget Act appropriation (Standardized Account Code Structure)		1,257	1,237
Allocation for Employee Compensation		-	30
Allocation for Other Post-Employment Benefits		-	1
Allocation for Staff Benefits		-	12
Section 3.60 Pension Contribution Adjustment		-	12
004 Budget Act appropriation		-	-
005 Budget Act appropriation (State Special Schools)		42,702	38,154
Allocation for Employee Compensation		-	917
Allocation for Other Post-Employment Benefits		-	35
Allocation for Staff Benefits		-	378
Section 3.60 Pension Contribution Adjustment		-	358
009 Budget Act appropriation (State Board of Education)		2,556	2,519
Allocation for Employee Compensation		-	57
Allocation for Other Post-Employment Benefits		-	1
Allocation for Staff Benefits		-	24
Section 3.60 Pension Contribution Adjustment		-	23
Pending Legislation (Special Olympics)		-	-
Education Code sections 8483.5 and 8483.51 (After School Education and Safety Program)		3,358	3,312
Allocation for Employee Compensation		-	76
Allocation for Other Post-Employment Benefits		-	1
Allocation for Staff Benefits		-	31
Section 3.60 Pension Contribution Adjustment		-	30
Prior Year Balances Available:			
Item 6100-001-0001, Budget Act of 2015 as reappropriated by Item 6100-491, Budget Act of 2016		135	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.



**6100 Department of Education - Continued**

Item 6100-001-0001, Budget Act of 2015 as reappropriated by Item 6100-491, Budget Acts of 2016 and 2018	-	-	297
Item 6100-005-0001, Budget Act of 2016	-	1,474	-
<b>Totals Available</b>	<b>\$109,259</b>	<b>\$110,310</b>	<b>\$111,213</b>
Unexpended balance, estimated savings	-1,515	-	-
Balance available in subsequent years	-1,474	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$106,270</b>	<b>\$110,310</b>	<b>\$111,213</b>
<b>0044 Motor Vehicle Account, State Transportation Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation	-	-	\$896
<b>TOTALS, EXPENDITURES</b>	<b>-</b>	<b>-</b>	<b>\$896</b>
<b>0140 California Environmental License Plate Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation	\$45	\$44	\$45
Allocation for Employee Compensation	-	1	-
<b>Totals Available</b>	<b>\$45</b>	<b>\$45</b>	<b>\$45</b>
Unexpended balance, estimated savings	-14	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$31</b>	<b>\$45</b>	<b>\$45</b>
<b>0178 Driver Training Penalty Assessment Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation	\$1,611	-	-
<b>Totals Available</b>	<b>\$1,611</b>	<b>-</b>	<b>-</b>
Unexpended balance, estimated savings	-96	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$1,515</b>	<b>-</b>	<b>-</b>
<b>0231 Health Education Account, Cigarette and Tobacco Products Surtax Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation (Drug Free Schools)	\$1,008	\$992	\$1,037
Allocation for Employee Compensation	-	24	-
Allocation for Staff Benefits	-	10	-
Section 3.60 Pension Contribution Adjustment	-	10	-
<b>Totals Available</b>	<b>\$1,008</b>	<b>\$1,036</b>	<b>\$1,037</b>
Unexpended balance, estimated savings	-44	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$964</b>	<b>\$1,036</b>	<b>\$1,037</b>
<b>0687 Donated Food Revolving Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation (Donated Food Revolving Fund)	\$6,571	\$6,539	\$6,591
Allocation for Employee Compensation	-	28	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	11	-
Section 3.60 Pension Contribution Adjustment	-	11	-
<b>Totals Available</b>	<b>\$6,571</b>	<b>\$6,590</b>	<b>\$6,591</b>
Unexpended balance, estimated savings	-2,746	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$3,825</b>	<b>\$6,590</b>	<b>\$6,591</b>
<b>0814 California State Lottery Education Fund</b>			
APPROPRIATIONS			
Government Code section 8880.5 (State Special Schools)	\$159	\$159	\$162
Lottery Revenue Adjustment for State Special Schools	-	3	-
Past Year Adjustments	133	-	-
<b>Totals Available</b>	<b>\$292</b>	<b>\$162</b>	<b>\$162</b>
Unexpended balance, estimated savings	-292	-	-
<b>TOTALS, EXPENDITURES</b>	<b>-</b>	<b>\$162</b>	<b>\$162</b>
<b>0890 Federal Trust Fund</b>			

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

APPROPRIATIONS

001 Budget Act appropriation (Department State Operations)	\$166,101	-	\$175,118
001 Budget Act appropriation (Department State Operations) as amended by Chapter 181, Statutes of 2017	-	175,817	-
Allocation for Employee Compensation	-	2,921	-
Allocation for Other Post-Employment Benefits	-	66	-
Allocation for Staff Benefits	-	1,205	-
Budget Position Transparency	-	-2,428	-
Expenditure by Category Redistribution	-	2,428	-
Section 3.60 Pension Contribution Adjustment	-	1,141	-
<b>Totals Available</b>	<b>\$166,101</b>	<b>\$181,150</b>	<b>\$175,118</b>
Unexpended balance, estimated savings	-14,364	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$151,737</b>	<b>\$181,150</b>	<b>\$175,118</b>

**0903 State Penalty Fund**

APPROPRIATIONS

001 Budget Act appropriation	-	\$838	-
Allocation for Employee Compensation	-	31	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	13	-
Section 3.60 Pension Contribution Adjustment	-	12	-
<b>TOTALS, EXPENDITURES</b>	-	<b>\$895</b>	-

**0942 Special Deposit Fund**

APPROPRIATIONS

Government Code section 16370 (California Career Resource Network)	-	-	\$19
Past Year Adjustments	19	-	-
Technical Adjustments to Align Account Codes	-	19	-
Government Code section 16370 (Endowment Fund)	-	-	224
Past Year Adjustments	224	-	-
Technical Adjustments to Align Account Codes	-	224	-
Government Code section 16370 (Miscellaneous Education Donations and Registration)	928	928	901
Past Year Adjustments	-27	-	-
Technical Adjustments to Align Account Codes	-	-27	-
Government Code section 16370 (General Education Diplomas)	1,586	1,567	1,038
Allocation for Employee Compensation	-	28	-
Allocation for Other Post-Employment Benefits	-	1	-
Allocation for Staff Benefits	-	12	-
Past Year Adjustments	-480	-	-
Section 3.60 Pension Contribution Adjustment	-	11	-
Technical Adjustments to Align Account Codes	-	-581	-
Education Code section 1330 (UI Administration)	72	72	11
Past Year Adjustments	-61	-	-
Technical Adjustments to Align Account Codes	-	-61	-
<b>TOTALS, EXPENDITURES</b>	<b>\$2,261</b>	<b>\$2,193</b>	<b>\$2,193</b>

**0995 Reimbursements**

APPROPRIATIONS

Reimbursements	\$16,157	\$29,165	\$25,337
<b>TOTALS, EXPENDITURES</b>	<b>\$16,157</b>	<b>\$29,165</b>	<b>\$25,337</b>

**3085 Mental Health Services Fund**

APPROPRIATIONS

001 Budget Act appropriation	\$140	\$138	\$156
Allocation for Employee Compensation	-	10	-
Allocation for Staff Benefits	-	4	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

Section 3.60 Pension Contribution Adjustment	-	4	-
<b>Totals Available</b>	<b>\$140</b>	<b>\$156</b>	<b>\$156</b>
Unexpended balance, estimated savings	-9	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$131</b>	<b>\$156</b>	<b>\$156</b>
<b>3170 Heritage Enrichment Resource Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation	\$40	\$40	\$40
<b>Totals Available</b>	<b>\$40</b>	<b>\$40</b>	<b>\$40</b>
Unexpended balance, estimated savings	-40	-	-
<b>TOTALS, EXPENDITURES</b>	<b>-</b>	<b>\$40</b>	<b>\$40</b>
<b>3286 Safe Neighborhoods and Schools Fund</b>			
APPROPRIATIONS			
Government Code section 7599.2(b)	\$493	\$565	\$803
<b>Totals Available</b>	<b>\$493</b>	<b>\$565</b>	<b>\$803</b>
Unexpended balance, estimated savings	-397	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$96</b>	<b>\$565</b>	<b>\$803</b>
<b>3309 Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation	-	\$1,574	-
<b>TOTALS, EXPENDITURES</b>	<b>-</b>	<b>\$1,574</b>	<b>-</b>
<b>3321 Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD</b>			
APPROPRIATIONS			
Revenue and Taxation Code section 30130.57(b)(1) and (f)	-	-	\$1,111
<b>TOTALS, EXPENDITURES</b>	<b>-</b>	<b>-</b>	<b>\$1,111</b>
<b>6036 2002 State School Facilities Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation	\$30	\$1,828	-
Allocation for Employee Compensation	-	40	-
Allocation for Staff Benefits	-	17	-
Section 3.60 Pension Contribution Adjustment	-	16	-
<b>Totals Available</b>	<b>\$30</b>	<b>\$1,901</b>	<b>-</b>
Unexpended balance, estimated savings	-15	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$15</b>	<b>\$1,901</b>	<b>-</b>
<b>6044 2004 State School Facilities Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation	\$833	\$1,139	\$2,636
Allocation for Employee Compensation	-	13	-
Allocation for Staff Benefits	-	5	-
Section 3.60 Pension Contribution Adjustment	-	5	-
<b>Totals Available</b>	<b>\$833</b>	<b>\$1,162</b>	<b>\$2,636</b>
Unexpended balance, estimated savings	-280	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$553</b>	<b>\$1,162</b>	<b>\$2,636</b>
<b>6057 2006 State School Facilities Fund</b>			
APPROPRIATIONS			
001 Budget Act appropriation	\$2,175	\$35	\$464
<b>Totals Available</b>	<b>\$2,175</b>	<b>\$35</b>	<b>\$464</b>
Unexpended balance, estimated savings	-623	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$1,552</b>	<b>\$35</b>	<b>\$464</b>
<b>Total Expenditures, All Funds, (State Operations)</b>	<b>\$341,007</b>	<b>\$394,830</b>	<b>\$385,708</b>

**2 LOCAL ASSISTANCE**

2016-17\*      2017-18\*      2018-19\*

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

**0001 General Fund, Proposition 98**

APPROPRIATIONS

106 Budget Act appropriation	-	-	\$11,534
107 Budget Act appropriation (County Offices of Education Fiscal Oversight)	5,299	5,299	6,271
113 Budget Act appropriation (Student Assessment Program)	110,225	-	128,517
113 Budget Act appropriation (Student Assessment Program) as amended by Chapter 181, Statutes of 2017	-	110,549	-
Align Student Assessment Funding to Estimated Costs	-	-2,133	-
119 Budget Act appropriation (Foster Youth Programs)	25,379	25,775	26,474
122 Budget Act appropriation (Specialized Secondary Program Grants)	4,892	4,892	4,892
149 Budget Act appropriation (Proposition 98 - After School Education and Safety Program Supplement)	-	-	50,000
149 Budget Act appropriation (Proposition 98 - After School Education and Safety Program Supplement) as amended by Chapter 181, Statutes of 2017	-	50,000	-
150 Budget Act appropriation (American Indian Early Childhood Education Program)	550	559	574
151 Budget Act appropriation (American Indian Education Centers)	4,078	4,142	4,254
158 Budget Act appropriation (Adults in Correctional Facilities)	15,096	15,096	15,331
161 Budget Act appropriation (Special Education)	3,195,281	3,124,258	3,299,416
Past Year Adjustments	-2,654	-	-
166 Budget Act appropriation (Partnership Academies)	21,428	21,428	21,428
167 Budget Act appropriation (Agricultural Vocational Education)	4,134	4,134	4,134
168 Budget Act appropriation (Proposition 98) Career Technical Education Incentive Grant	-	-	150,000
170 Budget Act appropriation (Proposition 98 - Career Technical Education Initiative Program)	-	15,360	15,360
172 Budget Act appropriation (College and Career Planning Website and Online Educational Resources)	-	5,500	6,500
172 Budget Act appropriation (College and Career Planning Website)	2,500	-	-
182 Budget Act appropriation as amended by Chapter 318, Statutes of 2016 (K-12 High Speed Network)	4,500	-	-
196 Budget Act appropriation (State Preschool)	-	-	1,215,467
196 Budget Act appropriation (State Preschool) as amended by Chapter 249, Statutes of 2017	-	1,122,428	-
196 Budget Act appropriation as amended by Chapter 318, Statutes of 2016 (State Preschool)	974,854	-	-
201 Budget Act appropriation (Child Nutrition Start-up Grants)	1,017	1,017	1,017
203 Budget Act appropriation (Child Nutrition)	158,780	162,502	164,228
209 Budget Act appropriation (Teacher Dismissal Apportionments)	40	40	100
295 Budget Act appropriation (State Mandates Reimbursements)	47	49	48
296 Budget Act appropriation (State Mandates Block Grant)	218,763	230,161	236,262
Education Code sections 42238.02 and 42238.03 (School District Apportionments)	22,586,839	25,643,565	31,079,421
District LCFF Education Protection Account Offset Adjustment	-2,318	-369,193	-
District LCFF Minimum State Aid Adjustment	9,355	9,355	-
District LCFF Property Tax Adjustment	-448,351	-361,178	-
Fire-Related Property Tax Loss Backfill for Basic Aid School Districts	-	2,399	-
K-14 Education Fire-Related Property Tax Loss Backfill	-	12,339	-
LCFF Additional Funding Adjustment	6,063	5,794	-
LCFF Floor Growth Adjustment	-15,682	51,585	-
Shift Former Categoricals into Base Continuous LCFF Item	6,160,829	6,160,671	-
Technical Adjustment to LCFF	-26,083	-26,083	-
Technical Offset Adjustment to K-14 Fire-Related Property Tax Loss Backfill	-	-12,339	-
Pending Legislation (State System of Support Regional Lead)	-	-	4,000
Education Code sections 2574 and 2575 (County Office of Education Apportionments)	429,861	419,948	441,938
County Office Education Protection Account Offset Adjustment	2,034	-3,499	-
County Office of Education LCFF Growth Adjustment	-22,355	-23,733	-

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

County Office of Education Local Revenue Adjustment	-7,749	3,664	-
County Office of Education Minimum State Aid Adjustment	25,854	25,854	-
Article XIII, Section 36 of the California Constitution (Proposition 30) (transfer to Education Protection Account)	6,708,585	6,436,705	7,278,288
Education Protection Account Current Year Correction	-	1	-
Education Protection Account Revenue Adjustment	-	372,408	-
Chapter 15, Statutes of 2017 (Proposition 98—Equity Performance and Improvement Team)	-	2,500	-
Chapter 15, Statutes of 2017 (Proposition 98—California-Grown Fresh School Meals Grant Program)	-	1,500	-
One-Time Funding for California-Grown Fresh School Meals Grant Program	1,000	-	-
Add One-Time Funding for the Local Control Funding Formula Budget Overview Electronic Template Development	200	-	-
Add One-Time Funding to Update the LCAP Electronic Template	200	-	-
Computer-Based ELPAC and Alternative ELPAC Assessments	27,075	-	-
Chapter 15, Statutes of 2017 (Bilingual Teacher Professional Development Program)	-	5,000	-
Education Code section 53070 (Career Technical Education Incentive Grant Program)	292,162	-	-
One-Time Homeless Students Grant	250	-	-
Education Code section 41329.57(a)(1) (Oakland Unified School District)	1,768	1,710	1,707
Loan Repayment Adjustment for Oakland Unified School District	-	72	-
Education Code section 41329.57(a)(1) (Vallejo City Unified School District)	515	490	492
Loan Repayment Adjustment for Vallejo Unified School District	-	23	-
Education Code section 41329.575 (South Monterey County Joint Union High School District)	300	264	265
Loan Repayment Adjustment for South Monterey County HSD	-	35	-
Public Resources Code section 26233 (Transfer to Clean Energy Job Creation Fund)	398,800	376,200	-
One-Time Funding for the Classified School Employees Professional Development Block Grant Program	-	50,000	-
One-Time Funding for the Classified School Employees Summer Assistance Program	50,000	-	-
Provide Funding for Lowest-Performing Students Block Grant	-	300,000	-
Inclusive Early Education Expansion Program (Local Educational Agencies)	-	167,242	-
Education Code sections 8483.5 and 8483.51 (After School Education and Safety Program)	546,642	546,688	546,547
ASES Local Assistance Workload Adjustments	-	-138	-
Provide Funding for After School Kids Code Grant Program	15,000	-	-
Community Engagement Initiative	13,274	-	-
Multi-Tiered Systems of Support-Improving School Climate	15,000	-	-
Chapter 29, Statutes of 2016 (Proposition 98-Evaluation Rubrics Support and Development)	500	-	-
Chapter 15, Statutes of 2017 (LCAP E-template and Dashboard)	-	400	-
Special Education Local Property Tax Revenue-Fire Related Backfill	-	267	-
Chapter 15, Statutes of 2017 (SoCal ROC Transition Funding)	-	4,000	-
Education Code section 42238.03 (District Local Control Funding Formula Adjustment)	6,160,829	6,160,671	-
Shift Former Categoricals into Base Continuous LCFF Item	-6,160,829	-6,160,671	-
Chapter 15, Statutes of 2017 (District LCFF Transition Funding)	-	1,362,383	-
Chapter 29, Statutes of 2016 (District LCFF Transition Funding)	2,941,980	-	-
Pending Legislation (District LCFF Transition Funding)	-	-	3,556,177
One-Time Funding for Discretionary Grants and Mandate Reimbursement	103,003	-	-
Chapter 15, Statutes of 2017 (Discretionary Grants - Mandate Funding)	-	876,581	-
One-Time Funding for Discretionary Grants and Mandate Reimbursement	-	294,756	-
Pending Legislation (Discretionary Grants and Mandate Reimbursements)	-	-	300,000
Prior Year Balances Available:			
Chapter 15, Statutes of 2017 (LCAP E-template and Dashboard)	-	-	300

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

Chapter 15, Statutes of 2017 (SoCal ROC Transition Funding)	-	-	3,000
Chapter 29, Statutes of 2016 (Proposition 98-Evaluation Rubrics Support and Development)	-	500	500
<b>Totals Available</b>	<b>\$44,558,760</b>	<b>\$47,239,792</b>	<b>\$48,574,442</b>
Unexpended balance, estimated savings	-47,403	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$44,511,357</b>	<b>\$47,239,792</b>	<b>\$48,574,442</b>

**0001 General Fund**

<b>APPROPRIATIONS</b>			
194 Budget Act appropriation (Child Development)	\$940,982	-	\$1,324,850
194 Budget Act appropriation (Child Development) as amended by Chapter 249, Statutes of 2017	-	1,016,706	-
Pending Legislation (Sweetwater USD Facility Improvements)	-	-	6,000
Pending Legislation (Suicide Prevention Training)	-	-	1,700
Public Resources Code section 26233 (Transfer to Clean Energy Job Creation Fund)	8,435	8,818	-
Past Year Adjustments	-25	-	-
Prior Year Balances Available:			
Reappropriation, Proposition 98 per Item 6100-488	-	219,809	238,958
Reappropriation, Proposition 98 per Item 6100-488, Budget Act of 2016	141,046	-	-
Reappropriation, Proposition 98 reversion account per Item 6100-485	12,377	104,880	80,331
<b>Totals Available</b>	<b>\$1,102,815</b>	<b>\$1,350,213</b>	<b>\$1,651,839</b>
Unexpended balance, estimated savings	-59	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$1,102,756</b>	<b>\$1,350,213</b>	<b>\$1,651,839</b>
Loan repayment per Chapter 14, Statutes of 2003 (Oakland Unified School District)	-2,095	-2,095	-2,095
Loan repayment per Chapter 53, Statutes of 2004 (Vallejo Unified School District)	-2,266	-2,266	-2,266
<b>NET TOTALS, EXPENDITURES</b>	<b>\$1,098,395</b>	<b>\$1,345,852</b>	<b>\$1,647,478</b>

**0140 California Environmental License Plate Fund**

<b>APPROPRIATIONS</b>			
181 Budget Act appropriation (Environmental Education)	\$360	\$360	\$360
<b>TOTALS, EXPENDITURES</b>	<b>\$360</b>	<b>\$360</b>	<b>\$360</b>

**0178 Driver Training Penalty Assessment Fund**

<b>APPROPRIATIONS</b>			
Transfer to various funds per Section 24.10	(\$23,221)	(-)	(-)
<b>TOTALS, EXPENDITURES</b>	<b>-</b>	<b>-</b>	<b>-</b>

**0231 Health Education Account, Cigarette and Tobacco Products Surtax Fund**

<b>APPROPRIATIONS</b>			
101 Budget Act appropriation (Drug Free Schools-County Offices)	\$4,409	\$3,687	\$3,086
Adjust County Office of Education Funding for Health and Physical Education Drug-Free Schools Program	-	-214	-
Reflect Current Year Estimated Savings	-	214	-
102 Budget Act appropriation (Drug Free Schools-District Grants)	13,135	10,938	9,875
Adjust School District Funding for Health and Physical Education Drug-Free Schools Program	-	-420	-
Reflect Current Year Estimated Savings	-	420	-
Prior Year Balances Available:			
Item 6100-102-0231, Budget Act of 2014	35	-	-
Item 6100-102-0321, Budget Act of 2016	-	226	-
<b>Totals Available</b>	<b>\$17,579</b>	<b>\$14,851</b>	<b>\$12,961</b>
Unexpended balance, estimated savings	-80	-634	-
Balance available in subsequent years	-226	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$17,273</b>	<b>\$14,217</b>	<b>\$12,961</b>

**0342 State School Fund**

<b>APPROPRIATIONS</b>			
Education Code section 14002	\$38,214,635	\$39,624,896	\$40,790,019

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.



**6100 Department of Education - Continued**

Past Year Adjustments	-1,201,847	-	-
State School Fund Adjustment	-	-526,342	-
<b>TOTALS, EXPENDITURES</b>	<b>\$37,012,788</b>	<b>\$39,098,554</b>	<b>\$40,790,019</b>
Less funding provided by General Fund	-36,993,947	-39,079,386	-40,770,851
<b>NET TOTALS, EXPENDITURES</b>	<b>\$18,841</b>	<b>\$19,168</b>	<b>\$19,168</b>

**0349 Educational Telecommunication Fund**

APPROPRIATIONS

Pending Legislation (Standardized Account Code Structure System Replacement Project)	-	-	\$716
--	---	---	-------

<b>TOTALS, EXPENDITURES</b>	<b>-</b>	<b>-</b>	<b>\$716</b>
-----------------------------	----------	----------	--------------

**0814 California State Lottery Education Fund**

APPROPRIATIONS

Government Code section 8880.5	\$1,184,232	\$1,184,232	\$1,200,696
K-12 Lottery Adjustment	-	17,373	-
Past Year Adjustments	17,320	-	-

<b>TOTALS, EXPENDITURES</b>	<b>\$1,201,552</b>	<b>\$1,201,605</b>	<b>\$1,200,696</b>
-----------------------------	--------------------	--------------------	--------------------

**0890 Federal Trust Fund**

APPROPRIATIONS

101 Budget Act appropriation (Project School Emergency Response to Violence)	-	-	\$2,000
102 Budget Act appropriation (Immediate Aid To Restart School Operations)	-	-	13,864
104 Budget Act appropriation (Project Advancing Wellness and Resilience in Education Grant)	2,313	1,998	1,469
112 Budget Act appropriation (Public Charter Schools)	35,400	40,964	26,873
113 Budget Act appropriation (Student Assessment Program)	24,121	-	21,129
113 Budget Act appropriation (Student Assessment Program) as amended by Chapter 181, Statutes of 2017	-	20,937	-
Align Federal Student Assessment Funding to Estimated Costs	-	2,133	-
119 Budget Act appropriation (Title I, Neglected and Delinquent)	1,215	-	3,112
119 Budget Act appropriation (Title I, Neglected and Delinquent) as amended by Chapter 181, Statutes of 2017	-	1,215	-
Adjust Federal Funds for the Neglected and Delinquent Children Program	-	447	-
125 Budget Act appropriation (Migrant Education and English Language Acquisition Program)	280,272	291,945	273,597
134 Budget Act appropriation (Title I School Improvement)	1,839,393	-	2,218,510
134 Budget Act appropriation (Title I School Improvement) as amended by Chapter 181, Statutes of 2017	-	1,816,694	-
Adjust Federal Funds for the Title I Basic Grant Program	-	29,728	-
136 Budget Act appropriation (McKinney-Vento Homeless Children Education)	7,930	9,711	9,262
137 Budget Act appropriation (Rural and Low Income Schools Grant)	1,436	3,512	3,680
156 Budget Act appropriation (Adult Education)	93,918	-	102,515
156 Budget Act appropriation (Adult Education) as amended by Chapter 181, Statutes of 2017	-	94,774	-
Adjust Federal Funds for the Adult Education Program	-	1,567	-
161 Budget Act appropriation (Special Education)	1,251,134	1,248,885	1,279,921
166 Budget Act appropriation (Vocational Education)	123,410	122,193	117,683
193 Budget Act appropriation (Title II, Mathematics and Science Partnership Grants)	20,656	2,703	323
194 Budget Act appropriation (Child Development)	648,873	-	938,039
194 Budget Act appropriation (Child Development) as amended by Chapter 181, Statutes of 2017	-	747,495	-
Base Child Care Development Fund Grant Adjustment (2017 BA)	-	9,008	-
Child Care Development Fund Quality Adjustment (2017 BA)	-	8,822	-
195 Budget Act appropriation (Title II, Part A-Improving Teacher Quality Grant)	-	238,878	235,316
195 Budget Act appropriation as amended by Chapter 318, Statutes of 2016 (Title II, Part A-Improving Teacher Quality Grant)	251,110	-	-
197 Budget Act appropriation (21st Century Community Learning Centers)	132,821	-	138,153

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

197 Budget Act appropriation (21st Century Community Learning Centers) as amended by Chapter 181, Statutes of 2017	-	135,071	-
21st Century Community Learning Centers Base Grant Adjustment (2017 BA)	-	3,921	-
201 Budget Act appropriation (Child Nutrition)	2,677,586	2,672,340	2,672,340
240 Budget Act appropriation (Advanced Placement Exam Fees)	13,676	11,064	11,064
294 Budget Act appropriation (Early Head Start - Child Care Partnership Grant)	6,710	5,566	3,662
<b>Totals Available</b>	<b>\$7,411,974</b>	<b>\$7,521,571</b>	<b>\$8,072,512</b>
Unexpended balance, estimated savings	-239,120	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$7,172,854</b>	<b>\$7,521,571</b>	<b>\$8,072,512</b>
<b>0986 Local Property Tax Revenues</b>			
APPROPRIATIONS			
District Local Revenue	\$17,632,405	\$18,479,316	\$19,992,782
K-12 District Local Property Tax Revenue Offset Adjustment	481,548	560,665	-
Technical Adjustment to K-12 Offsetting Property Tax Revenues Tracking Account	199	-123,375	-
County Offices Local Revenue	535,156	564,576	591,924
County Office of Education Local Property Tax Revenue Offset Adjustment	7,771	7,771	-
Technical Adjustment to K-12 Offsetting Property Tax Revenues Tracking Account	-21	-11,435	-
Special Education Local Revenue	577,923	602,581	634,139
Special Education Local Property Tax Revenue Offset Adjustment	3,468	3,596	-
Technical Adjustment to K-12 Offsetting Property Tax Revenues Tracking Account	-727	-7,893	-
<b>TOTALS, EXPENDITURES</b>	<b>\$19,237,722</b>	<b>\$20,075,802</b>	<b>\$21,218,845</b>
<b>0995 Reimbursements</b>			
APPROPRIATIONS			
Reimbursements	\$408,992	\$435,684	\$436,184
<b>TOTALS, EXPENDITURES</b>	<b>\$408,992</b>	<b>\$435,684</b>	<b>\$436,184</b>
<b>3207 Education Protection Account</b>			
APPROPRIATIONS			
Article XIII, Section 36 of the California Constitution (Proposition 30)	\$6,708,585	\$6,436,705	\$7,278,288
Education Protection Account Revenue Adjustment	-	372,409	-
<b>TOTALS, EXPENDITURES</b>	<b>\$6,708,585</b>	<b>\$6,809,114</b>	<b>\$7,278,288</b>
Less funding provided by General Fund	-6,708,585	-6,809,114	-7,278,288
<b>NET TOTALS, EXPENDITURES</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>3286 Safe Neighborhoods and Schools Fund</b>			
APPROPRIATIONS			
Government Code section 7599.1 (c)	\$9,369	\$10,731	\$15,263
<b>TOTALS, EXPENDITURES</b>	<b>\$9,369</b>	<b>\$10,731</b>	<b>\$15,263</b>
<b>3309 Tobacco Prevention and Control Programs Account, California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund</b>			
APPROPRIATIONS			
101 Budget Act appropriation as amended by Chapter 249, Statutes of 2017	-	\$30,389	-
<b>TOTALS, EXPENDITURES</b>	<b>-</b>	<b>\$30,389</b>	<b>-</b>
<b>3321 Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD</b>			
APPROPRIATIONS			
Revenue and Taxation Code section 30130.57(b)(1)	-	-	\$21,736
<b>TOTALS, EXPENDITURES</b>	<b>-</b>	<b>-</b>	<b>\$21,736</b>
<b>8080 Clean Energy Job Creation Fund</b>			
APPROPRIATIONS			
139 Budget Act appropriation	\$398,800	\$376,200	-
Prior Year Balances Available:			
Item 6100-139-8080, Budget Act of 2015	192,213	-	-
Item 6110-139-8080, Budget Act of 2013	82,869	-	-
Item 6110-139-8080, Budget Act of 2014	125,377	-	-
<b>Totals Available</b>	<b>\$799,259</b>	<b>\$376,200</b>	<b>-</b>

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

Unexpended balance, estimated savings	-408,531	-	-
<b>TOTALS, EXPENDITURES</b>	<b>\$390,728</b>	<b>\$376,200</b>	-
Less funding provided by General Fund	-407,210	-385,018	-
<b>NET TOTALS, EXPENDITURES</b>	<b>-\$16,482</b>	<b>-\$8,818</b>	-
<b>Total Expenditures, All Funds, (Local Assistance)</b>	<b>\$73,660,233</b>	<b>\$77,886,353</b>	<b>\$81,220,361</b>
<b>TOTALS, EXPENDITURES, ALL FUNDS (State Operations and Local Assistance)</b>	<b>\$74,001,240</b>	<b>\$78,281,183</b>	<b>\$81,606,069</b>

**FUND CONDITION STATEMENTS**

	2016-17*	2017-18*	2018-19*
<b>0178 Driver Training Penalty Assessment Fund<sup>s</sup></b>			
BEGINNING BALANCE	\$457	\$741	\$741
Prior Year Adjustments	885	-	-
Adjusted Beginning Balance	\$1,342	\$741	\$741
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Revenues:			
4136500 Traffic Violation Penalties	24,585	-	-
Transfers and Other Adjustments			
Revenue Transfer from Driver Training Penalty Assessment Fund (0178) to Corrections Training Fund (0170) per C.S. 24.10.	-9,800	-	-
Revenue Transfer from Driver Training Penalty Assessment Fund (0178) to Peace Officers' Training Fund (0268) per C.S. 24.10.	-9,200	-	-
Revenue Transfer from Driver Training Penalty Assessment Fund (0178) to Victim Witness Assistance Fund (0425) per C.S. 24.10.	-4,121	-	-
Revenue Transfer from Drivers Training Penalty Assessment Fund (0178) to Traumatic Brain Injury Fund (0311)	-360	-	-
Total Revenues, Transfers, and Other Adjustments	\$1,104	-	-
Total Resources	\$2,446	\$741	\$741
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (State Operations)	1,515	-	-
8880 Financial Information System for California (State Operations)	3	-	-
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	187	-	-
Total Expenditures and Expenditure Adjustments	\$1,705	-	-
FUND BALANCE	\$741	\$741	\$741
Reserve for economic uncertainties	741	741	741
<b>0342 State School Fund<sup>s</sup></b>			
BEGINNING BALANCE	\$2,647	\$2,029	\$2,029
Prior Year Adjustments	-1,002	-	-
Adjusted Beginning Balance	\$1,645	\$2,029	\$2,029
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Revenues:			
4154000 Royalties - Federal Land	22,472	22,472	22,472
4171300 Donations	78	78	78
Total Revenues, Transfers, and Other Adjustments	\$22,550	\$22,550	\$22,550
Total Resources	\$24,195	\$24,579	\$24,579
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (Local Assistance)	37,012,788	39,098,554	40,790,019
6870 Board of Governors of the California Community Colleges (Local Assistance)	4,075,305	4,457,234	5,011,378

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

Expenditure Adjustments:			
Less funding provided by General Fund (Local Assistance)	-36,993,947	-39,079,386	-40,770,851
Less funding provided by General Fund (Local Assistance)	-4,071,980	-4,453,852	-5,007,996
Total Expenditures and Expenditure Adjustments	<u>\$22,166</u>	<u>\$22,550</u>	<u>\$22,550</u>
FUND BALANCE	\$2,029	\$2,029	\$2,029
Reserve for economic uncertainties	2,029	2,029	2,029
<b>0349 Educational Telecommunication Fund<sup>S</sup></b>			
BEGINNING BALANCE	\$1,324	\$1,323	\$1,323
Prior Year Adjustments	-1	-	-
Adjusted Beginning Balance	<u>\$1,323</u>	<u>\$1,323</u>	<u>\$1,323</u>
Total Resources	\$1,323	\$1,323	\$1,323
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (Local Assistance)	-	-	716
Total Expenditures and Expenditure Adjustments	<u>-</u>	<u>-</u>	<u>\$716</u>
FUND BALANCE	\$1,323	\$1,323	\$607
Reserve for economic uncertainties	1,323	1,323	607
<b>3170 Heritage Enrichment Resource Fund<sup>S</sup></b>			
BEGINNING BALANCE	\$260	\$351	\$404
Prior Year Adjustments	-1	-	-
Adjusted Beginning Balance	<u>\$259</u>	<u>\$351</u>	<u>\$404</u>
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Revenues:			
4172500 Miscellaneous Revenue	98	98	98
Total Revenues, Transfers, and Other Adjustments	<u>\$98</u>	<u>\$98</u>	<u>\$98</u>
Total Resources	\$357	\$449	\$502
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (State Operations)	-	40	40
9892 Supplemental Pension Payments (State Operations)	-	-	4
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	6	5	3
Total Expenditures and Expenditure Adjustments	<u>\$6</u>	<u>\$45</u>	<u>\$47</u>
FUND BALANCE	\$351	\$404	\$455
Reserve for economic uncertainties	351	404	455
<b>3207 Education Protection Account<sup>S</sup></b>			
BEGINNING BALANCE	-	-	-
EXPENDITURE AND EXPENDITURE ADJUSTMENTS			
Expenditures:			
6100 Department of Education (Local Assistance)	\$6,708,585	\$6,809,114	\$7,278,288
6870 Board of Governors of the California Community Colleges (Local Assistance)	829,150	841,576	899,564
Expenditure Adjustments:			
Less funding provided by General Fund (Local Assistance)	-6,708,585	-6,809,114	-7,278,288
Less funding provided by General Fund (Local Assistance)	-829,150	-841,576	-899,564
FUND BALANCE	<u>-</u>	<u>-</u>	<u>-</u>
<b>3321 Education, Tobacco Prevention Ctrl Acct, CA Healthcare, Rsrch Prvt FD<sup>S</sup></b>			
BEGINNING BALANCE	-	-	-
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS			
Transfers and Other Adjustments			
Revenue Transfer From the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund (3304) to the Tobacco Prevention and Control	-	-	22,225

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

Programs Account Fund (3321) per Revenue and Tax Code Section 30130.55(b)(2)			
Revenue Transfer From the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund (3304) to the tobacco Prevention and Control Programs Account Fund (3321) per Revenue and Tax Code Section 30130.55(b)(2)	-	-	622
Total Revenues, Transfers, and Other Adjustments	-	-	\$22,847
Total Resources	-	-	\$22,847
<b>EXPENDITURE AND EXPENDITURE ADJUSTMENTS</b>			
Expenditures:			
6100 Department of Education (State Operations)	-	-	1,111
6100 Department of Education (Local Assistance)	-	-	21,736
Total Expenditures and Expenditure Adjustments	-	-	\$22,847
FUND BALANCE	-	-	-
<b>8080 Clean Energy Job Creation Fund<sup>S</sup></b>			
BEGINNING BALANCE	\$409,163	\$409,894	\$409,732
Prior Year Adjustments	123	-	-
Adjusted Beginning Balance	\$409,286	\$409,894	\$409,732
Total Resources	\$409,286	\$409,894	\$409,732
<b>EXPENDITURE AND EXPENDITURE ADJUSTMENTS</b>			
Expenditures:			
3340 California Conservation Corps (State Operations)	5,559	5,816	-
6100 Department of Education (Local Assistance)	390,728	376,200	-
6870 Board of Governors of the California Community Colleges (Local Assistance)	56,595	46,664	-
7120 California Workforce Development Board (State Operations)	3,000	3,000	-
Expenditure Adjustments:			
Less funding provided by General Fund (Local Assistance)	-407,210	-385,018	-
Less funding provided by General Fund (Local Assistance)	-49,280	-46,500	-
Total Expenditures and Expenditure Adjustments	-\$608	\$162	-
FUND BALANCE	\$409,894	\$409,732	\$409,732
Reserve for economic uncertainties	409,894	409,732	409,732

**CHANGES IN AUTHORIZED POSITIONS**

	Positions			Expenditures		
	2016-17	2017-18	2018-19	2016-17*	2017-18*	2018-19*
<b>Baseline Positions</b>	2,249.7	2,245.2	2,243.2	\$159,340	\$155,230	\$154,420
Budget Position Transparency	-	-28.0	-26.0	-	-4,855	1,950
<b>Salary and Other Adjustments</b>	-33.9	-	-	113	6,789	6,789
<b>Workload and Administrative Adjustments</b>						
<b>Cross-Agency Work to Support the Statewide System of Support (State Operations)</b>						
Educ Programs Consultant	-	-	-	-	-	173
<b>One-Time Federal Funds to Support the Early Math Initiative</b>						
Temporary Help (Limited Term 06-30-2019)	-	-	-	-	-	100
<b>One-Time Federal Immediate Aid to Restart School Operations Funds (State Operations)</b>						
Temporary Help (Limited Term 06-30-2019)	-	-	-	-	-	200
<b>Personnel Funding for Child Care Slot Expansion</b>						
Educ Programs Consultant	-	-	-	-	-	87
<b>Personnel Funding for Computer-Based ELPAC and Alternative ELPAC Assessments</b>						

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

**6100 Department of Education - Continued**

Assoc Info Sys Analyst (Spec)	-	-	-	-	-	73
Educ Programs Consultant	-	-	-	-	-	87
<b>Personnel Funding for Data Collection and Reporting Requirements for the District of Choice Program</b>						
Staff Info Sys Analyst (Spec)	-	-	-	-	-	77
<b>Personnel Funding for Educational Equity Compliance Reviews (AB 699)</b>						
Assoc Govtl Program Analyst	-	-	-	-	-	67
<b>Personnel Funding for High School Equivalency Exam Fee Waiver Backfill</b>						
Educ Programs Consultant	-	-	-	-	-	146
<b>Personnel Funding for Special Education Litigation Unit</b>						
Educ Administrator I	-	-	-	-	-	96
Educ Programs Consultant	-	-	-	-	-	260
Office Techn (Typing)	-	-	-	-	-	41
<b>Personnel Funding for State Preschool Expansion</b>						
Educ Programs Consultant	-	-	-	-	-	173
<b>Personnel Funding for Universal Meal Service Support (SB 138)</b>						
Assoc Govtl Program Analyst	-	-	-	-	-	67
<b>Personnel Funding for the Information Security and Privacy Office</b>						
Sys Software Spec III (Tech)	-	-	-	-	-	102
<b>Personnel Funding to Support District Reorganization Workload</b>						
Fld Rep - School Administration (Spec)	-	-	-	-	-	85
<b>Personnel Funding to Support Subsidized County Child Care Pilot Programs</b>						
Assoc Govtl Program Analyst	-	-	-	-	-	134
Assoc Info Sys Analyst (Spec)	-	-	-	-	-	72
Educ Programs Consultant	-	-	-	-	-	87
Staff Programmer Analyst (Spec)	-	-	-	-	-	79
<b>Personnel Funding to Support a Centralized Uniform Complaint Procedures Process and Database</b>						
Educ Programs Consultant	-	-	-	-	-	87
Staff Svcs Mgr I	-	-	-	-	-	76
<b>Sexual Health Education Backfill</b>						
Educ Programs Consultant	-	-	-	-	-	173
<b>TOTALS, WORKLOAD AND ADMINISTRATIVE ADJUSTMENTS</b>						
	-	-	-	\$-	\$-	\$2,542
<hr/>						
<b>Totals, Adjustments</b>	<b>-33.9</b>	<b>-28.0</b>	<b>-26.0</b>	<b>\$113</b>	<b>\$1,934</b>	<b>\$11,281</b>
<b>TOTALS, SALARIES AND WAGES</b>	<b>2,215.8</b>	<b>2,217.2</b>	<b>2,217.2</b>	<b>\$159,453</b>	<b>\$157,164</b>	<b>\$165,701</b>

**INFRASTRUCTURE OVERVIEW**

The State Special Schools Division has six facilities under its jurisdiction: three residential schools and three diagnostic centers. These facilities comprise a total of approximately 1,042,000 gross square feet on 167.29 acres.

The residential schools serve students ranging in age from 3 to 22. They include Schools for the Deaf in Riverside and Fremont and a School for the Blind in Fremont. The California Schools for the Deaf provide comprehensive educational programs composed of academic, extracurricular, and residential activities for students. The California School for the Blind is a statewide residential campus that provides intensive, disability-specific educational services for pupils who are blind, visually impaired, or deaf-blind. The diagnostic centers are regionally located in Fresno, Fremont, and Los Angeles; the centers address the unique educational needs of California's most difficult to serve special education students.

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.



**6100 Department of Education - Continued**

**SUMMARY OF PROJECTS**

		State Building Program Expenditures	2016-17*	2017-18*	2018-19*
<b>5230</b>	<b>CAPITAL OUTLAY Projects</b>				
0000409	New Gym and Pool Center Construction		-	2,156	-
0000720	Fremont School for the Deaf: Middle School Activity Center Preliminary Plans		266	1,483	-
	Working Drawings		70	-	-
	Construction		196	-	-
			-	1,483	-
<b>TOTALS, EXPENDITURES, ALL PROJECTS</b>			<b>\$266</b>	<b>\$3,639</b>	<b>\$-</b>
<b>FUNDING</b>			<b>2016-17*</b>	<b>2017-18*</b>	<b>2018-19*</b>
0001	General Fund		\$266	\$1,483	\$-
0660	Public Buildings Construction Fund		-	2,156	-
<b>TOTALS, EXPENDITURES, ALL FUNDS</b>			<b>\$266</b>	<b>\$3,639</b>	<b>\$-</b>

**DETAIL OF APPROPRIATIONS AND ADJUSTMENTS**

<b>3 CAPITAL OUTLAY</b>		2016-17*	2017-18*	2018-19*
<b>0001 General Fund</b>				
APPROPRIATIONS				
301	Budget Act appropriation	\$1,749	-	-
	Past Year Adjustments	196	-	-
Prior Year Balances Available:				
	Item 6100-301-0001, Budget Act of 2016 as reappropriated by Item 6100-492, Budget Act 2017	-	1,483	-
<b>Totals Available</b>		<b>\$1,945</b>	<b>\$1,483</b>	<b>-</b>
Balance available in subsequent years		-1,679	-	-
<b>TOTALS, EXPENDITURES</b>		<b>\$266</b>	<b>\$1,483</b>	<b>-</b>
<b>0660 Public Buildings Construction Fund</b>				
APPROPRIATIONS				
0000409	- Riverside: New Gymnasium and Pool Center (per AB 109, Chapter 249, Statutes of 2017) - C	-	\$2,156	-
<b>TOTALS, EXPENDITURES</b>		<b>-</b>	<b>\$2,156</b>	<b>-</b>
<b>Total Expenditures, All Funds, (Capital Outlay)</b>		<b>\$266</b>	<b>\$3,639</b>	<b>\$0</b>

\* Dollars in thousands, except in Salary Range. Numbers may not add or match to other statements due to rounding of budget details.

# **EXHIBIT B**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Director  
Office for Civil Rights  
Washington, D.C. 20201

June 21, 2016

**SENT VIA U.S. MAIL AND ELECTRONIC MAIL**

Catherine W. Short, Esq.  
Vice President of Legal Affairs  
Life Legal Defense Foundation  
P.O. Box 2105  
Napa, CA 94558

Matthew S. Bowman, Esq., Senior Legal Counsel  
Casey Mattox, Esq., Senior Legal Counsel  
Alliance Defending Freedom  
440 1<sup>st</sup> Street NW, Suite 600  
Washington, D.C. 20001

James F. Sweeney, Esq.  
Law Offices of James F. Sweeney  
P.O. Box 320130  
San Francisco, CA 94132

Michelle (Shelley) Rouillard, Director  
California Department of Managed Health Care  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814

Re: OCR Transaction Numbers: 14-193604, 15-193782, & 15-195665

Dear Ms. Short, Mr. Bowman, Mr. Mattox, Mr. Sweeney, and Ms. Rouillard:

The Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) has concluded its investigation of allegations that the California Department of Managed Health Care (CDMHC) engaged in discrimination under the Weldon Amendment<sup>1</sup> by issuing letters to several health insurers directing them to amend their plan documents to remove coverage exclusions and limitations regarding elective abortions. OCR received three complaints challenging the CDMHC letter, filed on behalf of a religious organization, churches and a

<sup>1</sup> Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Sec. 507(d) (Dec. 18, 2015).

church-run school, and employees of a religiously-affiliated university. The following sets forth the results of our investigation of these complaints.

### **Background**

On August 22, 2014, the Director of CDMHC notified seven California health insurance plans<sup>2</sup> that it had come to CDMHC's attention that each of them had issued insurance contracts that limited or excluded coverage for termination of pregnancies. CDMHC regulates health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 (Act), Cal. Health & Safety Code Sections 1340-1399.864, and its letter directed each health insurer to ensure that its health plans complied with the Act's requirement to cover legal abortions. CDMHC required the insurers to amend plan documents to remove coverage exclusions and limitations for "voluntary" or "elective" abortions and any limitations on coverage to only "therapeutic" or "medically necessary" abortions and to file revised documents within 90 days. A footnote in the letter stated that "no individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstance to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion."

Implementing regulations of the Federal Health Care Provider Conscience Laws designate OCR as the office to receive complaints alleging discrimination under the Weldon Amendment. 45 C.F.R. § 88.2. OCR investigated each of the three complaints it received about the CDMHC letter, including requesting, receiving, and analyzing a written response to the complaints from CDMHC; collecting additional information from the complainants; interviewing each of the seven health insurers contacted by CDMHC, some on several occasions; and engaging in follow-up conversations with CDMHC.

OCR's investigation found that each of the insurers that received the CDMHC letter had, at the time it received the letter, included coverage for voluntary abortions in plans that it offered; upon receipt of the letter, each amended its plan documents by CDMHC's deadline to eliminate the subject exclusions from any plans that contained them. None of the insurers asserted any objection to offering coverage for voluntary abortion services and none identified any religious or moral objection that it had to such coverage.

OCR's investigation also found that Blue Cross of California (dba Anthem Blue Cross) subsequently sought and received from CDMHC an exemption to allow it to offer a plan excluding elective abortion services for religious employers as defined under California law. Cal. Health & Safety Code Section 1367.25(c)(1). As a result, CDMHC has demonstrated its willingness to authorize insurers to offer products that exclude coverage for elective abortion to such religious employers.

---

<sup>2</sup> The seven health insurance plans were Aetna Health of California, Inc.; Blue Cross of California, dba Anthem Blue Cross; California Physicians' Service, dba Blue Shield of California; GEMCare Health Plan, Inc., dba ERD, Inc., Physicians Choice by GEMCare Health Plan; Health Net of California, Inc.; Kaiser Foundation Health Plan, Inc., dba Kaiser Foundation, Permanente Medical Care Program; and United Healthcare of California. OCR understands that GEMCare is no longer participating in the commercial insurance marketplace.

### **The Weldon Amendment**

The Weldon Amendment provides:

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.<sup>3</sup>

The amendment was passed to protect health care entities covered by the amendment from discrimination where those entities object to abortion on religious or moral grounds. *See State of California v. Lockyer*, 450 F.3d 436, 441 (9<sup>th</sup> Cir. 2006) (“Congress passed the Weldon Amendment precisely to keep doctors who have moral qualms about performing abortions from being put to the hard choice of acting in conformity with their beliefs or risking imprisonment or loss of professional livelihood”).

The amendment applies only to health care entities as defined therein. As the primary sponsor of the amendment, Representative Weldon himself made clear in discussing its scope:

This provision is intended to protect the decisions of physicians, nurses, clinics, hospitals, medical centers, and even health insurance providers from being forced by the government to provide, refer, or pay for abortions. . . . It explicitly clarifies existing law to state that a health care entity includes a hospital, a health professional, a provider-sponsored organization, a health maintenance organization, a health insurance plan or any other kind of health care facility. It goes on further to state that existing law protects health care entities from discrimination based on three kinds of participation in abortion: performing, training and referring.<sup>4</sup>

Representative Weldon further stated that the health care entities that are protected are those that “choose not to provide abortion services.”<sup>5</sup> In making clear that the amendment protects those who object to the provision of abortions, he stated, “[t]he Hyde-Weldon amendment . . . simply states you cannot force the unwilling” to participate in elective abortions. “The amendment does not apply to willing abortion providers.”<sup>6</sup>

---

<sup>3</sup> Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Sec. 507(d) (Dec. 18, 2015).

<sup>4</sup> 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004).

<sup>5</sup> *Id.*

<sup>6</sup> 151 Cong. Rec. H177 (Statement of Rep. Weldon) (Jan. 25, 2005).

Representative Weldon also made clear that the health care entities protected under the amendment are those that have objections based on religious or moral grounds:

[The Weldon Amendment] is a continuation of the Hyde policy of conscience protection. . . . The right of conscience is fundamental to our American freedoms. We should guarantee this freedom by protecting all health care providers from being forced to perform, refer, or pay for elective abortions.<sup>7</sup>

### **Findings**

CDMHC is an agency and instrumentality of the State, and thus an entity to which the terms of the Weldon Amendment apply. The State of California receives federal funding under the Appropriations Act that includes the Weldon Amendment.<sup>8</sup> The seven health insurers to which CDMHC sent the August 22, 2014 letter meet the definition of “health care entity” in the Weldon Amendment, as each is a “health insurance plan.” Based on the facts provided to OCR, none of the complainants meets the definition of a “health care entity” under the Weldon Amendment.

By its plain terms, the Weldon Amendment’s protections extend only to health care entities and not to individuals who are patients of, or institutions or individuals that are insured by, such entities. In addition, its author, Representative Weldon, made clear both that the amendment protects only those covered health care entities that object to the provision of abortions and that its basic purpose is to protect those entities whose objections are made on religious or moral grounds.

Here, none of the seven insurers that received the CDMHC letter – the entities that are covered under the Weldon Amendment – objected to providing coverage for abortions. All modified their plan documents to cover voluntary abortion in response to the CDMHC letter, and none has indicated to OCR that it has a religious or moral objection to abortion or to providing coverage for abortion in the products it offers. Indeed, as noted above, at the time CDMHC sent the letter, all of the insurers offered plans that covered abortion, demonstrating that they have no religious or moral objection to that procedure. As a result, there is no health care entity protected under the statute that has asserted religious or moral objections to abortion and therefore there is no covered entity that has been subject to discrimination within the meaning of the Weldon Amendment.<sup>9</sup>

We further note that the approach described above avoids a potentially unconstitutional application of the amendment. A finding that CDMHC has violated the Weldon Amendment might require the government to rescind all funds appropriated under the Appropriations Act to

---

<sup>7</sup> 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004).

<sup>8</sup> Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Sec. 507(d) (Dec. 18, 2015).

<sup>9</sup> We reiterate that to the extent that entities whose religious beliefs are not protected under the Weldon Amendment nonetheless object to CDMHC’s letter, CDMHC has demonstrated its willingness to authorize insurers to offer products that exclude coverage for elective abortion to entities that qualify as religious employers under California law. *See* discussion of Anthem Blue Cross *supra*. Some employers may also, of course, decide to self-insure; self-insured plans are not subject to the CDMHC policy.



the State of California – including funds provided to the State not only by HHS but also by the Departments of Education and Labor, as well as other agencies. HHS’ Office of General Counsel, after consulting with the Department of Justice, has advised that such a rescission would raise substantial questions about the constitutionality of the Weldon Amendment. Specifically, in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), the Supreme Court ruled that Congress could not condition a State’s preexisting Medicaid funding on the State’s compliance with an Affordable Care Act requirement to expand the program to include all low-income adults. The Court reasoned that this threat to terminate significant independent grants was so coercive as to deprive States of any meaningful choice whether to accept the condition attached to receipt of federal funds. Following accepted canons of statutory construction, OCR’s approach, which is consistent with the views of the primary sponsor of the amendment, avoids this potentially unconstitutional application of the statute. *See Gomez v. United States*, 490 U.S. 858, 864 (1989).

Accordingly, OCR is closing its investigation of these complaints without further action.

**Advisements**

The determinations in this letter are not intended, nor should they be construed, to cover any issues regarding CDMHC’s compliance with the Weldon Amendment that are not specifically addressed in this letter. It neither covers issues or authorities not specifically addressed herein nor precludes future determinations about compliance that are based on subsequent investigations.

The complainant has the right not to be intimidated, threatened, or coerced by a covered entity or other person because he or she has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing held in connection with a complaint. Please take all necessary steps to ensure that no adverse action is taken against the complainants or any other individual for the filing of this complaint, providing information to OCR, or otherwise participating in this investigation.

Under the Freedom of Information Act, it may be necessary to release this document and related correspondence and records upon request. In the event OCR receives such a request, we will seek to protect, to the extent provided by law, personal information which, if released, would constitute an unwarranted invasion of privacy.

Sincerely,



Jocelyn Samuels  
Director, Office for Civil Rights

cc: Gabriel Ravel  
Deputy Director, General Counsel  
California Department of Managed Health Care

# **EXHIBIT C**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Voice - (800) 368-1019 TDD - (800) 537-7697 Fax - (202) 619-3818  
<http://www.hhs.gov/ocr/>

OFFICE OF THE SECRETARY

Office for Civil Rights  
200 Independence Ave., SW  
Washington, DC 20201

VIA U.S. MAIL AND ELECTRONIC MAIL (*Xavier.Becerra@doj.ca.gov*)

January 18, 2019

Xavier Becerra, Esq.  
California Attorney General  
California Department of Justice  
P.O. Box 944255  
Sacramento, CA 94244

**Notice of Violation – OCR Transaction Numbers 16-224756 and 18-292848**

Dear Attorney General Becerra:

This letter notifies you that the U.S. Department of Health & Human Services (“HHS”) Office for Civil Rights (“OCR”) has completed investigations of the complaints filed by Sacramento Life Center (OCR Transaction Number 16-224756),<sup>1</sup> and LivingWell Medical Clinic, Inc., Pregnancy Center of the North Coast, Inc., and Confidence Pregnancy Center, Inc. (OCR Transaction Number 18-292848)<sup>2</sup> (collectively, the “Complainants”). The Complainants allege that the State of California (“California”) engaged in impermissible discrimination when it enacted the Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act (the “FACT Act”),<sup>3</sup> subjecting Complainants to potential fines if they refused to provide certain notices or refer for or make arrangements for abortion.

Under part 88 of 45 C.F.R., OCR is authorized to receive and handle complaints based on potential violations of the Weldon Amendment, the Church Amendments,<sup>4</sup> and the Coats-Snowe Amendment. OCR investigated the Complainants’ allegations under the Weldon and Coats-Snowe Amendments by conducting clarifying interviews, reviewing documents, and propounding data requests to California. OCR also reviewed relevant pleadings, briefs, and court decisions from Complainants’ Federal court litigation, as well as other relevant Federal court litigation. Based on its investigations, OCR has determined that California violated the Weldon Amendment<sup>5</sup> and the Coats-Snowe Amendment.<sup>6</sup>

<sup>1</sup> Letter from James F. Sweeney, Attorney, to Office for Civil Rights, U.S. Dep’t of Health & Human Servs. (Nov. 4, 2015) (on file with HHS OCR).

<sup>2</sup> Letter from Francis J. Manion & Geoffrey R. Surtees, Attorneys, Am. Ctr. for Law & Justice, to Office for Civil Rights, U.S. Dep’t of Health & Human Servs. (Jan. 10, 2018) (on file with HHS OCR).

<sup>3</sup> Cal. Health & Safety Code Ann. §§ 123470 *et seq.*

<sup>4</sup> 42 U.S.C. § 300a-7. OCR closes these complaints without making any findings under these complaints as to whether the FACT Act violates the Church Amendments.

<sup>5</sup> *E.g.*, Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018).

<sup>6</sup> 42 U.S.C. § 238n.

## BACKGROUND OF THE COMPLAINTS

### 1. Sacramento Life Center<sup>7</sup>

On November 4, 2015, Sacramento Life Center filed a complaint with OCR asserting that California discriminated against Sacramento Life Center in violation of the Weldon Amendment because it subjected Sacramento Life Center to potential fines for refusing to post the FACT Act's required notice in direct conflict with its convictions about abortion. This complaint with OCR was designated OCR Transaction Number 16-224756.

Sacramento Life Center is a non-profit, pro-life pregnancy resource center that is under the supervision of a medical director. It provides medical and other services, consistent with its convictions, that support pregnant mothers and the lives of their unborn children.<sup>8</sup> According to Sacramento Life Center's Complaint:

The mission of the Sacramento Life Center is to offer compassion, support, resources, and free medical care to women and couples facing unplanned or unsupported pregnancies, by providing them with realistic, high quality options other than abortion. In addition to being a social service agency, it is also a state-licensed medical clinic committed to ensuring all women and teen girls have access to free, or low cost, medical care. The Sacramento Life Center is a private, non-denominational, non-profit charitable organization that serves everyone regardless of financial standing, ethnic background, or religion. It is opposed to abortion and has, for the past forty years, worked tirelessly to offer women in crisis pregnancies abortion alternatives and compassionate care.<sup>9</sup>

Sacramento Life Center provides abortion alternatives through staff and volunteers that include nurses, a sonogram technician, and a licensed physician.<sup>10</sup>

Sacramento Life Center meets the definition of a "licensed covered facility" under the FACT Act. It is "a facility licensed under Section 1204 or an intermittent clinic operating under a primary care clinic pursuant to subdivision (h) of Section 1206, whose primary purpose is providing family planning or pregnancy-related services;"<sup>11</sup> it "offers obstetric ultrasounds, obstetric sonograms, or prenatal care to pregnant women;"<sup>12</sup> it "offers pregnancy testing or

---

<sup>7</sup> According to the plain text of the statutes, the Weldon and Coats-Snowe Amendments do not necessarily require the assertion of a religious or moral objection to abortion or abortion referrals. However, this Notice of Violation describes the Complainants, their beliefs, and their allegations, as well as the procedural background of their lawsuits where germane to OCR's completed investigations.

<sup>8</sup> OCR telephonic interview with Marie Leatherby, Exec. Dir., Sacramento Life Ctr. (Apr. 24, 2018) (on file with HHS OCR).

<sup>9</sup> Letter from James F. Sweeney, Attorney, to Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Nov. 4, 2015) (on file with HHS OCR).

<sup>10</sup> OCR telephonic interview with Marie Leatherby, Exec. Dir., Sacramento Life Ctr. (Apr. 24, 2018) (on file with HHS OCR).

<sup>11</sup> Cal. Health & Safety Code Ann. § 123471(a).

<sup>12</sup> *Id.* at § 123471(a)(1).

pregnancy diagnosis;”<sup>13</sup> it “advertises or solicits patrons with offers to provide prenatal sonography, pregnancy tests, or pregnancy options counseling;”<sup>14</sup> and it “has staff or volunteers who collect health information from clients.”<sup>15</sup> Sacramento Life Center does not meet any of the FACT Act’s exceptions.<sup>16</sup>

Because Sacramento Life Center meets the definition of a “licensed covered facility” under the FACT Act, it would be required to post notices stating that the state of California provides free or low-cost family planning services and abortion, and providing contact information on how to obtain such family planning services and abortion for qualifying members of the public.<sup>17</sup>

2. LivingWell Medical Clinic, Inc., Pregnancy Center of the North Coast, Inc., and Confidence Pregnancy Center, Inc.

On January 10, 2018, LivingWell Medical Clinic, Inc. (“LivingWell”); Pregnancy Center of the North Coast, Inc. (“North Coast”); and Confidence Pregnancy Center, Inc. (“Confidence”) filed a complaint with OCR asserting that California discriminated against them in violation of both the Weldon and Coats-Snowe Amendments, because California subjected them to potential fines for refusing to post the FACT Act’s required notice in direct conflict with their convictions about abortion. This complaint with OCR was designated OCR Transaction Number 18-292848.

LivingWell, North Coast, and Confidence are three non-profit, faith-based pregnancy resource centers that offer pregnancy-related care and counseling to pregnant mothers free of charge and consistent with their religious beliefs.<sup>18</sup> Because of those religious beliefs, LivingWell, North Coast, and Confidence will not perform, counsel for, refer for, or provide education about procedures that end human life through abortion or abortion-inducing drugs.<sup>19</sup>

According to the Complaint from LivingWell, North Coast, and Confidence, all three pregnancy resource centers “operate licensed clinics that provide services to women seeking help with unplanned pregnancies. Each of the Complainants, for religious reasons, objects to posting or distributing the State’s dictated message, because they view it as requiring them to approve of

---

<sup>13</sup> *Id.* at § 123471(a)(3).

<sup>14</sup> *Id.* at § 123471(a)(4).

<sup>15</sup> *Id.* at § 123471(a)(6).

<sup>16</sup> *Id.* at § 123471(c).

<sup>17</sup> Cal. Health & Safety Code Ann. § 123472(a)(1); *see also Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2371 (2018) (under the FACT Act, “licensed clinics must provide a government-drafted script about the availability of state-sponsored services, as well as contact information for how to obtain them”).

<sup>18</sup> OCR telephonic interview with Christine Morris, Exec. Dir., Confidence Pregnancy Ctr., Inc. (May 22, 2018) (on file with HHS OCR); OCR telephonic interview with Cindy Broese Van Groenou, Exec. Dir., Pregnancy Ctr. of the North Coast, Inc. (June 7, 2018) (on file with HHS OCR); OCR telephonic interview with Cathy Seapy, Chief Exec. Officer, LivingWell Med. Clinic, Inc. (June 12, 2018) (on file with HHS OCR).

<sup>19</sup> *Supra* note 18.



and refer for abortions.”<sup>20</sup> LivingWell, North Coast, and Confidence provide abortion alternatives through staff and volunteers that include nurses, sonogram technicians, and licensed physicians.<sup>21</sup>

For the same reasons that Sacramento Life Center qualifies as a “licensed covered facility,” LivingWell, North Coast, and Confidence also meet the definition of a “licensed covered facility” under the FACT Act. Nor do LivingWell, North Coast, or Confidence meet any of the FACT Act’s exceptions.<sup>22</sup>

Accordingly, all three pregnancy resource centers would be required to post notices stating that the State of California provides free or low-cost family planning services and abortion and providing contact information to members of the public.<sup>23</sup>

## PROCEDURAL BACKGROUND

On September 9, 2015, the California legislature passed the FACT Act, which was signed into law by Governor Jerry Brown on October 9, 2015, and went into effect on January 1, 2016.

On October 27, 2015, LivingWell, North Coast, and Confidence filed for injunctive relief against California in U.S. District Court for the Northern District of California, alleging that the FACT Act required them to post a government-dictated message they did not wish to communicate in violation of the First Amendment to the U.S. Constitution, among other grounds.<sup>24</sup>

On December 18, 2015, the District Court denied LivingWell, North Coast, and Confidence’s motion for a preliminary injunction, as well as a stay of the FACT Act pending appeal.<sup>25</sup> LivingWell, North Coast, and Confidence appealed to the Ninth Circuit Court of Appeals, which affirmed the District Court on October 14, 2016.<sup>26</sup> LivingWell, North Coast, and Confidence appealed to the U.S. Supreme Court.

OCR conducted an investigation following receipt of the complaints from Sacramento Life Center, LivingWell, North Coast, and Confidence. As part of OCR’s investigations, OCR conducted interviews with representatives from each Complainant and submitted detailed data requests to California requesting information on the FACT Act, California’s interpretation of the FACT Act, and California’s enforcement of the FACT Act.<sup>27</sup>

---

<sup>20</sup> Letter from Francis J. Manion & Geoffrey R. Surtees, Attorneys, Am. Ctr. for Law & Justice, to Office for Civil Rights, U.S. Dep’t of Health & Human Servs. (Jan. 10, 2018) (on file with HHS OCR).

<sup>21</sup> OCR telephonic interview with Christine Morris, Exec. Dir., Confidence Pregnancy Ctr., Inc. (May 22, 2018) (on file with HHS OCR); OCR telephonic interview with Cindy Broese Van Groenou, Exec. Dir., Pregnancy Ctr. of the North Coast, Inc. (June 7, 2018) (on file with HHS OCR); OCR telephonic interview with Cathy Seapy, Chief Exec. Officer, LivingWell Med. Clinic, Inc. (June 12, 2018) (on file with HHS OCR).

<sup>22</sup> Cal. Health & Safety Code Ann. § 123471(c).

<sup>23</sup> *Id.* at § 123472(a)(1).

<sup>24</sup> *LivingWell Med. Clinic, Inc. v. Harris*, No. 15-CV-04939, 2015 WL 13187682 (N.D. Cal. 2015).

<sup>25</sup> *Id.*

<sup>26</sup> *LivingWell Med. Clinic, Inc. v. Harris*, 669 Fed. Appx. 493 (9th Cir. 2016).

<sup>27</sup> Letter from Molly Wlodarczyk, Senior Investigator, Pacific Region, Office for Civil Rights, U.S. Dep’t of Health & Human Servs., to Cal. Gov. Edmund G. Brown, Jr., Cal. Attorney Gen. Xavier Becerra, and Cal. Sec’y of Health



On June 26, 2018, the Supreme Court issued its opinion in *National Institute of Family and Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) (“*NIFLA*”), in which it held that the plaintiffs in that case were likely to prevail on the merits of their claim that the FACT Act violated their First Amendment right of free speech.<sup>28</sup> The Supreme Court found that the FACT Act requires pregnancy resource centers like Complainants to “provide a government-drafted script about the availability of state-sponsored services, as well as contact information for how to obtain them. One of those services is abortion—the very practice that [Complainants] are devoted to opposing.”<sup>29</sup>

The Supreme Court further stated in *NIFLA* that, with respect to “licensed covered facilities,” the FACT Act is a content based regulation that compels speech, is “wildly underinclusive,” and in no way relates to the services provided by entities covered by the law.<sup>30</sup>

With respect to “unlicensed covered facilities,” the Supreme Court stated that the FACT Act targets pro-life pregnancy resource centers and imposes an unduly burdensome notice requirement that will chill their protected speech.<sup>31</sup>

On June 28, 2018, the Supreme Court granted LivingWell, North Coast, and Confidence’s petition for writ of certiorari, vacated the Ninth Circuit Court of Appeals’ judgement, and remanded the case for further consideration in light of *NIFLA*.<sup>32</sup> The Ninth Circuit subsequently reversed in part, vacated in part, and remanded the case back to the District Court for further consideration in light of *NIFLA* on August 28, 2018.<sup>33</sup>

Following the Supreme Court’s *NIFLA* decision protecting pro-life pregnancy resource centers from coerced speech, OCR requested additional information from California regarding its intentions to enforce the FACT Act.<sup>34</sup> The California Attorney General’s office responded on August 14, 2018, by stating, “[G]iven the status of pending litigation regarding the Act, this office has no plans to enforce the Act against any facility.”<sup>35</sup>

---

& Human Servs. Agency Diane S. Dooley Sept. 29, 2017) (on file with HHS OCR); Letter from Luis E. Perez, Deputy Dir., Conscience & Religious Freedom Div., Office for Civil Rights, U.S. Dep’t of Health & Human Servs., to Cal. Attorney Gen. Xavier Becerra (July 17, 2018) (on file with HHS OCR); and Letter from Luis E. Perez, Deputy Dir., Conscience & Religious Freedom Div., Office for Civil Rights, U.S. Dep’t of Health & Human Servs., to Cal. Gov. Edmund G. Brown, Jr., Cal. Attorney Gen. Xavier Becerra, and Cal. Sec’y of Health & Human Servs. Agency Diane S. Dooley (July 26, 2018) (on file with HHS OCR).

<sup>28</sup> 138 S. Ct. 2361, 2378 (2018).

<sup>29</sup> *Id.* at 2371.

<sup>30</sup> *Id.* at 2367.

<sup>31</sup> *Id.* at 2377.

<sup>32</sup> *LivingWell Med. Clinic, Inc. v. Becerra*, 138 S. Ct. 2701 (Mem) (2018).

<sup>33</sup> *LivingWell Med. Clinic, Inc. v. Becerra*, 901 F.3d 1168 (9th Cir. 2018).

<sup>34</sup> Letter from Luis E. Perez, Deputy Dir., Conscience & Religious Freedom Div., Office for Civil Rights, U.S. Dep’t of Health & Human Servs., to Cal. Attorney Gen. Xavier Becerra (July 17, 2018) (on file with HHS OCR); and Letter from Luis E. Perez, Deputy Dir., Conscience & Religious Freedom Div., Office for Civil Rights, U.S. Dep’t of Health & Human Servs., to Cal. Gov. Edmund G. Brown, Jr., Cal. Attorney Gen. Xavier Becerra, and Cal. Sec’y of Health & Human Servs. Agency Diane S. Dooley (July 26, 2018) (on file with HHS OCR).

<sup>35</sup> Letters from Jose A. Zelidon-Zepeda, Deputy Attorney Gen., to Office for Civil Rights, U.S. Dep’t of Health & Human Servs. (Aug. 14, 2018 & Aug. 24, 2018) (on file with HHS OCR).

On October 26, 2018, pursuant to the parties' stipulated judgment, the U.S. District Court for the Southern District of California entered a permanent injunction in favor of the plaintiffs and against California concerning the FACT Act.<sup>36</sup> The court order permanently enjoins California from enforcing the FACT Act and does not limit its application to the named plaintiffs. Thus, the injunction also protects Sacramento Life Center, LivingWell, North Coast, Confidence, and all similarly-situated pregnancy resource centers in California, both licensed and unlicensed.

## JURISDICTION AND OCR'S INVESTIGATION

As a recipient of Federal funds from HHS that are subject to the Weldon and Coats-Snowe Amendments, California is subject to the terms of the Weldon and Coats-Snowe Amendments. The Weldon Amendment states, in relevant part:

None of the funds made available in this Act may be made available to a . . . State or local government, if such . . . government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.<sup>37</sup>

The Coats-Snowe Amendment states, in relevant part:

The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that—(1) the entity refuses to . . . perform [induced] abortions, or to provide referrals for . . . such abortions, [or] (2) the entity refuses to make arrangements for any of the activities specified in paragraph (1).<sup>38</sup>

Throughout the FACT Act's introduction, passage, and enactment into law, California has received, and continues to receive, Federal financial assistance made available in the annual Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act. Based on the plain language of the Weldon and Coats-Snowe Amendments, California is prohibited from discriminating against a health care entity on the basis that the entity does not "refer for abortions" or make arrangements for abortion.<sup>39</sup>

---

<sup>36</sup> Order RE: Permanent Injunction at 2, *Nat'l Inst. of Family & Life Advocates v. Becerra*, No. 3:15-cv-02277 (S.D. Cal., Oct. 26, 2018).

<sup>37</sup> Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018). The Weldon Amendment defines "health care entity" as including (and, thus, not limited to) "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." *Id.* at § 507(d)(2).

<sup>38</sup> 42 U.S.C. § 238n. The Coats-Snowe Amendment defines "health care entity" as including (and, thus, not limited to) "an individual physician, a postgraduate training program, and a participant in a program of training in the health professions." *Id.* at § 238n(c)(2).

<sup>39</sup> Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018); 42 U.S.C. § 238n(a)(1) & (2).

## FINDINGS AND ANALYSIS<sup>40</sup>

### 1. California's FACT Act Requires Pro-Life Pregnancy Resource Centers that Meet the Definition of a "Licensed Covered Facility" to Post State-Mandated Notices Referring Their Clients for Abortion

The FACT Act requires all pregnancy resource centers that meet the definition of a "licensed covered facility" to publicly post the following notice:

California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women. To determine whether you qualify, contact the county social services office at [insert the telephone number].<sup>41</sup>

The FACT Act dictates, among other things, the notice's location, timing of presentation, medium, and the number of languages it must be stated in.<sup>42</sup> As set forth above, each Complainant satisfies the FACT Act's definition of a "licensed covered facility," and is therefore subject to the notice requirement.

In *NIFLA*, the Supreme Court said the following about the FACT Act's notice requirements for pregnancy resource centers that meet the definition of a "licensed covered facility":

This notice must be posted in the waiting room, printed and distributed to all clients, or provided digitally at check-in. §123472(a)(2). The notice must be in English and any additional languages identified by state law. §123472(a). In some counties, that means the notice must be spelled out in 13 different languages. See State of Cal., Dept. of Health Care Services, Frequency of Threshold Language Speakers in the MediCal Population by County for Jan. 2015, pp. 4–5 (Sept. 2016) (identifying the required languages for Los Angeles County as English, Spanish, Armenian, Mandarin, Cantonese, Korean, Vietnamese, Farsi, Tagalog, Russian, Cambodian, Other Chinese, and Arabic).<sup>43</sup>

### 2. California's FACT Act Requires Pro-Life Pregnancy Resource Centers that Meet the Definition of an "Unlicensed Covered Facility" to Post State-Mandated Notices

The FACT Act also requires all pregnancy resource centers that meet the definition of an "unlicensed covered facility" to publicly post the following notice:

This facility is not licensed as a medical facility by the State of California and has

---

<sup>40</sup> The findings in this letter are not intended, nor should they be construed, to cover any matters not specifically addressed.

<sup>41</sup> Cal. Health & Safety Code Ann. § 123472(a)(1).

<sup>42</sup> *Id.* at § 123472. See also *Nat'l Inst. of Family & Life Advocates*, 138 S. Ct. at 2369.

<sup>43</sup> *Nat'l Inst. of Family & Life Advocates*, 138 S. Ct. at 2369.

no licensed medical provider who provides or directly supervises the provision of services.<sup>44</sup>

Like the notice requirement for a “licensed covered facility,” the FACT Act dictates the placement, dimensions, and language(s) of the notice requirement for an “unlicensed covered facility.” In its *NIFLA* decision, the Supreme Court summarized the mandate’s requirements accordingly:

This notice must be provided on site and in all advertising materials. §§123472(b)(2), (3). Onsite, the notice must be posted ‘conspicuously’ at the entrance of the facility and in at least one waiting area. §123472(b)(2). It must be ‘at least 8.5 inches by 11 inches and written in no less than 48-point type.’ *Ibid.* In advertisements, the notice must be in the same size or larger font than the surrounding text, or otherwise set off in a way that draws attention to it. §123472(b)(3).

Like the licensed notice, the unlicensed notice must be in English and any additional languages specified by state law. §123471(b). Its stated purpose is to ensure ‘that pregnant women in California know when they are getting medical care from licensed professionals.’ Cal. Legis. Serv., §1(e).

As California conceded at oral argument, a billboard for an unlicensed facility that says ‘Choose Life’ would have to surround that two-word statement with a 29-word statement from the government, in as many as 13 different languages.<sup>45</sup>

3. Failure to Post the State-Mandated Notice Subjects a Pro-Life Pregnancy Resource Center to the Threat of Financial Penalties, Litigation by California’s State and Local Governmental Authorities, and Associated Costs and Attorney Fees

A violation of the FACT Act called for a civil fine of \$500 for a first offense and \$1,000 for each subsequent offense. Either the California Attorney General, a city attorney, or a county counsel were authorized to bring an action to enforce the FACT Act.<sup>46</sup>

4. The FACT Act Provides Broad Exemptions from its Mandates and Penalties – But not for Pro-Life Pregnancy Resource Centers

The U.S. Supreme Court deemed the underinclusive nature of the FACT Act to be tantamount to targeting pro-life pregnancy resource centers based upon their views regarding abortion:

---

<sup>44</sup> Cal. Health & Safety Code Ann. § 123472(b)(1).

<sup>45</sup> *Nat’l Inst. of Family & Life Advocates*, 138 S. Ct. at 2370, 2378.

<sup>46</sup> Cal. Health & Safety Code Ann. § 123473(a). *Cf. Hobby Lobby v. Burwell*, 134 S. Ct. 2751, 2779 (2014) (holding that a threatened imposition of a penalty unlawfully burdened plaintiffs’ religious freedom).

The California State Legislature enacted the FACT Act to regulate crisis pregnancy centers. Crisis pregnancy centers—according to a report commissioned by the California State Assembly ...—are ‘pro-life (largely Christian belief-based) organizations that offer a limited range of free pregnancy options, counseling, and other services to individuals that visit a center.’

‘[U]nfortunately,’ the author of the FACT Act stated, ‘there are nearly 200 licensed and unlicensed’ crisis pregnancy centers in California. These centers ‘aim to discourage and prevent women from seeking abortions. The author of the FACT Act observed that crisis pregnancy centers ‘are commonly affiliated with, or run by organizations whose stated goal’ is to oppose abortion....<sup>47</sup>

According to the Supreme Court in *NIFLA*, the FACT Act’s suspicious triggering thresholds and exceptions belie the State’s purported goal of increasing public awareness of the unlicensed status of pregnancy related facilities:

The unlicensed notice imposes a government-scripted, speaker-based disclosure requirement that is wholly disconnected from California’s informational interest. . . . And it covers a curiously narrow subset of speakers. . . . a facility that advertises and provides pregnancy tests is covered by the unlicensed notice, but a facility across the street that advertises and provides nonprescription contraceptives is excluded—even though the latter is no less likely to make women think it is licensed.<sup>48</sup>

Justice Kennedy’s concurring opinion also described how California targeted pro-life pregnancy resource centers for disfavor:

It does appear that viewpoint discrimination is inherent in the design and structure of this Act. This law is a paradigmatic example of the serious threat presented when government seeks to impose its own message in the place of individual speech, thought, and expression. For here the State requires primarily pro-life pregnancy centers to promote the State’s own preferred message advertising abortions. This compels individuals to contradict their most deeply held beliefs, beliefs grounded in basic philosophical, ethical, or religious precepts, or all of these.<sup>49</sup>

##### 5. The FACT Act Violated the Weldon and Coats-Snowe Amendments

California’s enactment of the FACT Act violates the Weldon and Coats-Snowe Amendments by discriminating against health care entities that object to referring for, or making arrangements for, abortion.

The Supreme Court held in *NIFLA* that the FACT Act deprives pro-life pregnancy resource

---

<sup>47</sup> *Nat’l Inst. of Family & Life Advocates*, 138 S.Ct. at 2368-2370.

<sup>48</sup> *Id.* at 2378.

<sup>49</sup> *Id.* at 2379 (Kennedy, J., concurring) (explaining why California’s FACT Act likely violates the First Amendment).

centers of their First Amendment rights because the FACT Act impermissibly compels speech. The FACT Act forces pro-life pregnancy resource centers “to promote the State’s own preferred message advertising abortions.”<sup>50</sup> By targeting those who will not promote its message, California engaged in discrimination prohibited by the Supreme Court and forbidden by the Weldon and Coats-Snowe Amendments.

Under the Weldon Amendment, a covered state or local government has a duty to refrain from subjecting “any . . . health care entity to discrimination on the basis that the health care entity does not . . . refer for abortions.”<sup>51</sup> The same is true under the Coats-Snowe Amendment: a covered state or local government has a duty to refrain from subjecting “any health care entity to discrimination on the basis that . . . the entity refuses to . . . provide referrals . . . for abortion . . . [or] make arrangements for [abortion].”<sup>52</sup>

The Weldon and Coats-Snowe Amendments both define “health care entity” in an illustrative, non-exhaustive fashion. Pursuant to the Weldon Amendment, “the term ‘health care entity’ includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.”<sup>53</sup> Pursuant to the Coats-Snowe Amendment, “The term ‘health care entity’ includes an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.”<sup>54</sup> Accordingly, the “licensed covered facilities,” as defined by the FACT Act, qualify as “health care entities” under Weldon and Coats-Snowe, and are therefore subject to the Amendments’ protections. While OCR does not, at this time, make a determination as to whether every entity that is designated as an “unlicensed covered facility” under the FACT Act would constitute a “health care entity” under either the Weldon or Coats-Snowe Amendments, OCR finds that at least those “unlicensed covered facilities” that provide obstetric ultrasounds/sonograms and prenatal care qualify as “health care entities” under the Weldon Amendment and are subject to that Amendment’s protections.

California subjected pro-life pregnancy resource centers that meet the definition of a “licensed covered facility” and at least some that meet the definition of an “unlicensed covered facility” to an untenable choice that violates the Weldon and/or Coats-Snowe Amendments: violate the FACT Act and face financial penalties, lawsuits, attorney fees, costs, and fines, or violate their protected right to be free from discrimination on the basis that they will not refer for or make arrangements for abortions.

This ultimatum facially violates the Weldon Amendment and Coats-Snowe Amendment as to entities designated as “licensed covered facilities” by requiring that they refer for abortions against their will. The ultimatum also violates the Weldon Amendment as applied to those

---

<sup>50</sup> *Nat’l Inst. of Family & Life Advocates*, 138 S. Ct. at 2379 (Kennedy, J., concurring).

<sup>51</sup> *E.g.*, Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018).

<sup>52</sup> 42 U.S.C. § 238n.

<sup>53</sup> *E.g.*, Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. at 764; 42 U.S.C. § 238n.

<sup>54</sup> 42 U.S.C. § 238n(c)(2).



“unlicensed covered facilities” that qualify as health care entities under the Weldon Amendment, because the FACT Act subjects such facilities to discrimination by targeting them for burdensome and unnecessary notice requirements because they do not refer for abortion.<sup>55</sup>

### CONCLUSION AND REMEDY

For all the above reasons, OCR finds that California’s FACT Act violates the Weldon and Coats-Snowe Amendments. OCR has determined that the FACT Act’s provisions facially violate the Weldon and Coats-Snowe Amendments with respect to entities designated as “licensed covered facilities” under the FACT Act and, as applied, violate the Weldon Amendment with respect to certain entities designated as “unlicensed covered facilities.” Therefore, the FACT Act cannot be enforced under the Weldon and Coats-Snowe Amendments.

OCR took into account California’s representation that the State of California will not enforce the challenged provisions of the FACT Act against any facility, including Complainants.<sup>56</sup> Ordinarily, OCR would require California’s assurances be made binding as to complainants and all similarly situated parties through a voluntary resolution agreement; however, in light of the District Court’s entering of a permanent injunction against any enforcement of the FACT Act against any covered entities (both licensed and unlicensed),<sup>57</sup> a voluntary resolution agreement is not necessary as California’s adherence to the court’s permanent injunction is a sufficient remedy to the violations found by OCR in this Notice.

OCR is therefore closing these complaints as satisfactorily resolved. However, if California were to violate the terms of the injunction it would be subject to a reopening of the complaints and further enforcement action by OCR.

OCR reminds the State of California to take all necessary steps to ensure that no adverse action is taken against the Complainants or any other health care entities discriminated against, or any other individual, for the filing of these complaints, providing information to OCR, or otherwise participating in this investigation. OCR’s closing of these complaints does not preclude future investigations based on new complaints or changed circumstances.

---

<sup>55</sup> *Nat’l Inst. of Family & Life Advocates*, 138 S. Ct. at 2378 (“The unlicensed notice imposes a government-scripted, speaker-based disclosure requirement that is wholly disconnected from California’s informational interest. . . . And it covers a curiously narrow subset of speakers. While the licensed notice applies to facilities that provide ‘family planning’ services and ‘contraception or contraceptive methods,’ § 123471(a), the California Legislature dropped these triggering conditions for the unlicensed notice.”).

<sup>56</sup> Letters from Jose A. Zelidon-Zepeda, Deputy Attorney Gen., to Office for Civil Rights, U.S. Dep’t of Health & Human Servs. (Aug. 14, 2018 & Aug. 24, 2018) (on file with HHS OCR).

<sup>57</sup> Order RE: Permanent Injunction at 2, *Nat’l Inst. of Family & Life Advocates v. Becerra*, No. 3:15-cv-02277 (S.D. Cal., Oct. 26, 2018).

Sincerely,

/s/

Roger T. Severino  
Director  
Office for Civil Rights

# **EXHIBIT D**



www. FIGO.org

Contents lists available at ScienceDirect

## International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo



## CONSCIENTIOUS OBJECTION

# Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses

Wendy Chavkin<sup>a,b,c,\*</sup>, Liddy Leitman<sup>a</sup>, Kate Polin<sup>a</sup>; for Global Doctors for Choice<sup>a</sup>Global Doctors for Choice, New York, USA<sup>b</sup>College of Physicians and Surgeons, Columbia University, New York, USA<sup>c</sup>Mailman School of Public Health, Columbia University, New York, USA

## ARTICLE INFO

## Keywords:

Abortion  
 Assisted reproductive technologies  
 Conscience-based refusal of care  
 Conscientious commitment  
 Conscientious objection  
 Contraception  
 Policy response  
 Reproductive health services

## ABSTRACT

**Background:** Global Doctors for Choice—a transnational network of physician advocates for reproductive health and rights—began exploring the phenomenon of conscience-based refusal of reproductive healthcare as a result of increasing reports of harms worldwide. The present White Paper examines the prevalence and impact of such refusal and reviews policy efforts to balance individual conscience, autonomy in reproductive decision making, safeguards for health, and professional medical integrity.

**Objectives and search strategy:** The White Paper draws on medical, public health, legal, ethical, and social science literature published between 1998 and 2013 in English, French, German, Italian, Portuguese, and Spanish. Estimates of prevalence are difficult to obtain, as there is no consensus about criteria for refuser status and no standardized definition of the practice, and the studies have sampling and other methodologic limitations. The White Paper reviews these data and offers logical frameworks to represent the possible health and health system consequences of conscience-based refusal to provide abortion; assisted reproductive technologies; contraception; treatment in cases of maternal health risk and inevitable pregnancy loss; and prenatal diagnosis. It concludes by categorizing legal, regulatory, and other policy responses to the practice.

**Conclusions:** Empirical evidence is essential for varied political actors as they respond with policies or regulations to the competing concerns at stake. Further research and training in diverse geopolitical settings are required. With dual commitments toward their own conscience and their obligations to patients' health and rights, providers and professional medical/public health societies must lead attempts to respond to conscience-based refusal and to safeguard reproductive health, medical integrity, and women's lives.

© 2013 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

## 1. Introduction

How can societies find the proper balance between women's rights to receive the reproductive healthcare they need and healthcare providers' rights to exercise their conscience? Global Doctors for Choice (GDC)—a transnational network of physician advocates for reproductive health and rights ([www.globaldoctorsforchoice.org](http://www.globaldoctorsforchoice.org))—began exploring the phenomenon of conscience-based refusal of reproductive healthcare in response to increasing reports of harms worldwide. The present White Paper addresses the varied interests and needs at stake when clinicians claim conscientious objector status when providing certain elements of reproductive healthcare. (While GDC represents physicians, in the present White Paper we use the terms providers or clinicians to also address refusal of care by nurses, midwives, and pharmacists.) As the focus is on health, we examine data on the prevalence of refusal; lay

out the potential consequences for the health of patients and the impact on other health providers and health systems; and report on legal, regulatory, and professional responses. Human rights are intertwined with health, and we draw upon human rights frameworks and decisions throughout. We also refer to bedrock bioethical principles that undergird the practice of medicine in general, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care that is urgently needed. Others have underscored the consequences of negotiating conscientious objection in healthcare in terms of secular/religious tension. Our contribution, which complements all of this previous work, is to provide the medical and public health perspectives and the evidence. We focus on the rights of the provider who conscientiously objects, together with that provider's professional obligations; the rights of the women who need healthcare and the consequences of refusal for their health; and the impact on the health system as a whole.

Conscientious objection is the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs [1]. This originated as opposition to mandatory military service but has increasingly been

\* Corresponding author: Wendy Chavkin, 60 Haven Avenue B-2, New York, NY 10032, USA. Tel.: +1 646 649 9903; fax: +1 646 366 1897.

E-mail address: [wendy@globaldoctorsforchoice.org](mailto:wendy@globaldoctorsforchoice.org); [wc9@columbia.edu](mailto:wc9@columbia.edu) (W. Chavkin).

raised in a wide variety of contested contexts such as education, capital punishment, driver's license requirements, marriage licenses for same-sex couples, and medicine and healthcare. While health providers have claimed conscientious objection to a variety of medical treatments (e.g. end-of-life palliative care and stem cell treatment), the present White Paper addresses conscientious objection to providing certain components of reproductive healthcare. (The terms conscientious objection and conscience-based refusal of care are used interchangeably throughout.) Refusal to provide this care has affected a wide swath of diagnostic procedures and treatments, including abortion and postabortion care; components of assisted reproductive technologies (ART) relating to embryo manipulation or selection; contraceptive services, including emergency contraception (EC); treatment in cases of unavoidable pregnancy loss or maternal illness during pregnancy; and prenatal diagnosis (PND).

Efforts have been made to balance the rights of objecting providers and other health personnel with those of patients. International and regional human rights conventions such as the Convention on the Elimination of All Forms of Discrimination against Women [2], the International Covenant on Civil and Political Rights (ICCPR) [1], the American Convention on Human Rights [3], and the European Convention for the Protection of Human Rights and Fundamental Freedoms [4], as well as UN treaty-monitoring bodies [5,6], have recognized both the right to have access to quality, affordable, and acceptable sexual and reproductive healthcare services and/or the right to freedom of religion, conscience, and thought. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa recognizes the right to be free from discrimination based on religion and acknowledges the right to health, especially reproductive health, as a key human right [7]. These instruments negotiate these apparently competing rights by stipulating that individuals have a right to belief but that the freedom to manifest one's religion or beliefs can be limited in order to protect the rights of others.

The ICCPR, a central pillar of human rights that gives legal force to the 1948 UN Universal Declaration of Human Rights, states in Article 18(1) that [1]:

Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

Article 18(3), however, states that [1]:

Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

International professional associations such as the World Medical Association (WMA) [8] and FIGO [9]—as well as national medical and nursing societies and groups such as the American Congress of Obstetricians and Gynecologists (ACOG) [10]; Grupo Médico por el Derecho a Decidir/GDC Colombia [11]; and the Royal College of Nursing, Australia [12]—have similarly agreed that the provider's right to conscientiously refuse to provide certain services must be secondary to his or her first duty, which is to the patient. They specify that this right to refuse must be bounded by obligations to ensure that the patient's rights to information and services are not infringed.

Conscience-based refusal of care appears to be widespread in many parts of the world. Although rigorous studies are few, estimates range from 10% of OB/GYNs refusing to provide abortions

reported in a UK study [13] to almost 70% of gynecologists who registered as conscientious objectors to abortion with the Italian Ministry of Health [14]. While the impact of the loss of providers may be immediate and most obvious in countries in which maternal death rates from pregnancy, delivery, and illegal abortion are high and represent major public health concerns, consequences at individual and systemic levels have also been reported in resource-rich settings. At the individual level, decreased access to health services brought about by conscientious objection has a disproportionate impact on those living in precarious circumstances, or at otherwise heightened risk, and aggravates inequities in health status. Indeed, too many women, men, and adolescents lack access to essential reproductive healthcare services because they live in countries with restrictive laws, scant health resources, too few providers and slots to train more, and limited infrastructure for healthcare and means to reach care (e.g. roads and transport). The inadequate number of providers is further depleted by the "brain drain" when trained personnel leave their home countries for more comfortable, technically fulfilling, and lucrative careers in wealthier lands [15]. Access to reproductive healthcare is additionally compromised when gynecologists, anesthesiologists, generalists, nurses, midwives, and pharmacists cite conscientious objection as grounds for refusing to provide specific elements of care.

The level of resources allocated by the health system greatly influences the impact caused by the loss of providers due to conscience-based refusal of care. In resource-constrained settings, where there are too few providers for population need, it is logical to assume the following chain of events: further reductions in available personnel lead to greater pressure on those remaining providers; more women present with complications due to decreased access to timely services; and complications require specialized services such as maternal/neonatal intensive care and more highly trained staff, in addition to incurring higher costs. The increased demand for specialized services and staffing burdens and diverts the human and infrastructural resources available for other priority health conditions. However, it is difficult to disentangle the impact of conscientious objection when it is one of many barriers to reproductive healthcare. It is conceptually and pragmatically complicated to sort the contribution to constrained access to reproductive care attributable to conscientious objectors from that due to limited resources, restrictive laws, or other barriers.

What are the criteria for establishing objector status and who is eligible to do so? In the military context, conscientious objector applicants must satisfy numerous procedural requirements and must provide evidence that their beliefs are sincere, deeply held, and consistent [16]. These requirements aim to parse genuine objectors from those who conflate conscientious objection with political or personal opinion. For example, the true conscientious objector to military involvement would refuse to fight in any war, whereas the latter describes someone who disagrees with a particular war but who would be willing to participate in a different, "just" war. Study findings and anecdotal reports from many countries suggest that some clinicians claim conscientious objection for reasons other than deeply held religious or ethical convictions. For example, some physicians in Brazil who described themselves as objectors were, nonetheless, willing to obtain or provide abortions for their immediate family members [17]. A Polish study described clinicians, such as those referred to as the White Coat Underground, who claim conscientious objection status in their public sector jobs but provide the same services in their fee-paying private practices [18]. Other investigations indicate that some claim objector status because they seek to avoid being associated with stigmatized services, rather than because they truly conscientiously object [19].

Moreover, some religiously affiliated healthcare institutions claim objector status and compel their employees to refuse to provide

legally permissible care [20,21]. The right to conscience is generally understood to belong to an individual, not to an institution, as claims of conscience are considered a way to maintain an individual's moral or religious integrity. Some disagree, however, and argue that a hospital's mission is analogous to a conscience-identity resembling that of an individual, and "warrant[s] substantial deference" [22]. Others dispute this on the grounds that healthcare institutions are licensed by states, often receive public financing, and may be the sole providers of healthcare services in communities. Wicclair and Charo both argue that, since a license bestows certain rights and privileges on an institution [22–24], "[W]hen licensees accept and enjoy these rights and privileges, they incur reciprocal obligations, including obligations to protect patients from harm, promote their health, and respect their autonomy" [22].

There are also disputes as to whether obligations and rights vary if a provider works in the public or private sector. Public sector providers are employees of the state and have obligations to serve the public for the greater good, providing the highest "standard of care," as codified in the laws and policies of the state [22]. The Institute of Medicine in the USA defines standard of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" and identifies safety, effectiveness, patient centeredness, and timeliness as key components [25]. WHO adds the concepts of equitability, accessibility, and efficiency to the list of essential components of quality of care [26]. There are legal precedents limiting the scope of conscientious objection for professionals who operate as state actors [23]. Some argue that such limitations can be extended to those who provide health services in the private sector because, as state licensure grants these professions a monopoly on a public service, the professions have a collective obligation to patients to provide non-discriminatory access to all lawful services [23,27]. However, it is more difficult to identify conscience-based refusal of care in the private sector because clinicians typically have discretion over the services they choose to offer, although the same professional obligations of providing patients with accurate information and referral pertain.

An alternative framing is provided by the concept of *conscientious commitment* to acknowledge those providers whose conscience motivates them to deliver reproductive health services and who place priority on patient care over adherence to religious doctrines or religious self-interest [28,29]. Dickens and Cook articulate that conscientious commitment "inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health" [28]. They assert that, because provision of care can be conscience based, full respect for conscience requires accommodation of both objection to participation and commitment to performance of services such that the latter group of providers also have the right to not suffer discrimination on the basis of their convictions [28]. This principle is articulated by FIGO [9]; according to the FIGO "Resolution on Conscientious Objection," "Practitioners have a right to respect for their conscientious convictions in respect both not to undertake and to undertake the delivery of lawful procedures" [30].

We begin the present White Paper with a review of the limited data regarding the prevalence of conscience-based refusal of care and objectors' motivations. Descriptive prevalence data are needed in order to assess the distribution and scope of this phenomenon and it is necessary to understand the concerns of those who refuse in order to design respectful and effective responses. We review the data; point out the methodologic, geographic, and other limitations; and specify some questions requiring further investigation. Next, we explore the consequences of conscientious objection for patients and for health systems. Ideally, we would evaluate empirical evidence on the impact of conscience-based

refusal on delay in obtaining care for patients and their families, society, healthcare providers, and health systems. As such research has not been conducted, we schematically delineate the logical sequence of events if care is refused.

We then look at responses to conscience-based refusal of care by transnational bodies, governments, health sector and other employers, and professional associations. These responses include establishment of criteria for obtaining objector status, required disclosure to patients, registration of objector status, mandatory referral to willing providers, and provision of emergency care. We draw upon analyses performed by others to categorize the different models used: legislative, constitutional, case law, regulatory, employment requirements, and professional standards of care. Finally, we provide recommendations for further research and for ways in which medical and public health organizations could contribute to the development and implementation of policies to manage conscientious objection.

The present White Paper draws upon medical, public health, legal, ethical, and social science literature of the past 15 years in English, French, German, Italian, Portuguese, and Spanish available in 2013. It is intended to be a state-of-the-art compendium useful for health and other policymakers negotiating the balance of an individual provider's rights to "conscience" with the systemic obligation to provide care and it will need updating as further evidence and policy experiences accrue. It is intended to highlight the importance of the medical and public health perspectives, employ a human rights framework for provision of reproductive health services, and emphasize the use of scientific evidence in policy deliberations about competing rights and obligations.

## 2. Review of the evidence

### 2.1. Methods

We reviewed data regarding the prevalence of conscientious objection and the motivations of objectors in order to assess the distribution and scope of the phenomenon and to have an empirical basis for designing respectful and effective responses. However, estimates of prevalence are difficult to obtain; there is no consensus about criteria for objector status and, thus, no standardized definition of the practice. Moreover, it is difficult to assess whether findings in some studies reflect intention or actual behavior. The few countries that require registration provide the most solid evidence of prevalence.

A systematic review could not be performed because the data are limited in a variety of ways (which we describe), making most of them ineligible for inclusion in such a process. We searched systematically for data from quantitative, qualitative, and ethnographic studies and found that many have non-representative or small samples, low response rates, and other methodologic limitations that limit their generalizability. Indeed, the studies reviewed are not comparable methodologically or topically. The majority focus on conscience-based refusal of abortion-related care and only a few examine refusal of emergency or other contraception, PND, or other elements of care. Some examine provider attitudes and practices related to abortion in general, while others investigate these in terms of the specific circumstances for which people seek the service: for example, financial reasons, sex selection, failed contraception, rape/incest, fetal anomaly, and maternal life endangerment. Some rely on closed-ended electronic or mail surveys, while others employ in-depth interviews. Most focus on physicians; fewer study nurses, midwives, or pharmacists.

These investigations are also limited geographically because more were conducted in higher-income than lower-income countries. Because of both greater resources and more liberalized reproductive health laws and policies, many higher-income coun-



tries offer a greater range of legal services and, consequently, more opportunities for objection. Assessment of the impact of conscience-based refusal of care in resource-constrained settings presents additional challenges because high costs and lack of skilled providers may dwarf this and other factors that impede access. Acknowledging that conscientious objection to reproductive health-care has yet to be rigorously studied, we included all studies we were able to locate within the past 15 years, and present the cross-cutting themes as topics for future systematic investigation.

## 2.2. Prevalence and attitudes

The sturdiest estimates of prevalence come from a limited sample of those few places that require objectors to register as such or to provide written notification. 70% of OB/GYNs and 50% of anesthesiologists have registered with the Italian Ministry of Health as objectors to abortion [31]. While Norway and Slovenia require some form of registration, neither has reported prevalence data [32–34]. Other estimates of prevalence derive from surveys with varied sampling strategies and response rates. In a random sample of OB/GYN trainees in the UK, almost one-third objected to abortion [35]. 14% of physicians of varied specialties surveyed in Hong Kong reported themselves to be objectors [36]. 17% of licensed Nevada pharmacists surveyed objected to dispensing mifepristone and 8% objected to EC [37]. A report from Austria describes many regions without providers and a report from Portugal indicates that approximately 80% of gynecologists there refuse to perform legal abortions [38–40].

Other studies have investigated opinions about abortion and intention to provide services. A convenience sample of Spanish medical and nursing students indicated that most support access to abortion and intend to provide it [41]. A survey of medical, nursing, and physician assistant students at a US university indicated that more than two-thirds support abortion yet only one-third intend to provide, with the nursing and physician assistant students evincing the strongest interest in doing so [42]. The 8 traditional healers interviewed in South Africa were opposed to abortion [43], and an ethnographic study of Senegalese OB/GYNs, midwives, and nurses reported that one-third thought the highly restrictive law there should permit abortion for rape/incest, although very few were willing to provide services (unpublished data).

Some studies indicate that a subset of providers claim to be conscientious objectors when, in fact, their objection is not absolute. Rather, it reflects opinions about patient characteristics or reasons for seeking a particular service. For example, a stratified random sample of US physicians revealed that half refuse contraception and abortion to adolescents without parental consent, although the law stipulates otherwise [44]. A survey of members of the US professional society of pediatric emergency room physicians indicated that the majority supported prescription of EC to adolescents but only a minority had done so [45]. A study of the postabortion care program in Senegal, intended to reduce morbidity and mortality due to complications from unsafe abortion, found that some providers nonetheless delayed care for women they suspected of having had an induced abortion (unpublished data).

Willingness to provide abortions varies by clinical context and reason for abortion, as demonstrated by a stratified random sample of OB/GYN members of the American Medical Association (AMA) [46]. A survey of family medicine residents in the USA assessing prevalence of moral objection to 14 legally available medical procedures revealed that 52% supported performing abortion for failed contraception [47]. Despite opposition to voluntary abortion, more than three-quarters of OB/GYNs working in public hospitals in the Buenos Aires area from 1998 to 1999 supported abortion for maternal health threat, severe fetal anomaly, and rape/incest [48]. While 10% of a random sample of consultant OB/GYNs in the UK

described themselves as objectors, most of this group supported abortion for severe fetal anomaly [13].

Other inconsistencies regarding refusal of care derived from the provider's familiarity with a patient, experience of stigmatization, or opportunism. A Brazilian study reported that Brazilian gynecologists were more likely to support abortion for themselves or a family member than for patients [17]. Physicians in Poland and Brazil reported reluctance to perform legally permissible abortions because of a hostile political atmosphere rather than because of conscience-based objection. The authors also noted that conscientious objection in the public sphere allowed doctors to funnel patients to private practices for higher fees [19].

Not surprisingly, higher levels of self-described religiosity were associated with higher levels of disapproval and objection regarding the provision of certain procedures [49]. Additionally, a random sample of UK general practitioners (GPs) [50], a study of Idaho licensed nurses [51], a study of OB/GYNs in a New York hospital [52], and a cross-sectional survey of OB/GYNs and midwives in Sweden [53] found self-reported religiosity to be associated with reluctance to perform abortion. A study of Texas pharmacists found the same association regarding refusal to prescribe EC [54].

Higher acceptance of these contested service components and lower rates of objection were associated with higher levels of training and experience in a survey of medical students and physicians in Cameroon and in a qualitative study of OB/GYN clinicians in Senegal [55,56]. Similar patterns prevailed in a survey of Norwegian medical students [57] and among pharmacists and OB/GYNs in the USA [45].

Clinicians' refusal to provide elements of ART and PND also varied, at times motivated by concerns about their own lack of competence with these procedures. And, while the majority of Danish OB/GYNs and nurses (87%) in a non-random sample supported abortion and ART, 69% opposed selective reduction [49]. A random sample of OB/GYNs from the UK indicated that 18% would not agree to provide a patient with PND [13].

Several studies report institutional-level implications consequent to refusal of care. Physicians and nurse managers in hospitals in Massachusetts said that nurse objection limited the ability to schedule procedures and caused delays for patients [58]. Half of a stratified random sample of US OB/GYNs practicing primarily at religiously affiliated hospitals reported conflicts with the hospital regarding clinical practice; 5% reported these to center on treatment of ectopic pregnancy [59]. 52% of a non-random sample of regional consultant OB/GYNs in the UK said that insufficient numbers of junior doctors are being trained to provide abortions owing to opting out and conscientious objection [35]. A 2011 South African report states that more than half of facilities designated to provide abortion do not do so, partly because of conscientious objection, resulting in the persistence of widespread unsafe abortion, morbidity, and mortality [60]. A non-random sample of Polish physicians reported that institutional, rather than individual, objection was common [19]. Similar observations have been made about Slovakian hospitals [61].

A few investigations have explored clinician attitudes toward regulation of conscience-based refusal of reproductive healthcare. Two studies from the USA indicate that majorities of family medicine physicians in Wisconsin and a random sample of US physicians believe physicians should disclose objector status to patients [44,47]. A survey of UK consultants revealed that half want the authority to include abortion provision in job descriptions for OB/GYN posts, and more than one-third think objectors should be required to state their reasons [35]. Interviews with a purposive sample of Irish physicians revealed mixed opinions about the obligation of objectors to refer to other willing providers, as well as awareness that women traveled abroad for abortions and related services that were denied at home [62].

While the reviewed literature indicates widespread occurrence of conscientious objection to providing some elements of reproductive healthcare, it does not offer a rigorously obtained evidentiary basis from which to map the global landscape. Assessment of the prevalence of conscientious objection requires ascertainment of the number objecting (numerator) and the total count of the relevant population of providers comprising the denominator (e.g. the number of OB/GYNs claiming conscientious objection to providing EC and the total population of OB/GYNs). Registration of objectors, as required by the Italian Ministry of Health, provides such data. Professional societies could also systematically gather data by surveying members on their practices related to conscience-based refusal of care or by including such self-identification on standard mandatory forms. Academic institutions or other research organizations could conduct formal studies or add questions on conscience-based refusal of care to ongoing general surveys of clinicians.

Aside from prevalence, there are a host of key questions. Further research on motivations of objectors is required in order to better understand reasons other than conscience-based objection that may lead to refusal of care. As the studies reviewed indicate, these factors may include desire to avoid stigma, to avoid burdensome administrative processes, and to earn more money by providing services in private practice rather than in public facilities; knowledge gaps in professional training; and lack of access to necessary supplies or equipment. Qualitative studies would best probe these complicated motivations.

What is the impact of conscience-based refusal of care? In the next section, we outline systemic and biologically plausible sequences of events when specified care components are refused. Research is needed to see whether these hold true and have health consequences for women and practical consequences for other clinicians and the health system as a whole. Research could illuminate women's experiences when refused care—their understanding, access to safe and unsafe alternatives, emotional response, and course of action. Investigations on the clinician side could further explore the experiences of those who do provide services after others have refused to do so. Each of these questions is likely to have context-specific answers, so research should take place in varied geopolitical settings, and the contextual nature of the findings must be made clear.

Do clinicians consider conscientious objection to be problematic? What kinds of constraints on provider behavior do clinicians consider appropriate or realistic? When enacted, have such policies or regulations been implemented? Have those implemented effectively met their purported objectives? What mechanisms of regulation do women consider reasonable? Do they perceive conscience-based refusal of care as a significant barrier to reproductive health services? Could enhanced training and updated medical and nursing school curricula devoted to reproductive health address the lack of clinical skills that contributes to refusal of care? Could further education clarify which services are permitted by law, and under which circumstances, and thus reassure clinicians sufficiently such that they provide care? Empirical evidence is essential as varied political actors try to respond to these competing concerns with policies or regulations.

### 3. Consequences of refusal of reproductive healthcare for women and for health systems

We lay out the potential implications of conscience-based refusal of care for patients and for health systems in 5 areas of reproductive healthcare—abortion and postabortion care, ART, contraception, treatment for maternal health risk and unavoidable pregnancy loss, and PND. Because we lack empirical data to explore the impact of conscience-based refusal of care on patients

and health systems, we build logical models delineating plausible consequences if a particular component of care is refused. We provide visual schemata to represent these pathways and we use data and examples of refusal from around the world to ground them.

We attempt to isolate the impact of conscientious objection for each of the 5 reproductive health components, although we recognize the difficulties of identifying the contributions attributable to other barriers to access. These include limited resources, inadequate infrastructure, failure to implement policies, sociocultural practices, and inadequate understanding of the relevant law by providers and patients alike.

We start from the premise that refusal of care leads to fewer clinicians providing specific services, thereby constraining access to these services. We posit that those who continue to provide these contested services may face stigma and/or become overburdened. We specify plausible health outcomes for patients, as well as the consequences of refusal for families, communities, health systems, and providers.

#### 3.1. Conscience-based refusal of abortion-related services

The availability of safe and legal abortion services varies greatly by setting. Nearly all countries in the world allow legal abortion in certain cases (e.g. to save the life of the woman, in cases of rape, and in cases of severe fetal anomaly). Few countries prohibit abortion in all circumstances. While some among these allow the criminal law defense of necessity to permit life-saving abortions, Chile, El Salvador, Malta, and Nicaragua restrict even this recourse. Other countries with restrictive laws are not explicit or clear about those circumstances in which abortion is allowed [63].

In many countries, particularly in low-resource areas, access to legal services is compromised by lack of resources for health services, lack of health information, inadequate understanding of the law, and societal stigma associated with abortion [64].

There is substantial evidence that countries that provide greater access to safe, legal abortion services have negligible rates of unsafe abortion [65]. Conversely, nearly all of the world's unsafe abortions occur in restrictive legal settings. Where access to legal abortion services is restricted, women seek services under unsafe circumstances. Approximately 21.6 million of the world's annual 46 million induced abortions are unsafe, with nearly all of these (98%) occurring in resource-limited countries [65,66]. In low-income countries, more than half of abortions performed (56%) are unsafe, compared with 6% in high-income areas [66]. Nearly one-quarter (more than 5 million) of these result in serious medical complications that require hospital-based treatment [67, 68]; 47,000 women die each year because of unsafe abortion and an additional unknown number of women experience complications from unsafe abortions but do not seek care [68]. While the international health community has sought to mitigate the high rates of maternal morbidity and mortality caused by unsafe abortion through postabortion care programs [56], the implementation and effectiveness of these have been undermined by conscience-based refusal of care [24,56,69].

We posit that conscience-based refusal of care will have less of an impact at the population level in countries with available safe, legal abortion services than in those where access is restricted. Women living in settings in which legal abortion is widely available and who experience provider refusal will be more likely to find other willing providers offering safe, legal services than women in settings in which abortion is more highly restricted. We ground our model (Fig. 1) in the following examples: (1) in South Africa, widespread conscientious objection limits the numbers of willing providers and, thus, access to safe care, and the number of unsafe abortions has not decreased since the legalization of abortion in

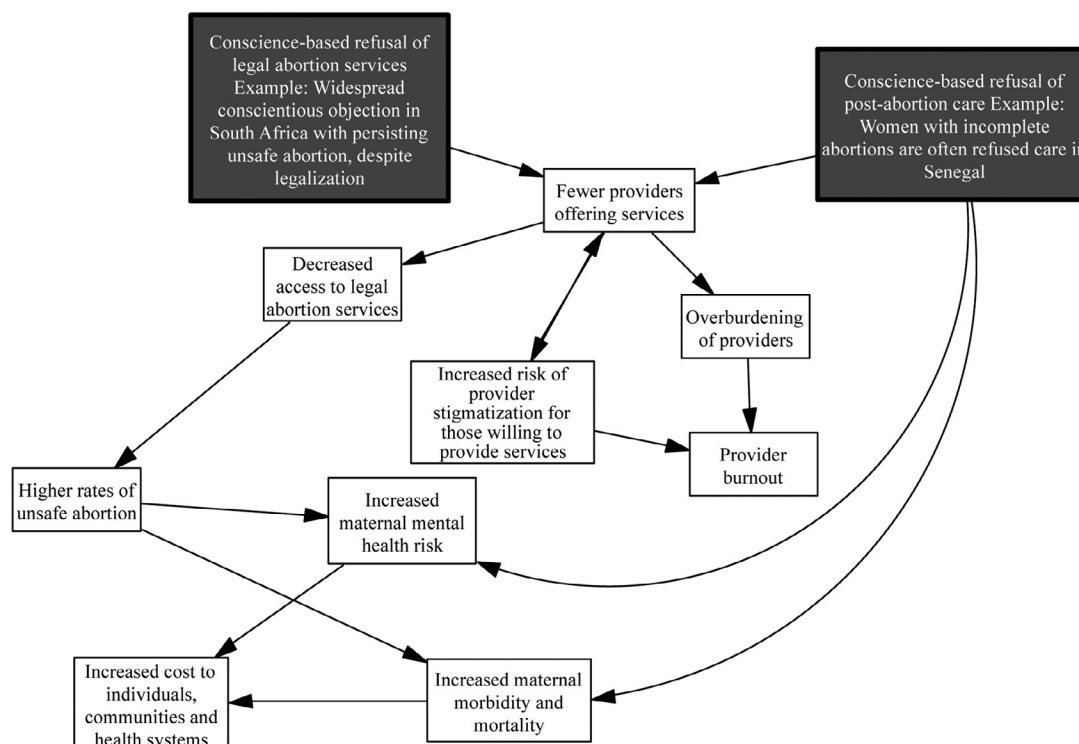


Fig. 1. Consequences of refusal of abortion-related services.

1996 [70,71]; (2) although Senegal's postabortion care program is meant to mitigate the grave consequences of unsafe abortion, conscientious objection is, nevertheless, often invoked when abortion is suspected of being induced rather than spontaneous [56] (unpublished data).

### 3.2. Conscience-based refusal of components of ART

Infertility is a global public health issue affecting approximately 8%–15% of couples [72,73], or 50–80 million people [74], worldwide. Although the majority of those affected reside in low-resource countries [72,73], the use of ART is much more likely in high-resource countries.

Access to specific ART varies by socioeconomic status and geographic location, between and within countries. In high-resource countries, the cost of treatment varies greatly depending on the healthcare system and the availability of government subsidy [75]. For example, in 2006, the price of a standard in vitro fertilization (IVF) cycle ranged from US\$3956 in Japan to \$12,513 in the USA [76]. After government subsidization in Australia, the cost of IVF averaged 6% of an individual's annual disposable income; it was 50% without subsidization in the USA [77]. In low-income countries, despite high rates of infertility, there are few resources available for ART, and costs are generally prohibitive for the majority of the population. Because these economic and infrastructural factors drive lack of access to ART in low-income countries, we posit that denial of services owing to conscience-based refusal of care is not a major contributing factor to limited access in these settings. Therefore, for the model (Fig. 2), we primarily examine the consequences of conscientious objection to components of ART in middle- to high-income countries. At times, regulations and policies regarding ART stem from empirically based concerns, grounded in medical evidence, about health outcomes for women and their offspring or health system priorities. Our focus, however, is on those instances in which some physicians practice according to moral or religious beliefs, even when these contradict best medical practices. In some Latin American countries, despite the medical evidence that mater-

nal and fetal outcomes are markedly superior when fewer embryos are implanted, the objection to embryo selection/reduction and cryopreservation promoted by the Catholic Church has reportedly led many physicians to avoid these [78]. Anecdotal reports from Argentina describe ART physicians' avoidance of cryopreservation and embryo selection/reduction following the self-appointment of a lawyer and member of Opus Dei as legal guardian for cryopreserved embryos [78,79]. The only example that illustrates the implications of denial of preimplantation genetic diagnosis (PGD) refers to a legal ban, rather than conscience-based refusal of care. Nonetheless, we use it to describe the potential consequences when such care is denied. In 2004, Italy passed a law banning PGD, cryopreservation, and gamete donation [80]. This ban compelled a couple who were both carriers of the gene for  $\beta$ -thalassemia to wait to undergo amniocentesis and then to have a second-trimester abortion rather than allow the abnormality to be detected prior to implantation [80] (Fig. 2).

### 3.3. Conscience-based refusal of contraceptive services

The availability of the range of contraceptive methods varies by setting, as does prevalence of use [81]. In general, contraceptive use is correlated with level of income. In 2011, 61.3% of women aged 15–49 years, married or in a union, in middle-upper-income countries were using modern methods, compared with 25% in the lowest-resource countries [81,82]. Within countries, access to and use of methods also vary. For example, according to the 2003 Demographic and Health Survey of Kenya (a cross-sectional study of a nationally representative sample), women in the richest quintile were reported to have significantly higher odds for using long-term contraceptive methods (intrauterine device, sterilization, implants) than women in the poorest quintile [82].

The legal status of particular contraceptive methods also varies by setting. In Honduras, Congress passed a bill banning EC, which has not yet been enacted into law [83]. Even when contraception is legal, lack of basic resources allocated by government programs may compromise availability of particular methods. High manufacturing

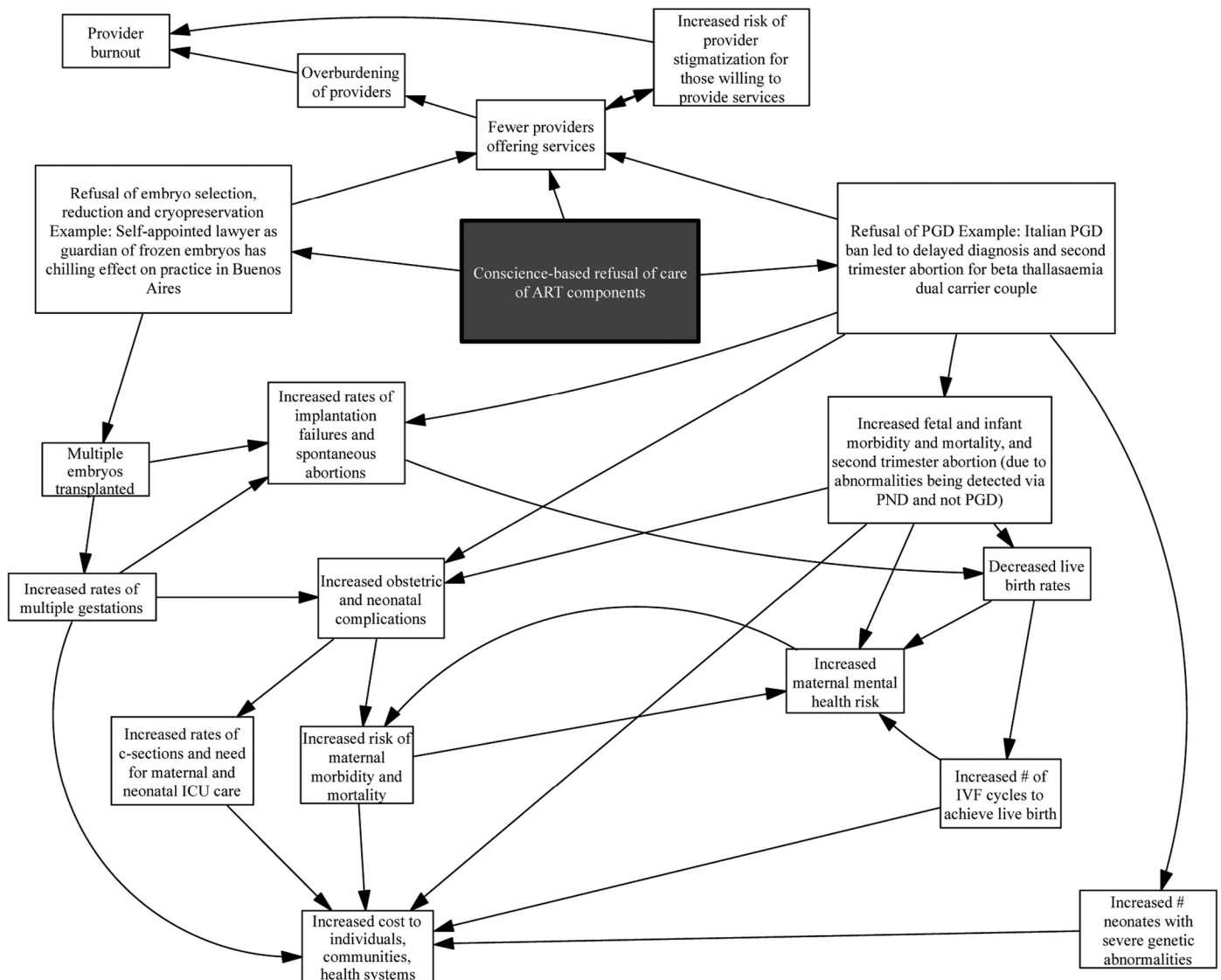


Fig. 2. Consequences of refusal of components of assisted reproductive technologies.

costs or steep prices can also undermine access [84]. In other cases, individual health providers opt not to provide contraception to all or to certain groups of women. Some providers refuse to provide specific methods such as EC or sterilization. In Poland, there is widespread refusal to provide contraceptive services (J. Mishtal, personal communication, April 2012). In Oklahoma, a rape victim was denied EC by a doctor [85], and in Germany a rape victim was denied EC by 2 Catholic hospitals in 2012 [86]. In Fig. 3, we delineate potential implications of conscience-based refusal of contraceptive services.

### 3.4. Conscience-based refusal of care in cases of risk to maternal health and unavoidable pregnancy loss

In some circumstances, pregnancy can exacerbate a serious maternal illness or maternal illness may require treatment hazardous to a fetus. In these cases, women require access to life-saving treatment, which may include abortion. Yet women have been denied appropriate treatment. Women seeking completion of inevitable pregnancy loss due to ectopic pregnancy or spontaneous abortion have also been denied necessary care.

It is beyond the scope of the present White Paper to define the full range of conditions that may be exacerbated by pregnancy

and jeopardize the health of the pregnant woman. However, the incidence of ectopic pregnancy ranges from 1% to 16% [87–90], and 10%–20% of all clinically recognized pregnancies end in spontaneous abortion [90]. Often, refusal of care in circumstances of maternal health risk occurs in the context of highly restrictive abortion laws. We refer to 3 cases from around the world (Fig. 4) to highlight this phenomenon in our model. In Ireland in 2012, Savita Halappanavar, 31, presented at a Galway hospital with ruptured membranes early in the second trimester. She was refused completion of the inevitable spontaneous abortion, developed sepsis, and subsequently died [91]. Z's daughter, a young Polish woman, was diagnosed with ulcerative colitis while she was pregnant [92]. She was repeatedly denied medical treatment; physicians stated that they would not conduct procedures or tests that might result in fetal harm or termination of the pregnancy [92]. She developed sepsis, experienced fetal demise, and died. The only example that illustrates the implications of denial of treatment for ectopic pregnancy derives from legal bans, rather than from an example of conscience-based refusal of care. In El Salvador, a total prohibition on abortion has led to physician refusal to treat ectopic pregnancy [93]; in Nicaragua, the abortion ban results in delay of treatment for ectopic pregnancies, despite law and medical guidelines mandating the contrary [94] (Fig. 4).



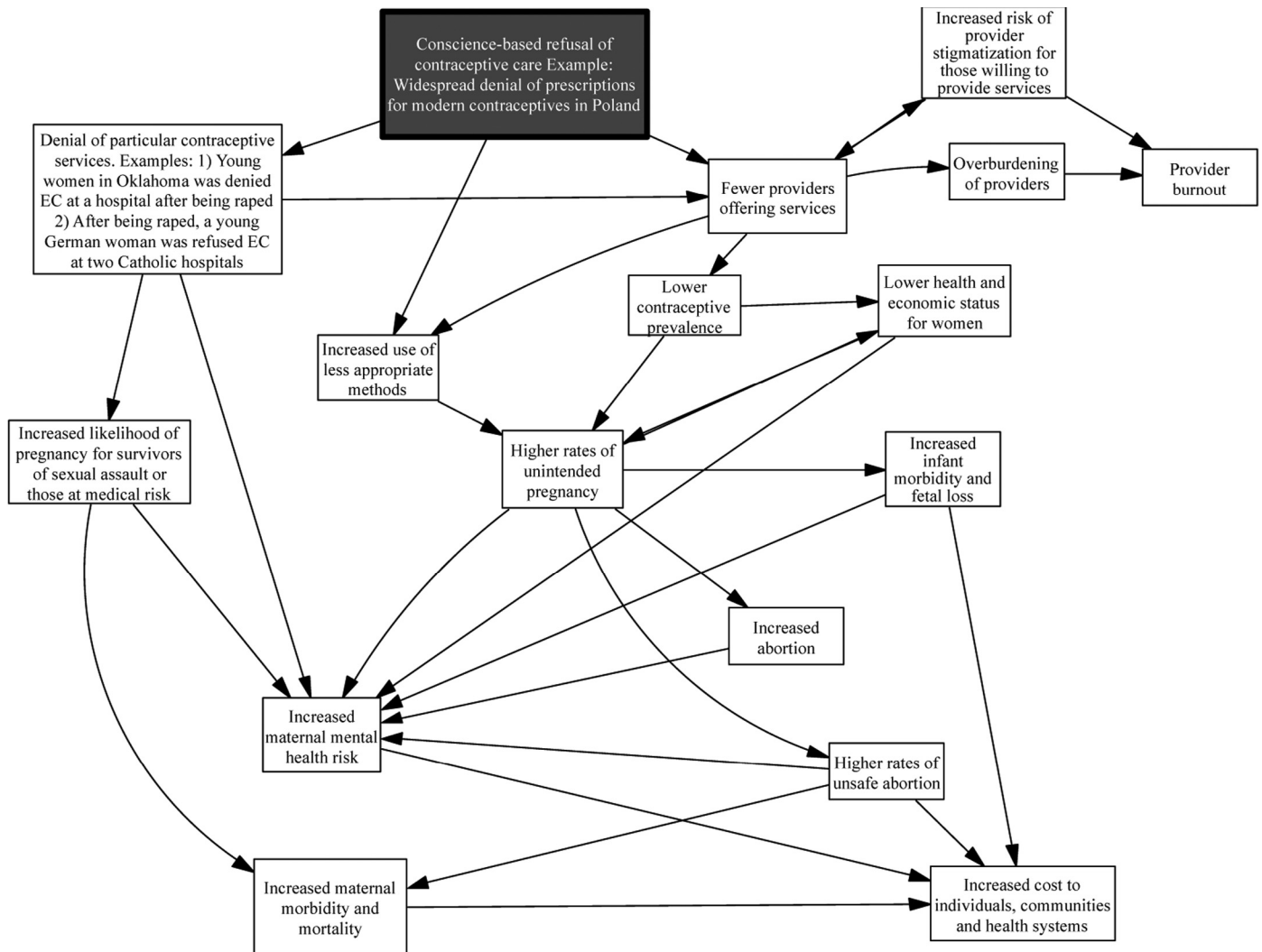


Fig. 3. Consequences of refusal of contraceptive services.

### 3.5. Conscience-based refusal of PND

The availability of PND varies greatly by setting—with those in middle–upper-income countries having access to testing for a variety of genetic conditions and structural anomalies, and fewer having access to a more limited series of testing in low-income countries. Access to PND provides women with information so that they can make decisions and/or preparations when severe or lethal fetal anomalies are detected. Outcomes for affected neonates vary by country resource level; PND enables physicians to plan for the level of care needed during delivery and in the neonatal period. With PND, families are also afforded the time to secure the necessary emotional and financial resources to prepare for the birth of a child with special needs [95,96]. In settings in which there are fewer resources available for PND, conscientious objection further restricts women's access to services. Figure 5 presents pathways and implications of provider conscience-based refusal to provide PND services. Because most data on access to PND are from high-resource countries, we must project what would happen in lower-income countries. We use the example of R.R., a Polish woman who was repeatedly refused diagnostic tests to assess fetal status after ultrasound detection of a nuchal hygroma [97] (Fig. 5).

### 4. Policy responses to manage conscience-based refusal of reproductive healthcare

Here, we review various policy interventions related to conscience-based refusal of care. Initially, we look at the context established by human rights standards or human rights bodies wherein freedom of conscience is enshrined. The UN Committee on Economic, Social and Cultural Rights (CESCR); the UN Committee on the Elimination of Discrimination against Women (CEDAW); and the UN Human Rights Committee have commented on the need to balance providers' rights to conscience with women's rights to have access to legal health services [98–104]. CEDAW asserts that “it is discriminatory for a country to refuse to legally provide for the performance of certain reproductive health services for women” and that, if healthcare providers refuse to provide services on the basis of conscientious objection, “measures should be introduced to ensure that women are referred to alternative health providers” [99]. CESCR has called on Poland to take measures to ensure that women enjoy their rights to sexual and reproductive health, including by “enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection” [104].

The international medical and public health communities, including FIGO in its Ethical Guidelines on Conscientious Objection (2005) [9] and WHO in its updated Safe Abortion Guidelines (2012) [105], have agreed on principles related to the management of

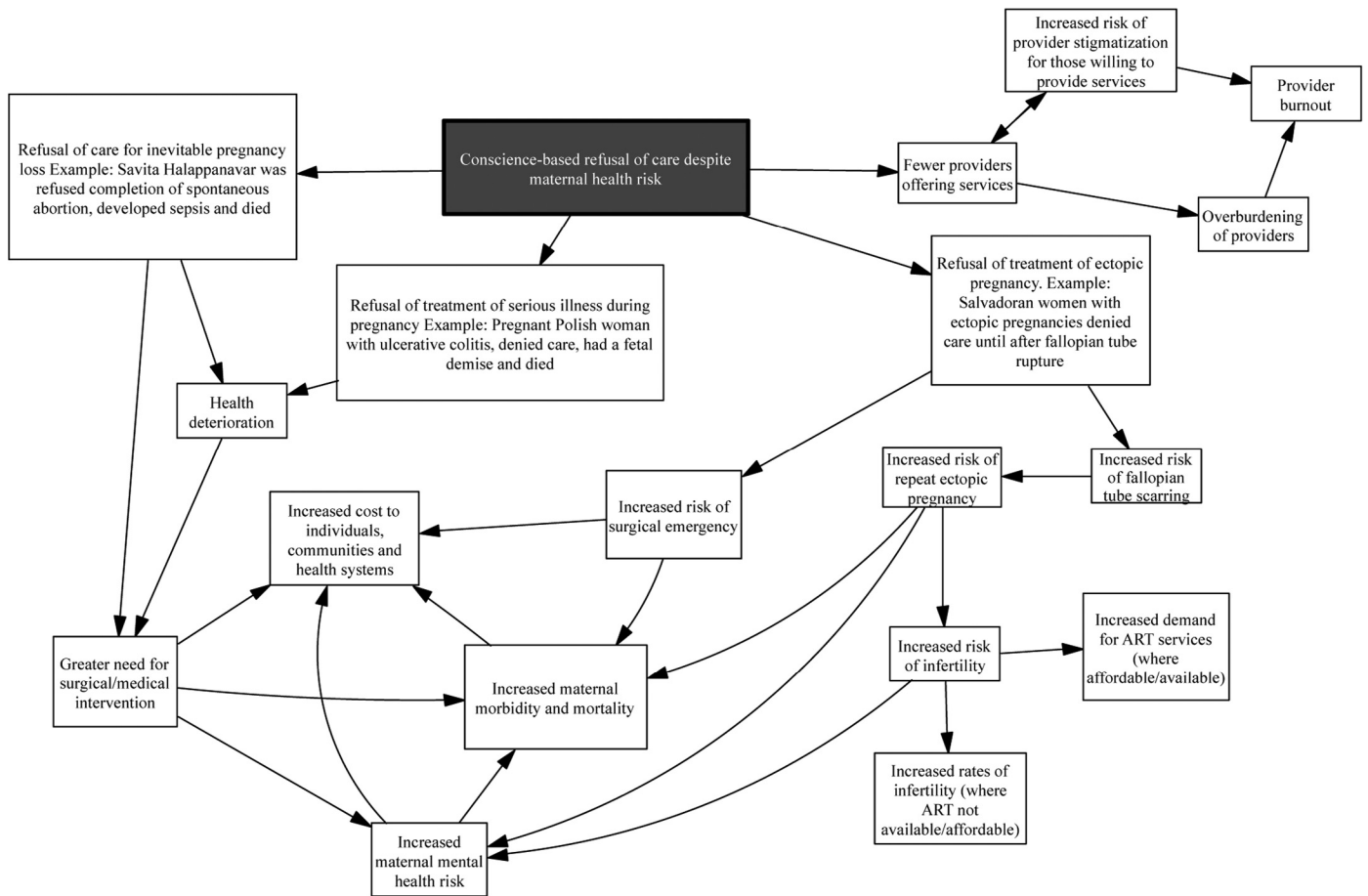


Fig. 4. Consequences of refusal of care in cases of risk to maternal health and unavoidable pregnancy loss.

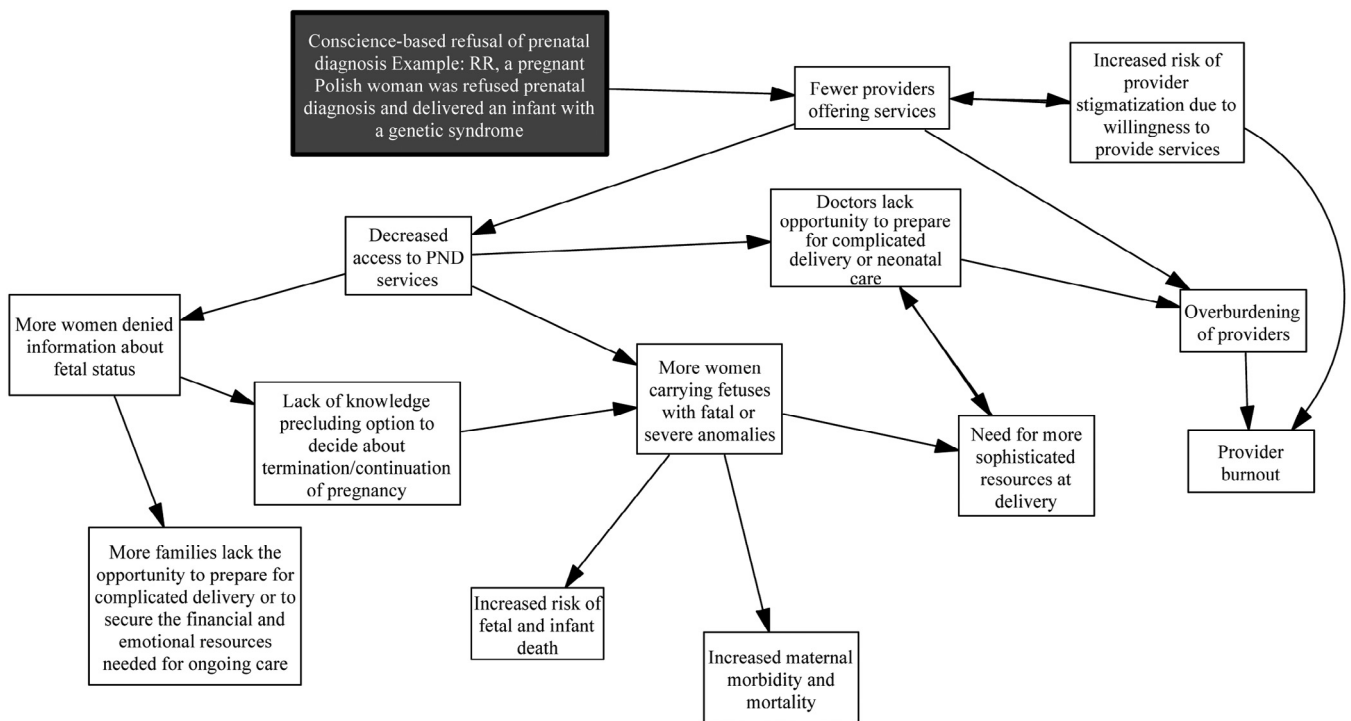


Fig. 5. Consequences of refusal of prenatal diagnosis.

conscientious objection to reproductive healthcare provision. While these are non-binding recommendations, they do assert professional standards of care. These include the following:

- Providers have a right to conscientious objection and not to suffer discrimination on the basis of their beliefs.
- The primary conscientious duty of healthcare providers is to



treat, or provide benefit and prevent harm to patients; conscientious objection is secondary to this primary duty.

Moreover, the following safeguards must be in place in order to ensure access to services without discrimination or undue delays:

- Providers have a professional duty to follow scientifically and professionally determined definitions of reproductive health services, and not to misrepresent them on the basis of personal beliefs.
- Patients have the right to be referred to practitioners who do not object for procedures medically indicated for their care.
- Healthcare providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, including those that providers object to on grounds of conscience.
- Providers must provide timely care to their patients when referral to other providers is not possible and delay would jeopardize patients' health.
- In emergency situations, providers must provide the medically indicated care, regardless of their own personal objections.

These statements support both sides of the tension: the right of patients to have access to appropriate medical care and the right of providers to object, for reasons of conscience, to providing particular forms of care. They underscore the professional obligation of healthcare providers to ensure timely access to care, through provision of accurate information, referral, and emergency care. At the transnational level, human rights consensus documents have asserted that institutions and individuals are similarly bound by their obligations to operate according to the bedrock principles that underpin the practice of medicine, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care in emergency situations.

At the country level, however, there is no agreement as to whether institutions can claim objector status. For example, Spain [106], Colombia [107], and South Africa [108] have laws stating that refusal to perform abortions is always an individual, not an institutional, decision. Conversely, Argentinian law [109,110] gives private institutions the ability to object and requires private health centers to register as conscientious objectors with local health authorities. In Uruguay, the Ethical Code does not require the institution employing a conscientious objector to provide referral services, although a newly proposed bill would require such referral [111,112]. In the USA, the question of institutional rights and obligations is hotly debated and the situation is complicated and unresolved. Currently, federal law forbids agencies receiving federal funding from discriminating against any healthcare entity that refuses to provide abortion services [113]. Yet other federal law requires institutions providing services for low-income people to maintain an adequate network of providers and to guarantee that individuals receive services without additional out-of-pocket cost [114].

International and regional human rights bodies, governments, courts, and health professional associations have developed various responses to address conscience-based refusal of care. These responses differ as to whose rights they protect: the rights of a woman to have access to legal services or the rights of a provider to object based on reasons of conscience. They might also have different emphases or targets. Some focus on ensuring an adequate number of providers for a certain service, some concentrate on ensuring that women receive timely referrals to non-objecting practitioners, and some seek to establish criteria for designation as an objector. For example, Norway established a comprehensive regulatory and oversight framework on conscientious objection to abortion, which includes ensuring the availability of providers

[33,115]. In Colombia, the Constitutional Court affirmed that conscientious objection must be grounded in true religious conviction, rather than in a personal judgment of "rightness" [116].

Some of these responses are legally binding through national constitutional provisions, legislation, or case law. The European Court of Human Rights (ECHR), whose rulings are legally binding for member nations, clarified the obligation of states to organize the practice of conscience-based refusal of care to ensure that patients have access to legal services, specifically to abortion [97]. Professional associations and employers have developed other interventions, including job requirements and non-binding recommendations. In Germany, for example, a Bavarian High Administrative Court decision [117], upheld by the Federal Administrative Court [118], ruled that it was permissible for a municipality to include ability and willingness to perform abortions as a job criterion. In Norway, employers can refuse to hire objectors and employment advertisements may require performance of abortion as a condition for employment [112]. In Sweden, Bulgaria, Czech Republic, Finland, and Iceland, healthcare providers are not legally permitted to conscientiously object to providing abortion services [38]. Some require referral to non-objecting providers. For example, in the recent *P. and S. v. Poland* case, the ECHR emphasized the need for referrals to be put in writing and included in patients' medical records [119]. In Argentina [110] and France [120], legislation requires doctors who conscientiously object to refer patients to non-objecting practitioners. Similar laws exist in Victoria, Australia [121], Colombia [116,122,123], Italy [124], and Norway [115]. Professional and medical associations around the world recommend that objectors refer patients to non-objecting colleagues. ACOG in the USA [125] and El Sindicato Médico in Uruguay [126] recommend that objectors refer patients to other practitioners. The British Medical Association (BMA) specifies that practitioners cannot claim exemption from giving advice or performing preparatory steps (including referral) where the request for an abortion meets legal requirements [127]. The WMA asserts that, if a physician must refuse a certain service on the basis of conscience, s/he may do so after ensuring the continuity of medical care by a qualified colleague [128]. FIGO maintains that patients are entitled to referral to practitioners who do not object [9].

Pharmacists' associations in the USA and UK have made similar recommendations. The American Society of Health-System Pharmacists asserts that pharmacists and other pharmacy employees have the right not to participate in therapies they consider to be morally objectionable but they must make referrals in an objective manner [129]; the AMA guidelines state that patients have the right to receive an immediate referral to another dispensing pharmacy if a pharmacist invokes conscientious objection [130]. In the UK, pharmacists must also have in place the means to make a referral to another relevant professional within an appropriate time frame [131].

Some jurisdictions mandate registration of objectors or require objectors to provide advance written notice to employers or government bodies. In Spain, for example, the law requires that conscientious objection must be expressed in advance and in written form to the health institution and the government [106]. Italian law also requires healthcare personnel to declare their conscientious objection to abortion to the medical director of the hospital or nursing home in which they are employed and to the provincial medical officer no later than 1 month after date of commencement of employment [124]. Victoria, Australia [118]; Colombia [123]; Norway [115]; Madagascar [132]; and Argentina [109] have similar laws. In Norway, the administrative head of a health institution must inform the county municipality of the number of different categories of health personnel who are exempted on grounds of conscience [115]. Argentinian law [109] gives private institutions the ability to object, requiring these

institutions to register as conscientious objectors with local health authorities and to guarantee care by referring women to other centers. Argentinian law also states that an individual objector cannot provide services in a private health center that s/he objects to the provision of in the public health system [110]. Regulation in Canada requires pharmacists to ensure that employers know about their conscientious objector status and to prearrange access to an alternative source for treatment, medication, or procedure [133]. The Code of Ethics for nurses in Australia also requires disclosure to employers [134]. In Northern Ireland, a guidance document by the Department of Health, Social Services and Public Safety asserts that an objecting provider “should have in place arrangements with practice colleagues, another GP practice, or a Health Social Care Trust to whom the woman can be referred” for advice or assessment for termination of pregnancy [135].

Other measures require disclosure to patients about providers’ status as objectors. For example, the law in the state of Victoria, Australia, requires objectors to inform the woman and refer her to a willing provider [121]. In Argentina, the Technical Guide for Comprehensive Legal Abortion Care 2010 [109] requires that all women be informed of the conscientious objections of medical, treating, and/or support staff at first visit. Portugal’s medical ethical guidelines encourage doctors to communicate their objection to patients [136].

The right to receive information in healthcare, including reproductive health information, is enshrined in international law. For example, the ECHR determined that denial of services essential to making an informed decision regarding abortion can constitute a violation of the right to be free from inhuman and degrading treatment [97]. At the national level, laws have mandated disclosure of health information to patients. For example, according to the South African abortion law, providers, including objectors, must ensure that pregnant women are aware of their legal rights to abortion [108]. In Spain, women are entitled to receive information about their pregnancies (including prenatal testing results) from all providers, including those registered as objectors [106]. In the UK, objectors are legally required to disclose their conscientious objector status to patients, to tell them they have the right to see another doctor, and to provide them with sufficient information to enable them to exercise that right [137–139].

Professional guidelines have also addressed disclosure of health information. In Argentina, any delaying tactics, provision of false information, or reluctance to carry out treatment by health professionals and authorities of hospitals is subject to administrative, civil, and/or criminal actions [109]. FIGO asserts that the ethical responsibility of OB/GYNs to prevent harm requires them to provide patients with timely access to medical services, including giving them information about the medically indicated options for their care [9].

Some require the provision of services in cases of emergency. For example, legislation in Victoria, Australia [121]; Mexico City [140]; Slovenia [141]; and the UK [138] stipulates that physicians may not refuse to provide services in cases of emergency and when urgent termination is required. US case law determined that a private hospital with a tradition of providing emergency care was still obliged to treat anyone relying on it even after its merger with a Catholic institution. This sets the standard for continuity of access after mergers of 2 hospitals with conflicting philosophies [142]. Also, ACOG urges clinicians to provide medically indicated care in emergency situations [125]. In Argentina, technical guidelines from the Ministry of Health stipulate that institutions must provide termination of pregnancy through another provider at the institution within 5 days or immediately if the situation is urgent [109]. In the UK, medical standards also prohibit conscience-based refusal of care in cases of emergency for nurses and midwives [143].

Other measures address the required provision of services when referral to an alternative provider is not possible. In Norway, for example, a doctor is not legally allowed to refuse care unless a patient has such reasonable access [115]. FIGO recommends that “practitioners must provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients’ health and well being, such as by patients experiencing unwanted pregnancy” [9].

Some interventions obligate the state to ensure services. In Colombia, for example, the health system is responsible for providing an adequate number of providers, and institutions must provide services even if individuals conscientiously object [107]. The law on voluntary sterilization and vasectomies in Argentina obligates health centers to ensure the immediate availability of alternative services when a provider has objected [144]. In Spain, the government will pay for transportation to an alternative willing public health facility [106]. Italian law requires healthcare institutions to ensure that women have access to abortion; regional healthcare entities are obliged to supervise and ensure such access, which may include transferring healthcare personnel [125]. In Mexico City, the public health code was amended to reinforce the duty of healthcare facilities to make abortion accessible, including their responsibility to limit the scope of conscientious objection [140].

Some measures specify which service providers are eligible to refuse and when they are allowed to do so. In the UK, for example, auxiliary staff are not entitled to conscientiously object [145,146]. According to the BMA guidelines, refusal to participate in paperwork or administration connected with abortion procedures lies outside the terms of the conscientious objection clause [127]. In Spain, only health professionals directly involved in termination of pregnancy have the right to object, and they must provide care to the woman before and after termination of pregnancy [106]. Similarly, doctors in Italy are legally required to assist before and after an abortion procedure even if they opt out of the procedure itself [124]. Also, medical guidelines in Argentina encourage practitioners to aid before and after legal abortion procedures even if they are invoking conscientious objection to participation in the procedure itself [109]. During the Bush administration, the US Department of Health and Human Services extended regulatory “conscience protections” to any individual peripherally participating in a health service [147]. This regulation was contested vigorously and retracted almost fully in February 2011 [148,149].

In Table 1, we lay out some benefits and limitations of policy responses to conscientious objection in order to provide varied actors with a menu of possibilities. As criteria are developed for invoking refusal, it is essential to address the questions of who is eligible to object, and to the provision of which services. We have added the categories of “data” and “standardization” as parameters in the table in recognition of the scant evidence available and the resulting inability to methodically assess the scope and efficacy of interventions. Selection of the various options delineated below will be influenced by the specific sociopolitical and economic context.

## 5. Conclusion

Refusal to provide certain components of reproductive healthcare because of moral or religious objection is widespread and seems to be increasing globally. Because lack of access to reproductive healthcare is a recognized route toward adverse health outcomes and inequalities, exacerbation of this through further depletion of clinicians constitutes a grave global health and rights concern. The limited evidence available indicates that objection occurs least when the law, public discourse, provider custom, and clinical experience all normalize the provision of the full range of reproductive healthcare services and promote women’s autonomy. While data on both the prevalence of conscience-based refusal of

**Table 1**  
Benefits and limitations of policy interventions

Option	Health system needs	Timely access to care	Balancing rights and obligations	Developing criteria for refusors	Standardization	Data needs
Referral to willing and accessible providers	Enables system planning for service delivery	Expedites patients' access to services	Upholds patients' rights to health-related information; providers' obligations to provide information and make refusal transparent; individual conscience	Establishes obligations of those claiming objector status while acknowledging legitimacy of objection	Policies and procedures for disclosure and referral standardized throughout health system	Provides indirect data on patients' encounters with refusal
Registration of objectors/written notice to employers	Informs on prevalence of objection, enabling system planning for service delivery	Leads to more timely access to care for women who can avoid seeking care from known objectors	Acknowledges provider right to object while informing patients. Requirement of formal documentation acknowledges health system stake in such knowledge	Delineates the specific instances in which objection is permitted, and by whom; formal notification of employers makes explicit the criteria for designation as an objector	Ensures that requirements for designation as objector are standardized throughout the health system	Registries provide data on prevalence by type of provider as well as component of care refused
Required disclosure of objector status to patients	Enables women to avoid unproductive visits to objectors and delayed care, promoting smoother functioning of system	Women go directly to willing provider	Acknowledges provider right to object while upholding patients' rights to autonomy and health-related information	Defines obligations of objectors	Standardizes information provided to patients	N/A
Required information to patients about available health options	Informed patients are better able to make decisions and to locate the services that they need	Facilitates patient access to appropriate care	Upholds patients' rights to obtain health-related information; underscores providers' obligations to provide accurate information and to inform about legally available options; asserts health system's commitment to science and to patients' rights	Limits scope of objection by specifying components of care individuals obligated to provide	Standardizes information to patients about health system's range of available services	N/A
Mandated provision of services in urgent situations or when no alternative exists	Facilitates planning for provision of emergency care and for associated policies, procedures, and oversight; ensures that medical sequelae of denial or delay of care are minimized	Provides critical care in a timely fashion	Obligations of the provider to operate in the best interests of patients and to provide appropriate care take precedence over the individual clinician's right to object	Sets limits on the scope of refusal to protect patients in emergency situations	Ensures that objectors adhere to contractual obligations to provide essential and/or life-saving care	Contributes to the ability to track urgent cases and to plan service provision needs
Willingness to provide and proficiency as criteria for employment	Underscores employers' needs to ensure sufficient number of providers to meet demand for specific services	Staff competency and willingness enable ready and timely access to appropriate care	Health systems' needs to employ proficient and willing providers to respond to the health needs of the community trump provider rights to object; providers free to adhere to conscience by choosing other employment	Limits objection because only those willing and trained are eligible for employment	Standardizes such requirements in job postings throughout health system	Tracks the number of proficient and willing candidates seeking employment
Medical certification contingent upon proficiency in specific services	Improves health system-level planning for service delivery by assuring that providers are proficient in needed services	Availability of trained providers facilitates timely access to care	Establishes that objectors have the right to choose other specialties, but not to refuse essential components of a specialty; ensures patient rights to receive appropriate services from providers designated as specialists; defines and safeguards professional standards	Clarifies that specialist objectors must be trained and ready to provide care in emergency situations or when other options not available	Specialty certification guarantees mastery of a set of skills and compliance with explicit obligations	Tracks number of providers certified and, therefore, proficient, thus facilitating planning
Medical society guidelines delineating expected standards of care	Recommends that priority go to patient receipt of care and to prevention of shortages of willing and qualified providers; guidelines may lack mechanisms for implementation	Recommends policies and procedures to ensure timely access to care but may lack force	Delineates the rights and obligations of providers and the rights of patients	Suggests criteria for designation as objector and associated obligations	Asserts standards of care	N/A



care and the consequences for women's health and health system function are inadequate, they indicate that refusal is unevenly distributed; that it may have the most severe impact in those parts of the world least able to sustain further personnel shortages; and that it also affects women in more privileged circumstances.

The present White Paper has laid out the available data and outlined research questions for further management of conscience-based refusal of care. It presents logical chains of consequences when refusal compromises access to specific components of reproductive healthcare and categorizes efforts to balance the claims of objectors with the claims of both those seeking healthcare and the systems obligated to provide these services. We highlight the claims of those whose conscience compels them to provide such care, despite hardship. As our emphasis is on medicine and science, we close by considering ways for medical professional and public health societies to develop and implement policies to manage conscientious objection.

One recommendation is to standardize a definition of the practice and to develop eligibility criteria for designation as an objector. Such designation would have accompanying obligations, such as disclosure to employers and patients, and duties to refer, to impart accurate information, and to provide urgently needed care. Importantly, professional organizational voices can uphold conformity with standards of care as the priority professional commitment of clinicians, thus eliminating refusal as an option for the care of ectopic pregnancy, inevitable spontaneous abortion, rape, and maternal illness. In sum, medical and public health professional organizations can establish a clinical standard of care for conscientious objection, to which clinicians could be held accountable by patients, medical societies, and health and legal systems.

There are additional avenues for professional organizations to explore in upholding standards. Clinical specialty boards might condition certification upon demonstration of proficiency in specific services. Clinical educators could ensure that trainees and members are educated about relevant laws and clinical protocols/procedures. Health systems may consider willingness to provide needed services and proficiency as criteria for employment. These last are noteworthy because they also move us from locating the issue at the individual level to consideration of obligations at the professional and health system levels.

These issues are neither simple nor one-sided. Conscience and integrity are critically important to individuals. Societies have the complicated task of honoring the rights of dissenters while also limiting their impact on other individuals and on communities. Although conscientious objection is only one of many barriers to reproductive healthcare, it is one that medical societies are well positioned to address because providers are at the nexus of health and rights concerns. They have the unique vantage point of caring simultaneously about their own conscience and about their obligations to patients' health and rights and to the highest standards of evidence-based care. The present White Paper has disentangled the range of implications for women's health and rights, health systems, and objecting and committed providers. Thus, it equips clinicians and their professional organizations to contribute a distinct medical voice, complementary to those of lawyers, ethicists, and others. We urge medical and public health societies to assert leadership in forging policies to balance these competing interests and to safeguard reproductive health, medical integrity, and women's lives.

## Acknowledgments

Ford Foundation and an anonymous donor supported the publication of the supplement. We thank all GDC funders for making the project possible.

## Conflict of interest

The authors have no conflicts of interest.

## References

- [1] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* March 23, 1976).
- [2] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* December 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (*entered into force* September 3, 1981).
- [3] Organization of American States. American Convention on Human Rights, "Pact of San Jose", Costa Rica. November 22, 1969. <http://www.unhcr.org/refworld/docid/3ae6b36510.html>. Accessed February 10, 2013.
- [4] Council of Europe. European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14. November 4, 1950, ETS 5. <http://www.unhcr.org/refworld/docid/3ae6b3b04.html>. Accessed February 10, 2013.
- [5] UN Committee on Economic, Social and Cultural Rights (CESCR). General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). August 11, 2000, E/C.12/2000/4. <http://www.refworld.org/docid/4538838d0.html>. Accessed May 7, 2013.
- [6] L.C. v. Peru, Communication No. 1153/2003, Human Rights Committee, para. 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).
- [7] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, *adopted* July 11, 2003, 2nd African Union Assembly, Maputo, Mozambique (*entered into force* 2005).
- [8] World Medical Association. Declaration of Helsinki—Ethical Principles for Medical Research Involving Human Subjects. Adopted 1964. <http://www.wma.net/en/30publications/10policies/b3/>. Accessed June 15, 2013.
- [9] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Ethical guidelines on conscientious objection. FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. *Int J Gynecol Obstet* 2006;92(3):333–4.
- [10] American College of Obstetricians and Gynecologists (ACOG). ACOG Committee Opinion, Committee on Ethics. The Limits of Conscientious Refusal in Reproductive Health Care. Number 385, November 2007 (*reaffirmed* 2010). <http://www.acog.org/Resources%20and%20Publications/Committee%20Opinions/Committee%20on%20Ethics/The%20Limits%20of%20Conscientious%20Refusal%20in%20Reproductive%20Medicine.aspx>. Accessed March 22, 2013.
- [11] González Vélez AC. Refusal of Care due to Conscientious Objection. Grupo Médico por el Derecho a Decidir. Global Doctors for Choice/Columbia 2012. <http://globaldoctorsforchoice.org/wp-content/uploads/Negaci%C3%B3n-de-servicios-por-razones-de-conciencia.pdf>. Accessed October 23, 2013.
- [12] Royal College of Nursing, Australia. Position Statement. Conscientious Objection. [http://www.rcna.org.au/wcm/RCNA/Policy/Position\\_statements/rcna/policy/position\\_statements\\_guidelines\\_and\\_communique.aspx](http://www.rcna.org.au/wcm/RCNA/Policy/Position_statements/rcna/policy/position_statements_guidelines_and_communique.aspx). Accessed March 22, 2013.
- [13] Green JM. Obstetricians' views on prenatal diagnosis and termination of pregnancy: 1980 compared with 1993. *British J Obstet Gynaecol* 1995;102(3):228–32.
- [14] Zampas C, Andion-Ibaniez X. Conscientious objection to sexual and reproductive health services: international human rights standards and European law and practice. *Eur J Health Law* 2012;19:231–56.
- [15] Dodani S, LaPorte R. Brain drain from developing countries: how can brain drain be converted into wisdom gain? *J R Soc Med* 2005;98(11):487–91.
- [16] United States Department of Defense Regulations. DoD Directive 1300.6: Conscientious Objectors. <http://www.dtic.mil/whs/directives/corres/pdf/130006p.pdf>. Published May 31, 2007. Accessed October 23, 2013.
- [17] Faundes A, Duarte GA, Neto JA, de Sousa MH. The closer you are, the better you understand: the reaction of Brazilian obstetrician-gynaecologists to unwanted pregnancy. *RHM* 2004;12(24 Suppl):47–56.
- [18] Mishtal J. Contradictions of Democratization: The Politics of Reproductive Rights and Policies in Postsocialist Poland. Dissertation submitted to the Faculty of the Graduate School of the University of Colorado in partial fulfillment of the requirement for the degree of Doctor of Philosophy. Department of Anthropology. 2006. [http://federa.org.pl/dokumenty\\_pdf/prawareprodukcyjne/Mishtal%20dissertation.pdf](http://federa.org.pl/dokumenty_pdf/prawareprodukcyjne/Mishtal%20dissertation.pdf). Accessed June 17, 2013.
- [19] De Zordo S, Mishtal J. Physicians and abortion: Provision, political participation and conflicts on the ground—The cases of Brazil and Poland. *Women's Health Issues* 2011;21(Suppl 3):S32–6.
- [20] MergerWatch. Religious Restrictions: Refusals to Provide Care. <http://www.mergerwatch.org/refusals/>. Accessed August 17, 2012.
- [21] Shelton DL. Chicago Tribune News. Appeals court sides with pharmacists in emergency contraceptives care. [http://articles.chicagotribune.com/2012-09-22/news/ct-met-emergency-contraceptives-20120922\\_1\\_emergency-contraceptives-conscience-act-pharmacists](http://articles.chicagotribune.com/2012-09-22/news/ct-met-emergency-contraceptives-20120922_1_emergency-contraceptives-conscience-act-pharmacists). Published September 22, 2012. Accessed March 22, 2013.

- [22] Wicclair MR. Refusals by hospitals and emergency contraception. *Cambridge Quarterly of Healthcare Ethics* 2011;20(1):130–8.
- [23] Charo RA. American Constitution Society for Law and Policy, Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience. *The Journal of the ACS Issue Groups* 2007: 119–35. [https://media.law.wisc.edu/m/yzdkn/charo\\_-\\_health\\_care\\_provider\\_refusals\\_-\\_feb\\_2007\\_-\\_advance\\_vol\\_1.pdf](https://media.law.wisc.edu/m/yzdkn/charo_-_health_care_provider_refusals_-_feb_2007_-_advance_vol_1.pdf).
- [24] Wicclair MR. *Conscientious Objection in Health Care*. Cambridge: Cambridge University Press; 2011.
- [25] Institute of Medicine. *Shaping the Future of Health. Crossing the Quality Chasm: A New Health System for the 21st Century*. <http://www.iom.edu/-/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>. Published 2001. Accessed May 8, 2013.
- [26] WHO. *Quality of Care: A Process for Making Strategic Choices in Health Systems*. Geneva: WHO; 2006. [http://www.who.int/management/quality/assurance/QualityCare\\_B.Def.pdf](http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf).
- [27] Endres v. Indiana State Police, 349 F.3d 922 (7th Cir. 2003) (cert. denied, 541 U.S. 989 (2004)), cited in Charo RA. American Constitution Society for Law and Policy, Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience. *The Journal of the ACS Issue Groups* 2007: 119–35. [https://media.law.wisc.edu/m/yzdkn/charo\\_-\\_health\\_care\\_provider\\_refusals\\_-\\_feb\\_2007\\_-\\_advance\\_vol\\_1.pdf](https://media.law.wisc.edu/m/yzdkn/charo_-_health_care_provider_refusals_-_feb_2007_-_advance_vol_1.pdf).
- [28] Dickens BM, Cook RJ. Conscientious commitment to women's health. *Int J Gynecol Obstet* 2011;113:163–6.
- [29] Harris L. Recognizing Conscience in Abortion Provision. *N Engl J Med* 2012;367(11):981–3.
- [30] FIGO. *Resolution on Conscientious Objection*. <http://www.figo.org/projects/conscientious>. Published 2005. Accessed June 1, 2013.
- [31] Republic of Italy. Ministry of Health. Report of the Ministry of Health on the Performance of the Law Containing Rules for the Social Care of Maternity and Voluntary Interruption of Pregnancy: 2006–2007 (2008).
- [32] The Act (13 June 1995 no. 50), concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978 no. 5, at 14 (Norway).
- [33] Health Services Act, Art. 56, Official Gazette of the Republic of Slovenia (Slovenia).
- [34] The Abortion Act, Act No. 595/1974, as amended through Act No. 998/2007 (Sweden).
- [35] Roe J, Francome C, Bush M. Recruitment and training of British obstetrician-gynaecologists for abortion provision: conscientious objection versus opting out. *RHM* 1999;7(14):97–105.
- [36] Lo SS, Kok WM, Fan SY. Emergency contraception: knowledge, attitude and prescription practice among doctors in different specialties in Hong Kong. *J Obstet Gynaecol Research* 2009;35(4):767–74.
- [37] Davidson LA, Pettis CT, Cook DM, Klugman CM. Religion and conscientious objection: a survey of pharmacists' willingness to dispense medications. *Soc Sci Med* 2010;71(1):161–5.
- [38] Heino A, Gissler M, Apter D, Fiala C. Conscientious objection and induced abortion in Europe. *Euro J Contracept Reprod Health Care* 2013;18:231–3.
- [39] Austrian Ministry of Health. *Austrian Women's Health Report 2010/2011*. Vienna: Ministry of Health; 2011.
- [40] Oliveira da Silva M. Reflections on the legalisation of abortion in Portugal. *Eur J Contracept Reprod Health Care* 2009;14:245–8.
- [41] Rodríguez-Calvo MS, Martínez-Silva IM, Concheiro L, Muñoz-Barús JI. University students' attitudes towards Voluntary Interruption of Pregnancy. *Legal Medicine* 2012;14(4):209–13.
- [42] Guttmacher Institute. Attitudes and intentions of future health care providers toward abortion provision. *Perspectives Sexual Reprod Health* 2004;36(2):58–63.
- [43] Rakhudu MA, Mmesi AMM, Myburgh CPH, Poggenpoel M. Exploration of the views of traditional healers regarding the termination of pregnancy (TOP) law. *Curatonia* 2006;29(3):56–60.
- [44] Curlin FA, Lawrence RE, Chin MH, Lantos JD. Religion, conscience, and controversial clinical practices. *N Engl J Med* 2007;356(6):593–600.
- [45] Goyal M, Zhao H, Mollen C. Exploring emergency contraception knowledge, prescription practices, and barriers to prescription for adolescents in the emergency department. *Pediatrics* 2009;123(3):765–70.
- [46] Harris LH, Cooper A, Rasinski KA, Curlin FA, Lyerly AD. Obstetrician-gynecologists' objections to and willingness to help patients obtain an abortion. *Obstet Gynecol* 2011;118(4):905–12.
- [47] Frank JE. Conscientious refusal in family medicine residency training. *Family Medicine* 2011;43(5):330–3.
- [48] Gogna M, Romero M, Ramos S, Petracci M, Szulik D. Abortion in a restrictive legal context: the views of obstetrician-gynaecologists in Buenos Aires, Argentina. *RHM* 2002;10(19):128–37.
- [49] de la Fuente Fonnest I, Sondergaard F, Fonnest G, Vedsted-Jacobsen A. Attitudes among health care professionals on the ethics of assisted reproductive technologies and legal abortion. *Acta Obstet Gynecol Scand* 2000;79(1):49–53.
- [50] Marie Stopes International. *General practitioners: attitudes to abortion* 2007. <http://www.mariestopes.org.uk/documents/GP%20attitudes%20to%20abortion%202007.pdf>. Published 2007. Accessed June 17, 2013.
- [51] Davis S, Schrader V, Belcheir MJ. Influencers of ethical beliefs and the impact on moral distress and conscientious objection. *Nurs Ethics* 2012;19(6):738–49.
- [52] Aiyer AN, Steinman A, Ho GY. Influence of physician attitudes on willingness to perform abortion. *Obstet Gynecol* 1999;93(4):576–80.
- [53] Hammarstedt M, Jacobsson L, Wulff M, Lalos A. Views of midwives and gynecologists on legal abortion—a population-based study. *Acta Obstet Gynecol Scand* 2005;84(1):58–64.
- [54] Griggs SK, Brown CM. Texas community pharmacists' willingness to participate in pharmacist-initiated emergency contraception. *JAPhA* 2007;47(1):48–57.
- [55] Wonkam A, Hurst SA. Acceptance of abortion by doctors and medical students in Cameroon. *Lancet* 2007;369(9578):1999.
- [56] Suh S. *Abortion Politics without Borders: The Implementation and Practice of Post-Abortion Care in Senegal*. SSRN 2013. <http://ssrn.com/abstract=2250193>. Published April 13, 2013.
- [57] Hagen GH, Hage CO, Magelssen M, Nortvedt P. Attitudes of medical students towards abortion. *Tidsskr Nor Laegeforen* 2011;131(18):1768–71.
- [58] Kade K, Kumar D, Polis C, Schaffer K. Effect of nurses' attitudes on hospital-based abortion procedures in Massachusetts. *Contraception* 2004;69(1):59–62.
- [59] Stulberg DB, Dude AM, Dahlquist I, Curlin FA. Obstetrician-gynecologists, religious institutions, and conflicts regarding patient-care policies. *Am J Obstet Gynecol* 2012;207(1):73 e1–5.
- [60] Guttmacher Institute. *Making Abortion Services Accessible in The Wake of Legal Reforms: A Framework And Six Case Studies*. <http://www.guttmacher.org/pubs/abortion-services-laws.pdf>. Published 2012. Accessed June 15, 2013.
- [61] International Planned Parenthood Federation. *Abortion, Legislation in Europe*. [http://www.ippfen.org/NR/rdonlyres/ED17CA78-43A8-4A49-ABE7-64A83C0413E/0/Abortionlegislation\\_May2012corr.pdf](http://www.ippfen.org/NR/rdonlyres/ED17CA78-43A8-4A49-ABE7-64A83C0413E/0/Abortionlegislation_May2012corr.pdf). Updated May 2012. Accessed May 8, 2013.
- [62] Mishtal J. *Quiet Contestations of Irish Abortion Law: Reproductive Health Politics in Flux*. In: Penny Light T, Stettner S, eds. *The History and Politics of Abortion*. Toronto: University of Toronto Press; 2014 (in press).
- [63] Center for Reproductive Rights. *The World's Abortion Laws Map 2013 and Update*. [http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap\\_Factsheet\\_2013.pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_Factsheet_2013.pdf) and <http://worldabortionlaws.com/>. Published 2013. Accessed June 15, 2013.
- [64] Cohen SA. *Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide*. Guttmacher Policy Review 2009;12(4).
- [65] Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, et al. Unsafe abortion: the preventable pandemic. *Lancet* 2006;368(9550):1908–19.
- [66] Guttmacher Institute. *In Brief: Fact Sheet. Facts on Induced Abortion Worldwide*. [http://www.guttmacher.org/pubs/fb\\_IAW.html](http://www.guttmacher.org/pubs/fb_IAW.html). Published 2012. Accessed June 17, 2013.
- [67] Singh S. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *Lancet* 2006;369(9550):1887–92.
- [68] Guttmacher Institute. *Media Kit. Worldwide Abortion: Legality, Incidence and Safety*. <http://www.guttmacher.org/media/presskits/abortion-WW/statsandfacts.html>. Accessed June 15, 2013.
- [69] Ipas. *Report on successes in achieving UN Global Strategy for Women's and Children's Health—September 2012*. [http://www.who.int/woman\\_child\\_accountability/ierg/reports/2012\\_105\\_ipas\\_submission\\_forIERGreport\\_1May2012.pdf](http://www.who.int/woman_child_accountability/ierg/reports/2012_105_ipas_submission_forIERGreport_1May2012.pdf). Published 2012. Accessed June 15, 2013.
- [70] Sangonet. *Unsafe Abortion in South Africa: A Preventable Pandemic*. <http://www.ngopulse.org/blogs/unsafe-abortion-south-africa-preventable-pandemic>. Published July 2012. Accessed May 8, 2013.
- [71] Republic of South Africa. *Saving Mothers: Short*. <http://www.doh.gov.za/docs/reports/2012/savingmothersshort.pdf>. Published 2012.
- [72] Poongothai J. Genetics of human male infertility. *Singapore Med J* 2009;50(4):337.
- [73] WHO. *Mother or nothing: The agony of fertility*. *Bull World Health Organ* 2010;88(12):877–953.
- [74] WHO. *Genomic Resource Centre. Gender and Genetics. Assisted Reproductive Technologies (ARTs)*. <http://www.who.int/genomics/gender/en/index6.html>. Accessed October 23, 2013.
- [75] Inhorn M. Global infertility and the globalization of new reproductive technologies: illustrations from Egypt. *Soc Sci Med* 2003;56(9):1837–51.
- [76] Chambers GM, Sullivan EA, Ishihara O, Chapman MG, Adamson GD. The economic impact of assisted reproductive technology: a review of selected developed countries. *Fertil Steril* 2009;91(6):2281–94.
- [77] Chambers GM. The costs and consequences of assisted reproductive technology: an economic perspective. *Hum Reprod Update* 2010;6(6):603–13.
- [78] Chavkin W. *The Old Meets the New: Religion and assisted reproductive technologies*. *Development* 2006;49(4):78–83.
- [79] Giubellino G. *I Would Not Freeze My Children*. *Clarín*. <http://edant.clarin.com/diario/2005/07/26/sociedad/s-03101.htm>. Published July 26, 2005.
- [80] Turone, F. Italian court upholds couple's demands for preimplantation genetic diagnosis. *BMJ* 2007;335(7622):687.

- [81] United Nations. Department of Economic and Social Affairs. Population Division. World Contraceptive Use 2011, Wall Chart, Front Side. <http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm>. Accessed May 8, 2013.
- [82] Creanga AA, Gillespie D, Karklins S, Tsui AO. Low use of contraception among poor women in Africa: an equity issue. *Bull World Health Organ* 2011;89(4):258–66.
- [83] Center for Reproductive Rights. Over 700,000 Petitioners Demand Honduran Congress Reject Law Criminalizing Emergency Contraception. <http://reproductiverights.org/en/press-room/over-700000-petitioners-demand-honduran-congress-reject-law-criminalizing-emergency-contr>. Published May 16, 2012.
- [84] WHO. Emergency Contraception Pills. . . Too Expensive? [http://www.who.int/reproductivehealth/topics/family\\_planning/ec/en/index.html](http://www.who.int/reproductivehealth/topics/family_planning/ec/en/index.html). Accessed October 23, 2013.
- [85] Pieklo J. Care2. Oklahoma Rape Victim Turned Away from Hospital. <http://www.care2.com/causes/oklahoma-rape-victim-turned-away-from-hospital.html>. Published 2012. Accessed June 15, 2013.
- [86] Spiegel Online. Cologne Archbishop Meisner approves “morning after” pill for rape victims. <http://www.spiegel.de/panorama/gesellschaft/koelner-erzbischof-meisner-billigt-pille-danach-fuer-vergewaltigungsopfer-a-880814.html>. Published January 31, 2013. Accessed June 15, 2013.
- [87] Murray H, Baakdah H, Bardell T, Tulandi T. Diagnosis and treatment of ectopic pregnancy. *CMAJ* 2005;173(8):905.
- [88] Togas T. Incidence, risk factors, and pathology of ectopic pregnancy. <http://www.uptodate.com/contents/incidence-risk-factors-and-pathology-of-ectopic-pregnancy>. Accessed February 23, 2012.
- [89] Sivalingam VN, Duncan WC, Kirk E, Shephard LA, Home AW. Diagnosis and management of ectopic pregnancy. *J Fam Plann Reprod Health Care* 2011;37(4):231–40.
- [90] American Pregnancy Association. Promoting Pregnancy Wellness. Miscarriage. <http://americanpregnancy.org/pregnancycomplications/miscarriage.html>. Accessed February 23, 2012.
- [91] Berer M. Termination of pregnancy as emergency obstetric care: the interpretation of Catholic health policy and the consequences for pregnant women: An analysis of the death of Savita Halappanavar in Ireland and similar cases. *RHM* 2013;21(41):9–17.
- [92] Case of Z v. Poland. Application no. 46132/08. Judgment (Merits and Just Satisfaction). [http://hudoc.echr.coe.int/sites/eng-press/pages/search.aspx?i=001-114521#{"itemid":\["001-114521"\]](http://hudoc.echr.coe.int/sites/eng-press/pages/search.aspx?i=001-114521#{). Published 2012. Accessed June 15, 2013.
- [93] Harvard University. David Rockefeller Center for Latin American Studies. Remobilization, Demobilization, and Incarceration: Women and Abortion in Post-war El Salvador. <http://www.drclas.harvard.edu/node/853>. Accessed October 23, 2013.
- [94] Mollmann M. Over Their Dead Bodies—Denial of Access to Emergency Obstetric Care and Therapeutic Abortion in Nicaragua. *Human Rights Watch* 2007;19(2)(B). <http://womenshealthnews.blogspot.com/2006/04/women-of-el-salvador.html>. Published 2009. Accessed June 8, 2013.
- [95] Skotko B. Mothers of children with Down syndrome reflect on their postnatal support. *Pediatrics* 2005;115(1):64–77.
- [96] Hoehn KS, Wernovsky G, Rychik J, Tian ZY, Donoghue D, Gaynor JW, et al. Parental decision-making in congenital heart disease. *Cardiol Young* 2004;14(2004):309–14.
- [97] R.R. v. Poland, No. 27617/04 ECHR. (2011).
- [98] UN Human Rights Committee. General Comment 22, Article 18: The Right to Freedom of Thought, Conscience and Religion. A/48/40 vol. I (1993), para. 11.2.
- [99] UN Committee on the Elimination of Discrimination against Women. General Recommendation 24: Article 12 of the Convention (women and health) (20th Sess., 1999), para.11. <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24>. Accessed February 23, 2012.
- [100] UN Committee on the Elimination of Discrimination against Women. Concluding Observations. Croatia, UN Doc. A/53/38 (1998), paras. 109, 117.
- [101] UN Committee on the Elimination of Discrimination against Women. Concluding Observations. Italy. UN Doc. A/52/38 Rev.1, Part II (1997), paras. 353, 360.
- [102] UN Committee on the Elimination of Discrimination against Women. Concluding Observations. South Africa. UN Doc. A/53/38/Rev.1 (1998), para. 113.
- [103] UN. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover—Mission to Poland, 20 May 2010, UN Doc. A/HRC/14/20/Add.3.
- [104] CESCR Committee. Concluding Observations. Poland. UN Doc. E/C.12/POL/CO/5 (2009), para. 28.
- [105] WHO. Safe abortion: technical and policy guidance for health systems. Second edition. [http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf). Published 2012. Accessed June 8, 2013.
- [106] Ley Orgánica 2/2010, de 3 de marzo, de Salud Sexual y Reproductiva y de la Interrupción Voluntaria del Embarazo. [Law of Sexual and Reproductive Health and Abortion] (2010), Arts.17(4) and 14(a) (Spain).
- [107] Law C-355 of 2006 (Colombia).
- [108] Choice of Termination of Pregnancy Act 1996 (South Africa).
- [109] Regulation to National Law No. 25.673, Art.10 (Argentina). Ministerio de Salud de la Nación [National Health Ministry]. Guía Técnica para la Atención Integral de los Abortos No Punibles [Technical Guide for Comprehensive Care for Legal Abortions] (2010) (Argentina).
- [110] National Law No. 26.130, Art.6 (Argentina).
- [111] Código de Ética Médica [Ethical Medical Code], Chapter 5. (Uruguay). <http://www.smu.org.uy/elsmu/institucion/documentos/doc/cem.html#cap5>. Accessed February 23, 2013.
- [112] Vique AB, Cabrera OA, Lugo FG, Hevia M. Women and Health in Uruguay. The Uruguayan Executive Veto for the Decriminalization of Abortion: Deconstructing the fundamentals. Notebooks: Contributions to the debate on health, citizenship and right. 2010; Epoca 1 (1). <http://www.archivos.hacelosvaler.org/Cuaderno%201%20Final.pdf>. Published 2010. Accessed February 23, 2012.
- [113] Public Health Service Act (1973) (United States).
- [114] Sonfeld A. Guttmacher Institute. Delineating the Obligations That Come with Conscientious Refusal: A Question of Balance. *Guttmacher Policy Review* 2009;12(30). <http://www.guttmacher.org/pubs/gpr/12/3/gpr120306.html>.
- [115] Regulations for the Implementation of the Act dated 13 June 1995 no. 50 concerning Termination of 31 Pregnancy, with Amendments in the Act dated 16 June 1978, no. 66, §20 (Norway).
- [116] Constitutional Court Decision, T-209 of 2008 (Colombia). <http://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=30206>. Published February 28, 2008.
- [117] Judgment of the Bavarian Higher Administrative Court of 03/07/1990, BayVGH DVBl. 1990, 880–82 41 (Federal Republic of Germany).
- [118] Judgment of the Federal Administrative Court of 12/13/1991, BVerwGE 89, 260–70 (Federal Republic of Germany).
- [119] P. and S. v. Poland, Application no. 57375/08, Decision, October 30, 2012. [http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-114098#{"itemid%22%22001-114098%22](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-114098#{). Accessed February 23, 2012.
- [120] Code de la Santé Publique, arts. L2212-8, R4127-18 32 (France).
- [121] Abortion Law Reform Act, Sec. 8 (Australia, Victoria).
- [122] Constitutional Court Decision, T-388 of 2009 (Colombia).
- [123] Colombia. Ministry of Social Protection. Governmental Decree 4444 of 2006, article 6. [http://www.womenslinkworldwide.org/pdf\\_programs/es\\_prog\\_rr\\_col\\_legaldocs\\_decreto4444.pdf](http://www.womenslinkworldwide.org/pdf_programs/es_prog_rr_col_legaldocs_decreto4444.pdf). Accessed July 19, 2012.
- [124] Law No. 194 of 22 May 1978 on the social protection of motherhood and the voluntary termination of pregnancy, Gazz. Uff., Part I, 22 May 1978, No. 140, 3642–46 (Italy). [http://www.columbia.edu/itc/history/degrazia/courseworks/legge\\_194.pdf](http://www.columbia.edu/itc/history/degrazia/courseworks/legge_194.pdf). Accessed February 23, 2012.
- [125] American Congress of Obstetricians and Gynecologists. ACOG Committee Opinion. The Limits of Conscientious Refusal in Reproductive Medicine 2007; Opinion Number 385. [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Ethics/The\\_Limits\\_of\\_Conscientious\\_Refusal\\_in\\_Reproductive\\_Medicine](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/The_Limits_of_Conscientious_Refusal_in_Reproductive_Medicine). Accessed August 27, 2013.
- [126] El Sindicato Médico del Uruguay [Medical Association of Uruguay]. Chap 5, Art. 37 (Uruguay). <http://www.smu.org.uy/publicaciones/libros/laetica/cem.htm#cap5>. Accessed August 20, 2013.
- [127] British Medical Association. Ethics Department. The Law and Ethics of Abortion: BMA Views. November 2007.
- [128] World Medical Association. World Medical Association Declaration on Therapeutic Abortion. <http://www.wma.net/e/policy/a1.htm>. Published 2006.
- [129] American Society of Health-System Pharmacists, Council on Legal and Public Affairs. ASHP Statement: Pharmacist’s Right of Conscience and Patient’s Right of Access to Therapy (0610). 2010.
- [130] Anderson RM, Bishop LJ, Darragh M, Gray H, Nolen A, Poland SC, et al. National Reference Center for Bioethics Literature. The Joseph and Rose Kennedy Institute of Ethics. Pharmacists and Conscientious Objection. <http://bioethics.georgetown.edu/publications/scopenotes/sn46.pdf>. Accessed August 27, 2013.
- [131] General Pharmaceutical Council. Standards of conduct, ethics and performance. July 2012.
- [132] Decree No. 98-945 of 4 December 1998, setting forth the Code of Medical Ethics (Madagascar).
- [133] National Association of Pharmacy Regulatory Authorities. Model Statement Regarding Pharmacists’ Refusal to Provide Products or Services for Moral or Religious Reasons. <http://www.nbpharmacists.ca/LinkClick.aspx?fileticket=wxc0ugUqRRE%3D&tabid=261&mid=695>. Published 1999.
- [134] Code of Ethics for Nurses in Australia, developed under the auspices of Australian Nursing and Midwifery Council, Royal College of Nursing, Australia, Australian Nursing Federation. 2008.
- [135] Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland, 16 July 2008, the Department of Health, Social Services and Public Safety.
- [136] Código Deontológico da Ordem dos Médicos [Code of Ethics of the Association of Doctors] (2008), Art. 37 (Portugal); 39 Lei No. [Law No.] 16/2007 de 17 de abril, Exclução da ilicitudenos casos de interrupção voluntária da gravidez [Exclusion of cases of voluntary interruption of pregnancy] 40 (Portugal).



- [137] Health Service Guidance HSG (94)39 (US).
- [138] Abortion Act 1967 (England) (Section 4(1) of the 1967 Act permits that "no person shall be under any duty, whether by contractor by any statutory or other legal requirement, to participate in any treatment ... to which he has a conscientious objection." This does not apply to emergency procedures.).
- [139] Enright and another v. Kwun and Another, [2003] E.W.H.C. 1000 (Q.B.).
- [140] Decree reforming Articles 145 and 148 of the new Penal Code of Mexico City and adding Articles 16 bis 6 and 16 bis 7 to the Health Law of Mexico City, reported in Official Gazette of Mexico City, 14, no. 7, 24 January 2004, pp. 6-7 (Mexico).
- [141] Health Services Act, Art. 56, Official Gazette of the Rep. of Slovenia 36, No. 9, enacted 1992 (Slovenia).
- [142] *Wilmington General Hospital v. Manlove*, 174 A2d 135 (Del SC 1961) (US).
- [143] Nursing and Midwifery Council, The Code of Conduct, Professional standards for nurses and midwives (UK).
- [144] National Law on Medical Practice, Dentistry, and Auxiliary Practices, Law 17.132 (Argentina).
- [145] *Janaway v. Salford Health Authority*, 1988 (UK).
- [146] Brahams D. Conscientious Objection and Referral Letter for Abortion. *Lancet* 1988;331(8590):893.
- [147] 73 Fed. Reg. 78071 (December 19, 2008). 45 CFR Part 88 (2008).
- [148] Galston WA, Rogers M. Brookings Institute. Governance Studies at Brookings. Health Care Providers' Consciences and Patients' Needs: The Quest for Balance. [http://www.brookings.edu/~media/research/files/papers/2012/2/23%20health%20care%20galston%20rogers/0223\\_health\\_care\\_galston\\_rogers.pdf](http://www.brookings.edu/~media/research/files/papers/2012/2/23%20health%20care%20galston%20rogers/0223_health_care_galston_rogers.pdf). Published February 23, 2012.
- [149] Office of the Secretary of Health and Human Services. Final Rule, Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws. <http://www.gpo.gov/fdsys/pkg/FR-2011-02-23/pdf/2011-3993.pdf>. Published February 23, 2011.

# **EXHIBIT E**

## May 2011: National poll shows majority support healthcare conscience rights, conscience law

### Highlights of *the polling company, inc.* Phone Survey of the American Public

On May 3, 2011, the Christian Medical Association and the Freedom2Care coalition released the results of a nationwide, scientific poll conducted April 29-May 1, 2011 by the polling company™, inc./ WomanTrend. Survey of 1000 American Adults, Field Dates: April 29-May 1, 2011, Margin of Error=±3.1.

1. **77%** of American adults surveyed said it is either "very" or "somewhat" important to them that "that healthcare professionals in the U.S. are **not forced to participate** in procedures or practices to which they have **moral objections.**" **16%** said it is not important.

<b>ALL</b>		<i>PRO-CHOICE</i> (n=465)	<i>PRO-LIFE</i> (n=461)
<b>77%</b>	Total <b>important</b> (net)	68%	85%
52%	Very important	42%	64%
25%	Somewhat important	26%	21%
<b>16%</b>	Total <b>not important</b> (net)	24%	8%
8%	Not too important	11%	5%
8%	Not at all important	13%	3%
8%	Do not know/depends	8%	6%
1%	Refused	*	

2. **50%** of American adults surveyed "strongly" or "somewhat" support "a **law** under which federal agencies and other government bodies that receive federal funds could **not discriminate** against hospitals and health care professionals who **decline to participate in abortions.**" **35%** opposed.

<b>ALL</b>		<i>PRO-CHOICE</i> (n=465)	<i>PRO-LIFE</i> (n=461)
<b>50%</b>	Total <b>support</b> (net)	45%	58%
29%	Strongly support	20%	40%
21%	Somewhat support	25%	18%
<b>35%</b>	Total <b>oppose</b> (net)	43%	32%
14%	Somewhat oppose	20%	10%
21%	Strongly oppose	23%	22%
7%	It depends/need more info.	7%	5%
7%	Do not know	6%	5%
1%	Refused	1%	1%

## April, 2009: Two National Polls<sup>1</sup> Reveal Broad Support for Conscience Rights in Health Care

### Highlights of *the polling company, inc.* Phone Survey of the American Public

39% Democrat • 33% Republican • 22% Independent

1. **88%** of American adults surveyed said it is either “very” or “somewhat” **important to them that they share a similar set of morals as their doctors, nurses, and other healthcare providers.**
2. **87%** of American adults surveyed believed it is important to “make sure that healthcare professionals in America are **not forced to participate** in procedures and practices to which they have moral objections.”
3. Support for the conscience protection regulation (rule finalized Dec. 2008):
  - **63% support conscience protection regulation**
  - 28% oppose conscience protection regulation
4. Support for Obama administration proposal to eliminate the new conscience protection regulation:
  - 30% support Obama administration proposal
  - **62% oppose Obama administration proposal**
5. Likelihood of voting for current Member of Congress who supported eliminating the conscience rule:
  - 25% more likely to vote for Member who supported eliminating rule
  - **54% less likely to vote for Member who supported eliminating rule**
6. "In 2004 the Hyde-Weldon Amendment was passed. It ruled that taxpayer funds must not be used by governments and government-funded programs to discriminate against hospitals, health insurance plans, and healthcare professionals who decline to participate in abortions. Do you support or oppose this law?"
  - **58% support Hyde-Weldon Amendment**
  - 31% oppose Hyde-Weldon Amendment

### Highlights of Online Survey of Faith-Based Professionals

2,865 faith-based healthcare professionals

1. **Over nine of ten (91%)** faith-based physicians agreed, "I would **rather stop practicing medicine** altogether than be forced to violate my conscience."
2. **32%** of faith-based healthcare professionals report having "been **pressured to refer a patient** for a procedure to which [they] had moral, ethical, or religious objections."
3. **39%** of faith-based healthcare professionals have “experienced pressure from or **discrimination by faculty** or administrators based on [their] moral, ethical, or religious beliefs”
4. **20%** of faith-based medical students say they are "**not pursuing a career in Obstetrics or Gynecology**" because of perceived discrimination and coercion in that field.

<sup>1</sup> Results of both 2009 surveys released April 8. On behalf of the Christian Medical Association, the polling companyTM, inc./ WomanTrend conducted a nationwide survey of 800 American adults. Field Dates: March 23 -25, 2009. The overall margin of error for the survey is ± 3.5% at a 95% confidence interval. The polling companyTM, inc./ WomanTrend also conducted an online survey of members of faith-based organizations, fielded March 31, 2009 to April 3, 2009. It was completed by 2,298 members of the Christian Medical Association, 400 members of the Catholic Medical Association, 69 members of the Fellowship of Christian Physicians Assistants, 206 members of the Christian Pharmacists Fellowship International, and 8 members of Nurses Christian Fellowship. <http://www.freedom2care.org/learn/page/surveys>

## **April 2009 Phone Survey of the American Public**

Americans of all characteristics and politics seek shared values with healthcare professionals.

Fully 88% of American adults surveyed said it is either “very” or “somewhat” important to them that they enjoy a similar set of morals as their doctors, nurses, and other healthcare providers. Intensity was strong, as 63% described this as “very” important while at the other end of the spectrum, just 6% said it is “not at all important,” a ratio of more than 10-to-1.

Voters will punish politicians who fail to defend healthcare providers’ conscience rights.

Finally, when asked how they would view their Member of Congress if he or she voted against conscience protection rights, 54% indicated they would be less likely to back their United States Representative. In fact, 36% said they would be much less likely, a figure three times greater than the 11 % who said they would be much more likely. Furthermore, 43% of respondents who said they voted for President Obama indicated that they would be less inclined to back a Member of Congress if he or she opposed conscience protection rights.

Healthcare providers’ conscience protections are viewed as an inalienable right.

A sizable 87% of American adults surveyed believed it is important to “make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections.” 65% of respondents considered it very essential. Also joining with these majorities were 95% of respondents who self-identified as “pro-life,” 78% who considered themselves “pro-choice,” 94% who voted for Senator McCain in November 2008 and 80% who cast a ballot for (now) President Obama.

Americans oppose forcing healthcare providers to act against their consciences...

A majority (57%) of American adults opposed regulations “that require medical professionals to perform or provide procedures to which they have moral or ethical objections.” In contrast, 38% favored such rules. A full 40% strongly objected to the rules while just 19% strongly backed them. A majority of conservative Republicans (69%), moderate Republicans (69%), and conservative Democrats (59%), as well as the plurality of liberal/moderate Democrats (49%), joining together to reject policies to that require doctors and nurses to act against their personal moral code or value set.

...Support laws that protect them from doing so...

Without any names or political parties being mentioned, support for the new conscience protection rule outpaced opposition by a margin of more than 2-to-1 (63% vs. 28%). Intensity favored the rule, with 42% strongly backing it and 19% strongly rejecting it. Endorsements for the rule spanned demographic and political spectra, with majorities in all cohorts offering their support. In fact, even 56% of adults who said they voted for President Obama last fall and 60% of respondents who self-identified as “pro-choice” said they favor this two-month old conscience protection rule.

... And oppose any efforts to remove such rules.

Opposition to revocation of the conscience protection rule outpaced support by a margin of more than 2- to-1 (62% vs. 30%). Intensity favored retention of the rule (44% strongly opposing rescission versus 17% strongly supporting it). There was consistent demographic alignment and cohesiveness across political lines, as 52% of self-identified Democrats, 67% of self-identified Independents, and 73% of self- identified Republicans, as well as 50% of liberals, 65% of moderates, and 69% of conservatives also opposed nullification. A narrow majority (53%) of people who considered themselves to be “pro-choice” opposed rescission. Notably, a small number

(7%) were ambivalent or undecided, saying they did not know or lacked the information to render an opinion one way or the other.

## Online Survey of Faith-Based Medical Professionals

1. Medical access will suffer if doctors are forced to act against their moral and ethical codes.

In the survey of 2,865 members of faith-based organizations, doctors and other medical professionals voiced their concerns that serious consequences could occur if doctors are forced to participate in or perform practices to which they have moral or ethical objections. Nearly three-quarters (74%) believed that elimination of the conscience protection could result in “fewer doctors practicing medicine,” 66% predicted “decreased access to healthcare providers, services, and/or facilities for patients in low-income areas,” 64% surmised “decreased access to healthcare providers, services, and/or facilities for patients in rural areas,” and 58% hypothesized “fewer hospitals providing services.”

Asked how rescission of the rule would affect them personally, 82% said it was either “very” or “somewhat” likely that they personally would limit the scope of their practice of medicine. This was true of 81% of medical professionals who practice in rural areas and 86% who work full-time serving poor and medically-underserved populations.

The conscience protection rule is fundamental and necessary in the medical profession.

Fully 97% of members who participated in the survey supported the two-month-old conscience protection clause and 96% objected to rescission of the rule. 91% of physicians agreed, "I would rather stop practicing medicine altogether than be forced to violate my conscience." The Department of Health and Human Services has asked whether the objectives of the conscience protection rule can be achieved “through non-regulatory means, such as outreach and education.” Nearly nine-in-ten (87%) members surveyed – those who are on the ground, in hospitals and clinics across the country – felt “outreach and education” alone were insufficient to accomplish the goal. Ninety-two percent declared the codification of conscience protection to be necessary (83% “very” and 9% “somewhat”) based on their knowledge of “discrimination in healthcare on the basis of conscience, religious, and moral values.”

Discrimination is widespread in education and professional practice.

Asked to assess their educational experiences:

- 39% have “experienced pressure from or discrimination by faculty or administrators based on [their] moral, ethical, or religious beliefs”
- 33% have “considered not pursuing a career in a particular medical specialty because of attitudes prevalent in that specialty that is not considered tolerant of [their] moral, ethical or religious beliefs.”
- 23% have “experienced discrimination during the medical school or residency application and interview process because of [their] moral, ethical or religious beliefs.”

Asked to assess their professional experiences:

- 32% have "been pressured to refer a patient for a procedure to which [they] had moral, ethical, or religious objections."
- 26% have "been pressured to write a prescription for a medication to which [they] had moral, ethical, or religious objections."
- 17% have "been pressured to participate in training for a procedure to which [they] had moral, ethical, or religious objections."
- 12% have "been pressured to perform a procedure to which [they] had moral, ethical, or religious objections."



Discrimination is forcing faith-based medical students to shun careers in Obstetrics and Gynecology.

- 20% of students surveyed agreed with the statement, "I am **not pursuing a career in Obstetrics or Gynecology** mainly because I do not want to be forced to compromise my moral, ethical, or religious beliefs by being required to perform or participate in certain procedures or provide certain medications."
- **96%** of medical students support (90% "Strongly Support") the conscience protection regulation.
- 32% of medical students say they "have experienced pressure from or **discrimination by faculty** or administrators based on your moral, ethical, or religious beliefs."

# **EXHIBIT F**

TO: Interested Parties

FROM: Kellyanne Conway, President & CEO  
the polling company™, inc./WomanTrend

DATE: April 8, 2009

RE: Key Findings on Conscience Rights Polling

*On behalf of the Christian Medical & Dental Association (CMDA), the polling company™, inc./WomanTrend conducted a nationwide survey of 800 American adults and an online survey of members of faith-based medical organizations. Full statements of methodology can be found at the conclusion of this document.*

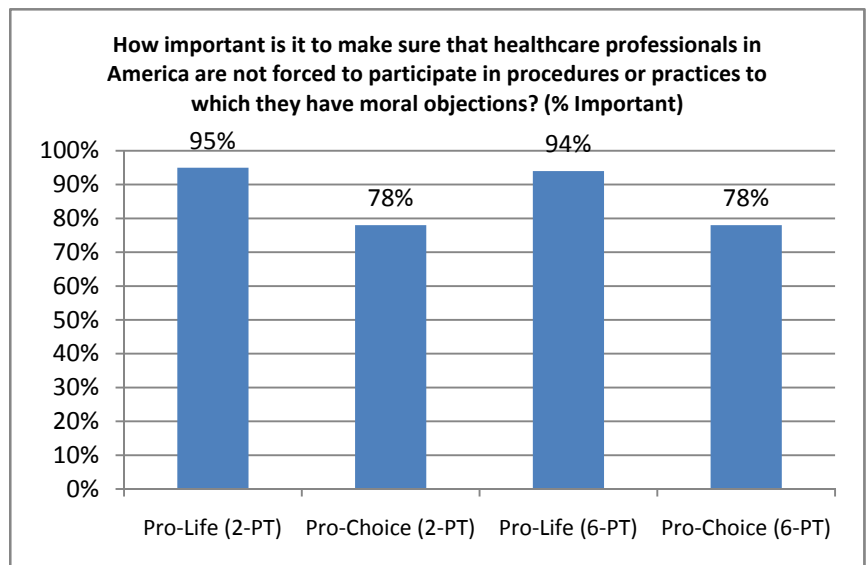
### **Americans of All Demographic Characteristics and Political Stripes Seek a Shared a Set of Values with their Healthcare Providers.**

Fully 88% of American adults surveyed said it is either “very” or “somewhat” important to them that they enjoy a similar set of morals as their doctors, nurses, and other healthcare providers. Intensity was strong, as 63% described this as “very” important while at the other end of the spectrum, just 6% said it is “not at all important,” a ratio of more than 10-to-1.

### **Healthcare Providers’ Conscience Protections Viewed as an Inalienable Right**

A sizable 87% of American adults surveyed believed it is important to **“make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections.”** Support for this

protection garnered considerable intensity as well, with 65% of respondents considering it very essential. Majorities of men, women, and adults of all ages, races, regions, and political affiliations considered it critical to defend the rights of healthcare providers to refuse to perform certain procedures on moral grounds. Also joining with these majorities were 95% of respondents who self-identified as “pro-life,” 78% who considered themselves “pro-choice,” 94% who voted for Senator McCain in November 2008 and 80% who cast a ballot for (now) President Obama.



### **Americans Oppose The *Principle* of Forcing Healthcare Providers to Act Against Their Consciences...**

A majority (57%) of American adults opposed regulations **“that require medical professionals to perform or provide procedures to which they have moral or ethical objections.”** In contrast, 38% favored such rules. The potency of opposition was twice that of the supporters: 40% strongly objected to the laws while just 19% strongly backed them. Politically, a majority of conservative Republicans (69%), moderate Republicans (69%), and conservative Democrats (59%), as well as the plurality of liberal/moderate Democrats (49%), joining together to reject policies to that require doctors and nurses to act against their personal moral code or value set.

### **...Support Laws That Protect Them From Doing So...**

Without any names or political parties being mentioned, respondents were provided with a short description of the new conscience protection law and its recent inception: **“Just two months ago, a federal law known as ‘conscience protection’ went into effect after reports of doctors being discriminated against for declining to perform abortions. It protects doctors and other medical professionals who work at institutions that receive federal money from performing medical procedures to which they object on moral or religious grounds.”**

After hearing this short description, support for this new law outpaced opposition by a margin of more than 2-to-1 (63% vs. 28%). Intensity favored the law, with 42% strongly backing it and 19% strongly rejecting it. Endorsements for the rule spanned demographic and political spectra, with majorities in all cohorts offering their support. **In fact, even 56% of adults who said they voted for President Obama last fall and 60% of respondents who self-identified as “pro-choice” said they favor this two-month old conscience protection rule.**

### **... And Oppose Any Efforts to Remove Such Laws.**

Next, respondents were asked to react to the proposed rescission of the conscience protection law: *“Earlier this month, officials from the U.S. Department of Health and Human Services introduced a rule change that would effectively eliminate the two-month-old conscience protection. This could mean that doctors and other medical professionals could be coerced to participate in medical procedures to which they object on moral or religious grounds.”*

Opposition to revocation of the conscience protection law outpaced support by a margin of more than 2-to-1 (62% vs. 30%). As was the case in the previous question, intensity favored retention of the law (44% strongly opposing rescission versus 17% strongly supporting it). Again, there was consistent demographic alignment, as a majority of men, women, and adults of all ages, races, incomes, regions, and geographic types stood together to reject removal of the law. And, there was cohesiveness across political lines, as 52% of self-identified Democrats, 67% of self-identified Independents, and 73% of self-identified Republicans, as well as 50% of liberals, 65% of moderates, and 69% of conservatives also opposed nullification. A narrow majority (53%) of people who considered themselves to be “pro-choice” opposed rescission. Notably, a small number (7%) were ambivalent or undecided, saying they did not know or lacked the information to render an opinion one way or the other.

### **Rescission of Conscience Protection Viewed by a Majority as Government Insinuating Itself into the Patient-Physician Relationship.**

When asked whether rescission of the rule and a resulting forced participation of doctors in abortions is a sign of more, less, or the right amount of government involvement in medicine, the majority (58%) said it exemplified excessive participation. Just 18% thought it reflected the ideal role and 11% believed it was still too minimal.

### **The Political Currency Calculus: Voters Will Punish Politicians Who Fail to Defend Healthcare Providers’ Rights to Refuse to Violate Their Conscience in the Name of Medicine.**

Finally, when asked how they would view their Member of Congress if he or she voted *against* conscience protection rights, 54% indicated they would be less likely to back their United States Representative. In fact, 36% said they would be *much less likely*, a figure three times greater than the 11% who said they would be *much more likely*. Furthermore, 43% of respondents who said they voted for President Obama indicated that they would be less inclined to back a Member of Congress if he or she opposed conscience protection rights.

**Rescission of Conscience Protections May be a Priority for Obama Administration, but not for his Constituents.**

When presented with a list of 13 areas for the sitting Congress and current President to address and allowed to select multiple answers, only 10% of American adults preferred that Washington devote its time and energy to abortion policy. In fact, the issue of abortion was ranked 9<sup>th</sup> out of 13 among the issues offered to survey respondents. Moreover, adults desirous of action on abortion policy were six times more likely to be “pro-life” than “pro-choice” (19% vs. 3%). In contrast, no less than 68% of any demographic or political cohort studied said that President Obama and Congressional leaders should focus on the economy and jobs.

**Real Effects Likely to Be Felt in Medical Community If Doctors Forced to Act Against Their Moral and Ethical Codes**

In the survey of 2,865 members of faith-based organizations, doctors and other medical professionals voiced their concerns that serious consequences could occur if doctors are forced to participate in or perform practices to which they have moral or ethical objections. Nearly three-quarters (74%) believed that elimination of the conscience protection could result in “fewer doctors practicing medicine.” 66% predicted “decreased access to healthcare providers, services, and/or facilities for patients in low-income areas.” 64% surmised “decreased access to healthcare providers, services, and/or facilities for patients in rural areas,” and 58% hypothesized “fewer hospitals providing services.”

When asked how rescission of the conscience rule would affect them personally, fully 82% said it was either “very” or “somewhat” likely that they personally would limit the scope of their practice of medicine. This was true of 81% of medical professionals who practice mainly in rural areas and 86% who work full-time in serving poor and medically-underserved populations.

**Conscience Protection Rule Fundamental and Necessary in the Medical Profession, According to Members of the Christian Medical & Dental Association, the Catholic Medical Association, and the Christian Pharmacists Fellowship International**

Fully 97% of members who participated in the survey supported the two-month-old conscience protection clause and 96% objected to rescission of the rule.

The Department of Health and Human Services has asked whether the objectives of the conscience protection law can be achieved “through non-regulatory means, such as outreach and education.” Nearly nine-in-ten (87%) members surveyed – those who are on the ground, in hospitals and clinics across the country – felt “outreach and education” alone were insufficient to accomplish the goal.

Ninety-two percent declared the codification of conscience protection to be necessary (83% “very” and 9% “somewhat”) based on their knowledge of “discrimination in healthcare on the basis of conscience, religious, and moral values.” Many respondents held this opinion due in part to their own personal experience. When asked to assess their educational experiences:

- 39% have “experience pressure from or discrimination by faculty or administrators based on [their] moral, ethical, or religious beliefs”
- 33% have “considered not pursuing a career in a particular medical specialty because of attitudes prevalent in that specialty that is not considered tolerant of [their] moral, ethical or religious beliefs.”
- 23% have “experienced discrimination during the medical school or residency application and interview process because of [their] moral, ethical or religious beliefs.”

And, when asked to assess their professional experiences:

- 32% have “been pressured to refer a patient for a procedure to which [they] had moral, ethical, or religious objections
- 26% have “been pressured to write a prescription for a medication to which [they] had moral, ethical, or religious objections
- 17% have “been pressured to participate in training for a procedure to which [they] had moral, ethical, or religious objections.”
- 12% have “been pressured to perform a procedure to which you had moral, ethical, or religious objections.”

### **STATEMENT OF METHODOLOGY**

#### ***Nationwide Survey of Adults:***

On behalf of the **Christian Medical & Dental Association, the polling company™, inc./ WomanTrend** conducted a nationwide survey of 800 American Adults (18+). The survey contained one screener question, 10 substantive questions, and 13 demographic inquiries. All substantive questions were closed-ended in nature.

The survey was fielded March 23-25, 2009 at a Computer-Assisted Telephone Interviewing (CATI) facility using live callers. The sample was drawn utilizing Random Digit Dial, a computer dialing technique that ensures that every household in the nation with a landline telephone has an equal chance of being called. Each respondent was screened to ensure he or she was 18 years of age.

Sampling controls were used to ensure that a proportional and representative number of people were interviewed from such demographic groups as age, race and ethnicity, and region according to the most recent figures available from the U.S. Census Bureau and voter registration and turnout figures. After data collection, weighting was used to ensure that the sample reflected the current population. This is a common and industry-accepted practice. Age, race, and gender were allowed four points of flexibility in pre-set quotas while three points of flexibility was permitted on region.

The overall margin of error for the survey is  $\pm 3.5\%$  at a 95% confidence interval, meaning that in 19 out of 20 cases, the data obtained would not differ by any more than 3.5 percentage points in either direction if the survey were repeated multiple times employing this methodology and sampling method. Margins of error for subgroups are higher.

#### ***Online Survey of Members of Faith-Based Medical Organizations:***

On behalf of the **Christian Medical & Dental Association, the polling company™, inc./ WomanTrend** conducted an online survey of members of faith-based organizations. The Catholic Medical Association and Christian Pharmacists Fellowship International also invited their members to participate.

The survey was fielded March 31, 2009 to April 3, 2009 and was completed by 2,865 members of the Christian Medical and Dental Association (CMDA), 400 members of the Catholic Medical Association (CMA), 69 members of the Fellowship of Christian Physicians Assistants, 206 members of the Christian Pharmacists Fellowship International, and 8 members of Nurses Christian Fellowship. Respondents were allowed to select membership in multiple organizations.

Each respondent was provided with a unique hyperlink to take the survey, allowing no member to take the survey more than once and prohibiting respondents from passing the link to another individual after completing the survey.

This survey is intended to demonstrate the views and opinions of members surveyed. It is not intended to be representative of the entire medical profession nor of the entire membership rosters of these organizations. Respondents who participated in the survey were self-selecting.



# **EXHIBIT G**



March 26, 2018

Alex Azar, Secretary  
U.S. Department of Health and Human Services  
Office for Civil Rights  
Hubert H. Humphrey Building, Room 509F  
200 Independence Avenue SW  
Washington, DC 20201

RE: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN: 0945-ZA03  
Comments

Dear Secretary Azar:

On behalf of the more than 123,000 PAs (physician assistants) throughout the United States, the American Academy of PAs (AAPA) welcomes the opportunity to submit comments to the Department of Health and Human Services (HHS) regarding the recent creation of the Conscience and Religious Freedom Division, along with the release of a rule to impose additional enforcement mechanisms with regard to federal laws that grant healthcare professionals the right to decline to participate in medical procedures to which they are opposed on moral or religious grounds.

In the proposed rule, the Office for Civil Rights (OCR) seeks to strengthen enforcement of existing statutory conscience protections for healthcare providers to protect them from being coerced into participating in activities that may violate their beliefs. The proposed rule also creates a new Conscience and Religious Freedom Division within OCR.

AAPA's policy, which is contained in its Guidelines for Ethical Conduct for the PA Profession, provides guidance on how PAs should act in situations where they believe their beliefs may be compromised, and how best to manage these beliefs in relation to a PA's obligation to provide the best possible care to their patients.

AAPA is concerned that the proposal's effort to broaden the scope of conscience objection regulations and to increase related enforcement efforts could have a negative impact on access to healthcare for patients, especially those who are most vulnerable and those who may live in rural or underserved areas. AAPA is also concerned new paperwork requirements related to "Assurance and Certification of Compliance" could be excessively burdensome to healthcare providers.

#### **PA Practice**

PAs are medical professionals who manage the full scope of patient care, often serving patients with multiple comorbidities. They conduct physical exams, order and interpret tests, diagnose and treat illnesses, develop and manage treatment plans, prescribe medications, assist in surgery, and counsel

patients on preventative healthcare, and often serve as a patient’s principal healthcare professional. PAs are one of three categories of healthcare professionals, including physicians and nurse practitioners, who are authorized by law to provide primary care in the United States. In addition to primary care, PAs practice in a wide range of settings and medical specialties, improving healthcare access and quality.

### **AAPA Policy on Personal Beliefs and Patient Access to Care**

The foremost value of the PA profession is respect for the health, safety, welfare, and dignity of all human beings, which requires PAs to always act in the best interest of their patients. This concept is the foundation of the patient–PA relationship, and underpins PAs’ ethical obligation to see that each of their patients receives appropriate care.

The PA profession’s policy on nondiscrimination is as follows: “PAs should not discriminate against classes or categories of patients in the delivery of needed healthcare. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation.”

Importantly, our policy also holds that, “While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. A PA has an ethical duty to offer each patient the full range of information on relevant options for their healthcare. *If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer a patient to another qualified provider.*” [Emphasis added.]

### **AAPA View and Recommendations**

AAPA has significant concerns about the proposed regulatory changes because they put the personal beliefs of healthcare providers above each provider’s paramount responsibility to ensure that every patient has access to care. We urge the administration to be cognizant of creating new barriers for healthcare for our most vulnerable populations, which would undermine the progress made in addressing medical disparities among these groups. Doing what is best for the patient must continue to be of utmost concern.

In promulgating the final rule and undertaking new initiatives, AAPA urges the department to work with all relevant healthcare provider groups to ensure that any actions are supported by and consistent with best healthcare practices, and that every patient has access to appropriate care.

AAPA looks forward to working with Secretary Azar, HHS and all relevant parties moving forward. Please do not hesitate to contact Tate Heuer, AAPA Vice President, Federal Advocacy, at 571-319-4338 or [theuer@aapa.org](mailto:theuer@aapa.org), with any questions.

Sincerely,



L. Gail Curtis, MPAS, PA-C, DFAAPA  
President and Chair of the Board

# **EXHIBIT H**



March 23, 2018

Office for Civil Rights  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 509F  
200 Constitution Avenue, NW  
Washington, DC 20210

Attention: Conscience Notice of Proposed Rule Making (NPRM), RIN 0945-ZA03

Submitted electronically to [www.regulations.gov](http://www.regulations.gov)

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority  
[HHS-OCR-2018-0002; RIN 0945-ZA03]

Dear Sir/Madam:

The American Nurses Association (ANA) and the American Academy of Nursing (AAN) submit the following comments in response to the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) Proposed Rule: *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*. This proposed rule requests comment on a number of provisions contained therein, and ANA and AAN through this comment letter seek to highlight the potential negative and unintended impacts which might follow from the final implementation of such, and offers policy recommendations. ANA is the premier organization representing the interests of the nation's 3.6 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. AAN serves the public and the nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. The Academy's more than 2,400 fellows are nursing's most accomplished leaders in education, management, practice, and research.

ANA and AAN strongly support the right and prerogative of nurses - and all healthcare workers – to heed their moral and ethical values when making care decisions. However, the primacy of the patient in nursing practice is paramount, and the moral and ethical considerations of the nurse should never, under any circumstance, result in the inability of the patient to receive quality, medically necessary, and compassionate care.

ANA and AAN are concerned that this proposed rule, in strengthening the authority of OCR to enforce statutory conscience rights under the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other federal statutes, could lead to inordinate discrimination against certain patient populations – namely individuals seeking reproductive

March 23, 2018

Page 2 of 8

health care services and lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) individuals. Proliferation of such discrimination – which in the case of LGBTQ individuals is unlawful under Section 1557 of the Affordable Care Act (ACA) – could result in reduced access to crucial and medically necessary health care services and the further exacerbation of health disparities between these groups and the overall population.

Discrimination in health care settings remains a grave and widespread problem for many vulnerable populations and contributes to a wide range of health disparities. Existing religion-based exemptions already create hardships for many individuals. The mission of HHS is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, patient care, public health, and social services. This proposed rule fails to ensure that all people have equal access to comprehensive and nondiscriminatory services, and dangerously expands the ability of institutions and entities, including hospitals, pharmacies, doctors, nurses, even receptionists, to use their religious or moral beliefs to discriminate and deny patients health care. All patients deserve universal access to high quality care and we as health care providers must guard against any erosion of civil rights protections in health care that would lead to denied or delayed care.

ANA and AAN believe that HHS should rescind this proposed rule and instead, through OCR, should create a standard for health systems and individual practices to ensure prompt, easy access to critical health care services if an individual provider has a moral or ethical objection to certain health care services; such a standard should build on evidence-based and effective mechanisms to accommodate conscientious objections to services including abortion, sterilization, or assisted suicide as cited in the proposed rule. ANA and AAN also believe that in no instance should a nurse – or any health care provider – refuse to treat a patient based on that patient’s individual attributes; such treatment violates one of the central tenets of the professional *Code of Ethics for Nurses*. No patient should ever be deprived of necessary health care services or of compassionate health care; it is incumbent upon HHS to work to create accommodations to that end.

### **Code of Ethics for Nurses and Moral and Ethical Obligations**

The critical importance of the relationship between the patient and the nurse is inherent in the fact that Provision 1 and Provision 2 of the *Code of Ethics for Nurses*<sup>1</sup> deal explicitly with these topics.

Affirming Health through Relationships of Dignity and Respect: *Provision 1 of the Code of Ethics*: states that “The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.”<sup>2</sup> This includes respect for the human dignity of the patient and the demand that nurses must never behave prejudicially – which is to say, with

---

<sup>1</sup>American Nurses Association. *Code of Ethics for Nurses with Interpretive Statements*. 2015: Second Edition.

<sup>2</sup>Ibid: Pg. 1.



March 23, 2018

Page 3 of 8

unjust discrimination. Nurses can and should base patient care on individual attributes, but only in the sense that those individual attributes inform the patient's care plan; nurses must always respect the dignity of such individual attributes.

Health care professionals work within a matrix of legal, institutional, and professional constraints and obligations, and their primary commitment to patients remains the foundational responsibility of health care.<sup>3</sup> *Provision 2* states that "The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population."<sup>4</sup> *Provision 2* explicitly establishes the primacy of the patient's interests in health care settings; this principle also situates the nurse-patient relationship within a larger "ethic of care" which encompasses the entire relational nexus in which the nurse and patient are situated, including the patient, the patient's family or close relationships, the nurse, the healthcare team, the institution or agency, and even societal expectations of care."<sup>5</sup>

While the primacy of the patient is not the only consideration when a nurse makes a care decision, it is the consideration which carries by far the most relative weight. Nurses then must base care decisions primarily on patients' needs. If a nurse feels that a moral or ethical consideration prevents him or her from delivering health care services, then the nurse, the full medical team, and/or the practice, institution, health system, or agency, should make an exhaustive and good-faith effort to ensure that the patient easily and promptly receives those health care services. In addition to the provisions contained within this proposed rule, OCR must implement guidelines by which the aforementioned stakeholders must ensure access to essential and quality health care services for all patients.

### **Considerations for Access to Reproductive Health Care Services**

In addition to providing competent, professional and high quality care, there is also an emphasis on providing evidence-informed patient education and support as part of the nursing standard of care. The nursing profession holds sacred the patient's right of autonomy to make informed decisions to direct his or her care, as well as the crucial role that nurses play in supporting the patient. Patient education and advocacy are essential elements of the nursing process. Thus, it is the patients' decisions, regardless of faith or moral convictions, that should guide healthcare providers' care of patients, as articulated in the Code of Ethics for Nurses with Interpretive Statements.

For nurses who have concerns about the provision of specific healthcare services, existing laws and ethical guidelines are more than adequate to protect the rights of health care providers to follow their moral and religious convictions. There already exist effective models to accommodate providers' moral and religious beliefs in training and practice, while striking a

---

<sup>3</sup>Stahl, Ronit Y. and Emanuel, Ezekiel J. *Physicians, Not Conscripts — Conscientious Objection in Health Care*. The New England Journal of Medicine: 2017 April; 376: 1380-1385.

<sup>4</sup>American Nurses Association. *Code of Ethics for Nurses*: Pgs. 25-26.

<sup>5</sup>Ibid: Pg. 28.

March 23, 2018

Page 4 of 8

crucial balance with delivering evidence-based, patient-centered care.<sup>6</sup> This proposed rule skews that balance, lowers the bar for care necessary for patients in vulnerable populations, and exposes women who seek reproductive health care to discrimination and harmful delays.<sup>7</sup> Such discrimination is well-documented – one study notes that 24% of women were denied treatment by a health care provider for pregnancy termination.<sup>8</sup> The proposed rule defines “discrimination” for the first time in a way that subverts the language of landmark civil rights statutes to shield those who discriminate, rather than protecting against discrimination.<sup>9</sup>

The proposed rule provides a broad definition of “assist in the performance” of an activity to which an individual can refuse to participate. The definition allows for blanket discrimination by permitting a broad interpretation of not only what type of services that can be refused but also the individuals who can refuse. For example, under this proposed rule, a receptionist can refuse to schedule a patient’s pregnancy termination or appointment for contraception consultation. This expansion violates the plain meaning of the existing law and goes against the stated mission of HHS.

Data suggest that health care providers believe that even when they are morally opposed to offering care, they are willing to make referrals and coordinate care according to care coordination standards to ensure adequate, timely and safe care, as well as full information about standard of care and available services, is provided for all patients.<sup>10</sup> Yet, the proposed rule creates a definition of “referral” that allows refusal to provide any information that could help the patient receive the proper care necessary; withholding information or complete care recommendations (e.g., professionals withholding diagnostic or treatment information) is unethical.

International professional associations such as the World Medical Association, as well as national medical and nursing societies and groups such as the American Congress of Obstetricians and Gynecologists and the Royal College of Nursing, Australia, have similarly agreed that the provider’s right to conscientiously refuse to provide certain services must be secondary to his or her first duty, which is to the patient.<sup>11</sup> This right to refuse must be bound

---

<sup>6</sup>National Women’s Law Center. *Trump Administration Proposes Sweeping Rule to Permit Personal Beliefs to Dictate Health Care*. February 16, 2018. Web: <https://nwlc.org/resources/trump-administration-proposes-sweeping-rule-to-permit-personal-beliefs-to-dictate-health-care/>

<sup>7</sup>Ibid.

<sup>8</sup>Biggs, M. Antonia and John M. Neuhaus and Diana G. Foster. *Mental Health Diagnoses 3 Years After Receiving or Being Denied an Abortion in the United States*. The American Journal of Public Health: 2015 December; 105(12): 2557-2563.

<sup>9</sup>National Women’s Law Center. *Trump Administration Proposes Sweeping Rule to Permit Personal Beliefs to Dictate Health Care*.

<sup>10</sup>Harris, LH et al. *Obstetrician-gynecologists’ objections to and willingness to help patients obtain an abortion*. Obstetrics and Gynecology: 2011 October; 118(4): 905-912.

<sup>11</sup>Chavkin, W. et al. *Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences, and policy responses*. The International Journal of Gynaecology and Obstetrics: 2013 December; 123 Supplement 3: S41-56.

March 23, 2018

Page 5 of 8

by obligations to ensure that the patient's autonomous rights to information and services are not infringed upon.<sup>12</sup>

### Considerations for the Protection of LGBTQ Access to Health Care Services

LGBTQ populations experience a significant rate of discrimination in health care settings, and also experience negative health outcomes compared with the overall population. The reasons for this are complex and varied, but many stem from a pattern of societal stigma and discrimination<sup>13</sup> exacerbated by the historical designation of homosexuality as a mental disorder<sup>14</sup>, the onset of the HIV/AIDS epidemic<sup>15</sup>, religious prejudice with respect to homosexuality<sup>16</sup>, and government policy such as *Don't Ask, Don't Tell*.<sup>17</sup> Indeed, the current administration filed a brief in federal court with the U.S. Court of Appeals for the 2<sup>nd</sup> Circuit in the case of *Zarda v. Altitude Express* arguing that sex discrimination provisions under Title VII of the 1964 Civil Rights Act do not protect employees from discrimination based on sexual orientation.<sup>18</sup>

HHS in May 2016 issued a rule to implement Section 1557 of the ACA, which clarifies that discrimination based on sex stereotyping and gender identity is impermissible sex discrimination under the law.<sup>19</sup> The current administration has failed to defend this regulation in federal court in the case of *Franciscan Alliance v. Burwell* (a different federal court recently ruled that Section 1557 *ipso facto* provides for the rule's aforementioned protections);<sup>20</sup> this seems to point to a preferential pattern of treatment in favor of religious conscience objections over the civil rights of LGBTQ populations despite consistent federal court opinions to the contrary.

---

<sup>12</sup>Ibid.

<sup>13</sup>U.S. Centers for Disease Control and Prevention. *Gay and Bisexual Men's Health: Stigma and Discrimination*. February 29, 2016. Web: <https://www.cdc.gov/msmhealth/stigma-and-discrimination.htm>

<sup>14</sup>Burton, Neel. *When Homosexuality Stopped Being a Mental Disorder*. Psychology Today (Blog). September 18, 2015. Web: <https://www.psychologytoday.com/blog/hidden-and-ignored/201509/when-homosexuality-stopped-being-mental-disorder>

<sup>15</sup>Barnes, David M. and Meyer, Ilan H. *Religious Affiliation, Internalized Homophobia, and Mental Health in Lesbians, Gay Men, and Bisexuals*. American Journal of Orthopsychiatry: 2012 October; 82(4): 505-515.

<sup>16</sup>DeCarlo, Pamela and Ekstrand, Maria. *How does stigma affect HIV prevention and treatment?* University of California, San Francisco: October 2016. Web: <https://prevention.ucsf.edu/library/stigma>

<sup>17</sup>U.S. Department of Defense. *Don't Ask, Don't Tell Is Repealed*. September 2011. Web: [http://archive.defense.gov/home/features/2010/0610\\_dadt/](http://archive.defense.gov/home/features/2010/0610_dadt/)

<sup>18</sup>Feuer, Alan and Weiser, Benjamin. *Civil Rights Act Protects Gay Workers, Appeals Court Rules*. The New York Times: February 26, 2018. Web: <https://www.nytimes.com/2018/02/26/nyregion/gender-discrimination-civil-rights-lawsuit-zarda.html>

<sup>19</sup>Gruberg, Sharita and Bewkes, Frank J. *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*. Center for American Progress: March 7, 2018: Pg. 1. Web: <https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/>

<sup>20</sup>Ibid: Pg. 2.

March 23, 2018

Page 6 of 8

OCR is responsible for accepting and investigating such complaints under Section 1557; the Center for American Progress in 2018 conducted an independent analysis of such complaints from May 2010 to January 2017 and found the following breakdown of complaint issues:<sup>21</sup>

- Denied care because of gender identity – non-transition related (24.3%)
- Misgendering or other derogatory language (18.9%)
- Denied insurance coverage for transition care (13.2%)
- Provider denied transition care (10.8%)
- Inadequate care because of gender identity (10.8%)
- Other discrimination based on sexual orientation (8.1%)
- Denied insurance coverage because of gender identity – non-transition-related (5.4%)
- Denied care because of sexual orientation or HIV status (5.4%)
- Inadequate care because of sexual orientation (2.7%)

It is worth noting that the number of Section 1557 complaints during this 7-year period (34) is comparable to the number of health care conscience complaints (44) during the 10-year period cited in the proposed rule. This comparison not only highlights the balance that must be struck between these two types of complaints, but also raises the question as to how such discrimination translates to actual health outcomes.

Negative health outcomes that disproportionately impact LGBTQ individuals include: increased instances of mood and anxiety disorders and depression, and an elevated risk for suicidal ideation and attempts; higher rates of smoking, alcohol use, and substance use; higher instances of stigma, discrimination, and violence; less frequent use of preventive health services; and increased levels of homelessness among LGBTQ youth.<sup>22</sup> Men who have sex with men (MSM) and transgender women also experience significantly higher rates of HIV/AIDS infections, complications, and deaths; this burden falls particularly heavily on young, African-American MSM and transgender women. As evidenced in the Section 1557 complaints above, this disease burden is itself known to contribute to discrimination against LGBTQ individuals. Transgender individuals also face particularly severe discrimination in health care settings: 33% of transgender patients say that a health care provider turned them away because of being transgender.<sup>23</sup>

As noted in the “*Code of Ethics for Nurses and Moral and Ethical Obligations*” section of this comment letter, nurses are obligated to respect the human dignity of all patients and to ensure that all patients receive quality, medically necessary, and compassionate care that is timely and safe. The health disparities highlighted in this section demonstrate the negative outcomes

---

<sup>21</sup>Ibid: Pg. 5.

<sup>22</sup>U.S. Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press; 2011.

<sup>23</sup>James, Sandy E. et al. *The Report of the U.S. Transgender Survey*. 2016: 96-97. Web: [www.ustranssurvey.org/report](http://www.ustranssurvey.org/report)

March 23, 2018

Page 7 of 8

associated with failure to provide such care. The civil rights of LGBTQ individuals – including the accessibility of quality health care services for LGBTQ individuals – should be protected in a manner consistent with the statutory conscience rights of health care workers under this proposed rule; the protection of such conscience rights should never impede the ability of LGBTQ individuals to access health care services.

### **Policy Recommendations and Conclusion**

ANA and AAN do not wish to diminish the role of moral and ethical considerations in patient care. In fact, the *Code of Ethics for Nurses* acknowledges both implicitly and explicitly that such considerations play critical roles when it comes to a patient's care plan. ANA and AAN do, however, reiterate the primacy of the patient in nursing care; ensuring that all patients are able to access quality, medically necessary, and compassionate care is paramount to nursing practice. ANA and AAN also acknowledge the dual roles that OCR plays with respect to simultaneously enforcing the ACA's Section 1557 provisions and the statutory conscience rights provisions referenced in the proposed rule, including those under the Church Amendments, the Coats-Snowe Amendment, and the Weldon Amendment.

To this end, ANA and AAN believe that in order to accommodate both priorities, OCR should implement guidelines for individual providers, practices, agencies, health systems, and institutions to accommodate both employees and patients. Namely, these guidelines must ensure that if any of the aforementioned stakeholders has a moral or ethical objection to providing certain health care services, they must have in place an organized plan by which the patient – without creating or exacerbating inequities - is able to easily access the quality, affordable, compassionate, and comprehensive health care that they need. Such guidelines reflect the primacy of the patient while at the same time recognizing that various federal statutes protect the conscience rights of health care workers. HHS and OCR must also work with stakeholders to implement existing, evidence-based models that facilitate a standard of care that integrates timely care coordination when health care providers or their employers exhibit a moral or ethical objection to providing certain health care services; such models must also protect the ability of the patient to access evidence-informed care and must not expose women and other marginalized populations to discrimination.

ANA and AAN also reiterate in no uncertain terms that nurses (or any other health care provider) cannot cite conscience rights protections as a reason for refusing to treat certain patient populations, including women seeking reproductive health care and LGBTQ populations. Such refusals go far beyond the provisions of any of the federal statutes cited in the proposed rule, a fact again borne out consistently in federal court opinions. As noted above, the nurse's primary concern is the patient's care. To provide inequitable care for an individual, or to refuse to provide that care entirely, would demonstrate unjust discrimination toward that patient. Such care (or lack thereof) directly contradicts one of the central tenets of nursing practice, violates federal law – including Section 1557 of the ACA – and leads to negative health outcomes and population health disparities.

March 23, 2018

Page 8 of 8

ANA and AAN believe that this proposed rule should be rescinded and that HHS should develop a standard for accommodation for conscientious objection to certain services which in no way limits the ability of the patient to receive timely, affordable, quality, and compassionate care. This proposed rule is restrictive with respect to ensuring such care. Given the current administration's track record when it comes to defending religious objections at the expense of individual rights, it seems to follow that this proposed rule would represent a significant lurch toward such defense in the health care field. This is unacceptable; in health care practice, patients come first, and HHS must make every attempt to strike an equitable balance between conscientious objections and patients' inalienable rights.

ANA and AAN welcome an opportunity to further discuss the issue of statutory conscience rights protections for health care workers. If you have questions, please contact Liz Stokes, Director, Center for Ethics and Human Rights ([liz.stokes@ana.org](mailto:liz.stokes@ana.org)) or Mary Beth Bresch White, Director, Health Policy ([marybreschwhite@ana.org](mailto:marybreschwhite@ana.org)).

Sincerely,



Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN  
President

American Nurses Association



Karen S. Cox, PhD, RN, FACHE, FAAN  
President

American Academy of Nursing

cc: Debbie Hatmaker, PhD, RN, FAAN, Interim Chief Executive Officer, American Nurses Assoc.  
Cheryl G. Sullivan, MSES, Chief Executive Officer, American Academy of Nursing



# **EXHIBIT I**

March 27, 2018

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

**RE: RIN 0945–ZA03**

To Whom It May Concern:

The California Primary Care Association (CPCA) represents over 1,300 not-for-profit community clinics and health centers (CCHCs) in California that provide comprehensive, high quality health care services to low-income, uninsured, and underserved Californians. CPCA member health centers provide nearly 20 million patient encounters to over 6.2 million patients each year. CCHC patients are primarily low income, often speak a primary language other than English, come from diverse cultural and ethnic backgrounds, and often have a limited choice of providers due to language, culture, geographic, or income barriers. The potential impact of this regulation will fall heavily on those patients who already face enormous barriers to getting the care they need, making access even harder for vulnerable groups such as those seeking end-of-life care, persons affected by HIV/AIDS, women, persons of color, and lesbian, gay, bisexual, and transgender individuals.

**I. The Proposed Rule is Contrary to the Mission of CCHCs**

CPCA strongly believes that employers, including health centers, should maintain the right to hire individuals who are able to meet the requirements of their job description, including the provision of the full spectrum of care needed by CCHC patients. Health centers must - by mission and design - conduct their business in a way that meets the health needs of their specific underserved communities. Any efforts by providers or other health care personnel to limit the information and access that patients are entitled to receive, even when the CCHC may not provide those services itself, is incompatible with the mission and function of the organization. As primary care providers who care for patients and communities, we must maintain the ability of our health centers to employ individuals who further our mission of providing comprehensive primary and preventive care and furthering important public health goals.

Nearly all CPCA member health centers have a consumer-majority board of directors that must have the discretion to build a facility and company culture that reflects the core values and meets the health needs of their communities. Forcing health centers to employ practitioners regardless of their aversion to clear, evidence-based public health priorities, such as vaccinations, contraceptives, mental health treatment, and other services covered under this rule, contradicts the spirit and the efficacy of the community health center program.

## II. The Proposed Rule Undermines Patient Safety and Medical Standards of Care

The language of this rule is broad and ambiguous enough that medical staff may interpret the regulation to indicate that they can not only refuse, but decline to tell the patient where he would be able to obtain lifesaving services or even inform patients of their treatment options. This puts the health of the patient, and potentially that of others, at risk. Further, the proposed rule threatens informed consent, a necessary principle of patient-centered decision-making. Informed consent relies on disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether. This right relies on two factors: access to relevant and medically-accurate information about treatment choices and alternatives, and provider guidance based on generally accepted standards of practice. Both factors make trust between patients and health care professionals a critical component of quality of care. However, this proposed rule suggests that a medical provider or staff could refuse to offer information, if that information might be used to obtain a service to which the refuser objects, allowing staff to impose their own religious beliefs on their patients by withholding vital information about treatment options. Such an attenuated relationship to informed consent could result in withholding information that would violate medical standards of care.

## III. The Office of Civil Rights Should Prevent Discrimination

CPCA appreciates and strongly supports the Office of Civil Rights' (OCR) efforts to prevent discrimination. Always, health centers and our employees act without regard to race, religion, ethnicity, gender identity, or sexual orientation. However, this proposed rule, while cloaked in the language of non-discrimination, is designed to deny care and exclude disadvantaged and vulnerable populations.

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. By issuing the proposed rule along with the newly created "Conscience and Religious Freedom Division," the Department seeks to use OCR's 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.

Rather than preventing discrimination, this proposed rule puts individuals into a position of power to discriminate against those seeking essential care. **For these reasons, CPCA stands firmly against this proposed rule.**

Thank you for the opportunity to comment.

Sincerely,

Andie Patterson  
Director of Government Affairs  
California Primary Care Association

# **EXHIBIT J**



## California LGBT Health & Human Services Network

March 27, 2018

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

**RE: Public Comment in Response to the Proposed Regulation, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03**

To whom it may concern:

I am writing on behalf of the California LGBT Health and Human Services Network in response to the request for public comment regarding the proposed rule entitled, “Protecting Statutory Conscience Rights in Health Care” published January 26. The California LGBT Health and Human Services Network is a statewide coalition of over 60 non-profit providers, community centers, and researchers working collectively to advocate for state level policies and resources that will advance LGBT health. We strive to provide coordinated leadership about lesbian, gay, bisexual, transgender, and queer (LGBTQ) health policy in a proactive, responsive manner that promotes health and wellness as part of the movement for LGBT equality.

**The proposed rule goes far beyond the scope of the underlying statutes, and strays from the original purpose of the Office of Civil Rights (OCR).** OCR was created to uphold the principle that all people in the United States have a right to receive health care in a nondiscriminatory manner. OCR has always been an office focused on protecting the rights of consumers and increasing access to health care. The proposed rule would stray from this core tenet of OCR, and instead restrict consumers access to nondiscriminatory health care.

**The enforcement actions outlined against recipients of federal funds and subrecipients alike will have the likely impact of encouraging discrimination by health care entities.** This new proposal from HHS encourages health care providers to abandon the principle of “first, do no harm” in favor of their personal beliefs. This puts transgender patients, people who need reproductive health care, and many others at risk of being denied necessary and even life-saving

care. The proposed enforcement measures are likely illegal and will result in great costs the health care industry, and to individual patients.

LGBTQ people, women, and other vulnerable groups around the country already face enormous barriers to getting the care they need.<sup>1</sup> In the past year, out of respondents to the 2015 U.S. Transgender Survey who saw a health care provider, one-third were denied treatment, turned away, or mistreated.<sup>2</sup> Accessing quality, culturally competent care and overcoming outright discrimination is even a greater challenge for those living in areas with already limited access to health providers. The proposed regulation threatens to make access even harder and for some people nearly impossible. By expanding the definition of a health care entity, this rule will likely make it more difficult for patients and consumers to access comprehensive and affirming sexual health care.

**The proposed rule is in conflict with existing state and local nondiscrimination protections.** Even in California, where we have taken proactive steps to increase accessing to affirming health care – that is available in a patient’s spoken language, is developmentally appropriate, and culturally responsive – many LGBTQ people still struggle to find supportive and knowledgeable providers. And yet, this proposed rule would have us go backwards. The proposed rule tramples on California’s efforts to protect patients’ health and safety, including through the California Insurance Gender Nondiscrimination Act, and other rules that have made it clear that all people the right to access coverage for medically necessary care regardless of their gender identity or gender expression.<sup>3</sup> By claiming to allow individuals and institutions to refuse care to patients based on the providers’ religious or moral beliefs in such a sweeping way, the proposed rule creates conflicts with hundreds of state and local nondiscrimination laws around the country that apply to health care. It therefore is disingenuous for the Department to claim that the proposed rule “does not impose substantial direct effects on States,” “does not alter or have any substantial

---

<sup>1</sup> 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](http://www.ustranssurvey.org/report); Lambda Legal, *When Health Care Isn’t Caring: Lambda Legal’s Survey on Discrimination Against LGBT People and People Living with HIV* (2010), <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>.

<sup>2</sup> James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

<sup>3</sup> See, e.g., California Department of Managed Health Care, *Letter No. 12-K: Gender Nondiscrimination Requirements* (April 9, 2013), <http://translaw.wpengine.com/wp-content/uploads/2013/04/DMHC-Director-Letter-re-Gender-NonDiscrimination-Requirements.pdf>.



direct effects on the relationship between the Federal government and the States,” and “does not implicate” federalism concerns under Executive Order 13132.

The proposed rule goes far beyond established law, appears to have been developed in a rushed and arbitrary manner, and most importantly will put the health and potentially even the lives of patients at risk. We urge you to withdraw the proposed rule.

Sincerely,

A handwritten signature in black ink that reads "Amanda Wallner". The signature is written in a cursive style with a long horizontal line extending to the right.

Amanda Wallner

Director, California LGBT Health and Human Services Network

# **EXHIBIT K**



National Association of County & City Health Officials

*The National Connection for Local Public Health*

March 27, 2018

The Honorable Alex Azar  
Secretary  
U.S. Department of Health and Human Services  
Attention: Office for Civil Rights  
Conscience NPRM  
RIN 0945-ZA03  
Hubert H. Humphrey Building, Room 209F  
200 Independence Avenue SW  
Washington, DC 20201

Dear Secretary Azar:

On behalf of the National Association of County and City Health Officials (NACCHO) and nearly 3,000 local health departments, thank you for the opportunity to provide comments on the proposed Department of Health and Human Services (HHS) regulation entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."

Local public health departments are the governmental agencies that work every day in their communities to prevent disease, promote wellness, and protect health. They organize community partnerships and facilitate important conversations with a number of stakeholders about how to create the conditions in which all people can be healthy.

NACCHO has several concerns about the proposed rule and its effect on access to necessary primary care services. **The rule's emphasis on accommodating religious beliefs could interfere with delivery of appropriate care and services.** As proposed, the rule will give health care providers a license based on religious beliefs to opt out of evidence-based care that the medical community endorses. If this rule were to be implemented, more women, particularly women of color, will be put in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services.

NACCHO calls on HHS to include explicit language making clear that religious beliefs will not be used to deny access to health services or to discriminate against people based on reproductive health decisions, gender identity or sexual orientation. In addition, NACCHO calls on HHS to continue activities to identify and address health disparities with the ultimate goal of eliminating them. In activities spanning the Office for Civil Rights, Office of Minority Health, Office of Women's Health as well as the Centers for Medicare & Medicaid Services, all of HHS' endeavors must ensure that disparities are not heightened but are prevented.

Teen births are decreasing and abortion rates are the lowest they have been since the *Roe v Wade* Supreme Court decision, in large part because of increased access to evidence-based health education and health services. We cannot afford to turn back the clock on this progress. The proposed rule may open the door to discrimination by health care providers based on individually held beliefs. To protect the public's health, the patient's needs must come first. Furthermore, these new priorities are worrisome as they reflect an ideology that aims to dictate the decisions people can make about their bodies and health care.

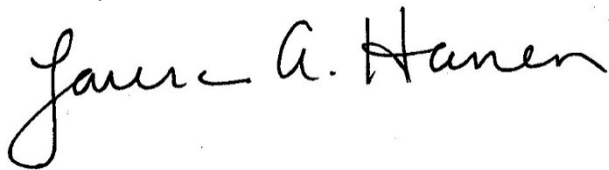


Lesbian, gay, bisexual and transgender (LGBT) people are considered a vulnerable population as it concerns their health. LGBT people face higher rates of HIV/AIDS, depression, an increased risk of some cancers, and are twice as likely as their heterosexual peers to have a substance use disorder. Transgender people in particular are at higher risk for a range of poor health outcomes. For example, the 2015 U.S. Transgender Survey, a national study of nearly 28,000 transgender adults, found that respondents were nearly five times more likely to be living with HIV than the general population, with even higher rates for some populations: for example, nearly one in five (19%) Black transgender women living with HIV, more than 63 times the rate in the general population. Transgender respondents were nearly eight times more like than the general population to be living with serious psychological distress based on the Kessler 6 scale, with higher rates correlating with experiences of discrimination, violence, and rejection.

The medical community and scientific research has repeatedly demonstrated that the poor health outcomes that LGBT people face are not associated with any inherent pathology, but rather high rates of poverty, discrimination in the workplace, schools, and other areas, and barriers to nondiscriminatory health care that meets their needs. Refusals to treat individuals according to medical standards of care put patients' health at risk, particularly for women and LGBT individuals. Expanding religious refusals will further put needed care, including reproductive health care, out of reach for many. Given the broadly-written and unclear language of the proposed rule, if implemented, some providers may misuse this rule to deny services to LGBT individuals on the basis of perceived or actual sexual orientation and gender identity. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care impairs the ability of patients to make a health decision that expresses their self-determination.

Thank you again for the opportunity to comment on "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority." NACCHO and local health departments look forward to continued opportunities to partner with the federal government to protect the public and ensure optimal health. Please contact me at [lhansen@naccho.org](mailto:lhansen@naccho.org)/202-507-4255 for any further information.

Sincerely,

A handwritten signature in black ink that reads "Laura A. Hanen". The signature is written in a cursive, flowing style.

Laura A. Hanen, MPP  
Interim Executive Director & Chief of Government Affairs

# **EXHIBIT L**



Jodi Magee  
President/CEO

**BOARD OF DIRECTORS**

Willie J. Parker, MD, MPH, MSc  
Chair

Angela Janis, MD  
Secretary

Nancy J. Auer, MD  
Treasurer

Cassing Hammond, MD  
At-Large Member

Seymour L. Romney, MD  
Founding Chair Emeritus  
(1917-2010)

Nazanin Ahmadiéh  
Medical Student

Sarp Aksel, MD

Carol Ball, MD

Margaret Boozer, MD, MPH

Curtis Boyd, MD

Kristyn Brandi, MD, MPH

Michelle Debbink, MD, PhD

Kohar Der Simonian, MD

Duane L. Dowell, MD, FAAP

Megan Evans, MD, MPH

Bhavik Kumar, MD, MPH

Amber Lau, MPH, OMSII  
Medical Student

Jill Meadows, MD

Jason Rafferty, MD, MPH, EdM

Yashica Robinson, MD

Brandi Shah, MD, MPH

Timothy Spurrell, MD, MEd

David Turok, MD, MPH

Valerie Williams, MD

Alyssa Yee, MD

Matthew Zerden, MD, MPH

March 27, 2018

The Honorable Alex Azar  
Secretary of Health and Human Services  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

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

Dear Secretary Azar:

Physicians for Reproductive Health is committed to ensuring all individuals have access to health care, regardless of their gender identity, sexual orientation, and/or the type of services being requested, including abortion, contraception or sterilization.

Physicians for Reproductive Health (Physicians) is a doctor-led national advocacy organization that uses evidence-based medicine to promote sound reproductive health policies. Physicians unites the medical community and concerned supporters. Together, we work to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients. Physicians believes a health care provider's personal beliefs should never determine the care a patient receives. By allowing patient care to be compromised by religious or personal beliefs without consideration of the best medical care for the patient, this rule stands to undermine the very foundation of the doctor-patient relationship. Indeed, one of the reasons cited for the proposed rule is a case—*Chamorro v. Dignity Health*—we filed in California against a Catholic





hospital network regarding their refusal to allow doctors to provide patients with the standard of care in the form of postpartum tubal ligations. That is why we strongly oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule"), which seeks to permit discrimination in all aspects of health care.<sup>1</sup>

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 beliefs to deny people the care they need. For these reasons Physicians 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 Personal Belief*

The Proposed Rule will exacerbate health inequities by expanding the ability to refuse critical services, including abortion 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)."<sup>2</sup> Read in conjunction with

---

<sup>1</sup> 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].

<sup>2</sup> *See id.* at 12.



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 beliefs to determine a patient’s access to care.

*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.<sup>3</sup> 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.<sup>4</sup> 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.<sup>5</sup> Such an attempted expansion 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

---

<sup>3</sup> 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](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>.

<sup>4</sup> The Church Amendments, 42 U.S.C. § 300a-7 (2018).

<sup>5</sup> See Rule *supra* note 1, at 185.



refused to include merely “making arrangements for the procedure” no matter how tangential.<sup>6</sup> 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.<sup>7</sup>

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.<sup>8</sup> 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.<sup>9</sup> 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.<sup>10</sup>

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.”<sup>11</sup> 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.”<sup>12</sup> In a Proposed Rule that seeks to protect those who want to discriminate, this broad definition is nonsensical and inappropriate. Further, such a vague and

---

<sup>6</sup> *Id.* at 180.

<sup>7</sup> *Id.* at 183.

<sup>8</sup> 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).

<sup>9</sup> See Rule *supra* note 1, at 182.

<sup>10</sup> 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.

<sup>11</sup> See Rule *supra* note 1, at 180.

<sup>12</sup> *Id.*



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.<sup>13</sup> 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.<sup>14</sup> Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.<sup>15</sup> In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.<sup>16</sup> 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.<sup>17</sup> 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

---

<sup>13</sup> See, e.g., *supra* note 3.

<sup>14</sup> 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>.

<sup>15</sup> 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](https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf).

<sup>16</sup> 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>.

<sup>17</sup> 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](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).



the following days, the hospital did not give her full information about her condition and treatment options.<sup>18</sup>

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

Refusals of care based on personal beliefs already make it difficult for many individuals to 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.<sup>19</sup> 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.<sup>20</sup> In rural areas there may be no other sources of health and life preserving medical care.<sup>21</sup> In developing countries where many health systems are weak, health care options and supplies are often unavailable.<sup>22</sup> 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

---

<sup>18</sup> 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>.

<sup>19</sup> 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>.

<sup>20</sup> 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>.

<sup>21</sup> 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/>.

<sup>22</sup> 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>.



states, women of color are more likely than white women to give birth in Catholic hospitals.<sup>23</sup> 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.<sup>24</sup> 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.<sup>25</sup> The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.<sup>26</sup> 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.<sup>27</sup>

*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 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.”<sup>28</sup> The Proposed Rule plainly fails on both counts. Although the Proposed Rule attempts to quantify the costs of compliance, it

<sup>23</sup> 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>.

<sup>24</sup> See *id.* at 10-13.

<sup>25</sup> 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/>.

<sup>26</sup> 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>.

<sup>27</sup> 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/>.

<sup>28</sup> 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>.





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.<sup>29</sup>

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.<sup>30</sup> Because the Proposed Rule would cause substantial harm, including to patients, it would violate the Establishment Clause.<sup>31</sup>

### **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.<sup>32</sup> For instance, Congress has specifically required that under the Title X program, providers must offer non-directive pregnancy options counseling<sup>33</sup> and current regulations require that pregnant women receive “referral[s] upon request” for prenatal care and delivery, adoption, and/or pregnancy termination.<sup>34</sup> 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

<sup>29</sup> See Rule *supra* note 1, at 94-177.

<sup>30</sup> 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).

<sup>31</sup> Respecting religious exercise may not “unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling.” See *Burwell v. Hobby Lobby*, 134 S. Ct. at 2787. When considering whether the birth control coverage requirement was the least restrictive means in *Hobby Lobby*, the Court considered that the accommodation offered by the government ensured that affected employees “have precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing coverage.” See *id.* at 2759. In other words, the effect of the accommodation on women would be “precisely zero.” *Id.* at 2760.

<sup>32</sup> 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>.

<sup>33</sup> See, e.g., Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).

<sup>34</sup> See *What Requirements Must be Met by a Family Planning Project?*, 42 C.F.R. § 59.5(a)(5) (2000).



funds are generally conditioned.<sup>35</sup> 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.<sup>36</sup> When it comes to Title X, the Proposed Rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objectives. Every year millions of low-income, including under-insured, and uninsured individuals, rely on Title X clinics to access services they otherwise might not be able to afford.<sup>37</sup>

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

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care. 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.<sup>38</sup> 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.<sup>39</sup> 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

---

<sup>35</sup> See, e.g., Rule *supra* note 1, at 180-185.

<sup>36</sup> See NFPRHA *supra* note 34.

<sup>37</sup> See *id.*

<sup>38</sup> 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](https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf).

<sup>39</sup> 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).



altogether.<sup>40</sup> 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.<sup>41</sup>

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.<sup>42</sup> Individuals seeking reproductive health care, 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.<sup>43</sup> No health care professional should face

---

<sup>40</sup> *See id.*

<sup>41</sup> *See Rule supra* note 1, at 150-151.

<sup>42</sup> For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant. AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE § 114-15, S117 (2017), available at [http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement\\_1.DC1/DC\\_40\\_S1\\_final.pdf](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).

<sup>43</sup> *See* The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).



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.<sup>44</sup> 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.<sup>45</sup> 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.<sup>46</sup> If finalized, however, the Proposed Rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities. Through robust enforcement of civil rights laws, OCR has worked to reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities,

---

<sup>44</sup> *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.").

<sup>45</sup> See Rule *supra* note 1, at 203-214.

<sup>46</sup> As one of its first official acts in 1967, the Office of Equal Health Opportunity undertook the massive effort of inspecting 3,000 hospitals to ensure they were complying with Title VI's prohibition against discrimination on the basis of race, color, or national origin. 42 U.S.C. § 2000d (1964). After this auspicious start, the Office of Equal Health Opportunity which would eventually become OCR would go on to ensure that health programs and activities it regulated complied with key anti-discrimination laws including Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1973), Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 (1972), the Age Discrimination Act of 1976, 42 U.S.C. § 6101 (1976), and Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116 (2010), among others. Through robust enforcement of these laws, OCR has worked to reduce discrimination in health care.



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.<sup>47</sup>

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.<sup>48</sup> 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.<sup>49</sup> Further, the disparity in maternal mortality is growing rather than decreasing,<sup>50</sup> 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.<sup>51</sup> 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.<sup>52</sup> Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.<sup>53</sup> Eight percent of

---

<sup>47</sup> 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>.

<sup>48</sup> 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>.

<sup>49</sup> 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>.

<sup>50</sup> See *id.*

<sup>51</sup> 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).

<sup>52</sup> 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).

<sup>53</sup> 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](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



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 in the year before the survey.<sup>54</sup>

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.<sup>55</sup>

### **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,<sup>56</sup> the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.<sup>57</sup> 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.<sup>58</sup> 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

---

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

<sup>54</sup> 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](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf).

<sup>55</sup> See *supra* note 46.

<sup>56</sup> 42 U.S.C. § 2000e-2 (1964).

<sup>57</sup> *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>.

<sup>58</sup> See *id.*





comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.<sup>59</sup>

Furthermore, the language in the Proposed Rule would seem to put health care entities in the position of being forced to hire people who intend to refuse to perform essential elements of a position even though Title VII would not require such an “accommodation.” For example, there is no guidance about whether it is impermissible “discrimination” for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling even though the employer would not be required to do so under Title VII.<sup>60</sup> 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.<sup>61</sup> Under EMTALA every hospital is required to comply – even those that are religiously affiliated.<sup>62</sup> 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.

---

<sup>59</sup> 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](https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html).

<sup>60</sup> See Rule *supra* note 1, at 180-181.

<sup>61</sup> 42 U.S.C. § 1295dd(a)-(c) (2003).

<sup>62</sup> 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 (3<sup>rd</sup> Cir. 2000); *In re Baby K*, 16 F.3d 590, 597 (4<sup>th</sup> 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).



### **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.<sup>63</sup> 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.<sup>64</sup>

### **Conclusion**

The Proposed Rule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The Proposed Rule is discriminatory, violates multiple federal statutes and the Constitution, ignores congressional intent, fosters confusion, and harms patients, contrary to the Department's stated mission. For these reasons Physicians for Reproductive Health calls on the Department to withdraw the Proposed Rule in its entirety.

Sincerely,

Board of Directors, Physicians for Reproductive Health

---

<sup>63</sup> See, e.g., Rule, *Supra* note 1, at 3888-89.

<sup>64</sup> See *id.*

**EXHIBIT M**



Association of  
American Medical Colleges  
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399  
T 202 828 0400  
www.aamc.org

Via Electronic Submission ([www.regulations.gov](http://www.regulations.gov))

March 26, 2018

Roger Severino  
Director, Office of Civil Rights  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

***Re: Protecting Statutory Conscience Rights in Health Care, HHS (HHS-OCR-2018-0002)***

Dear Mr. Severino:

The Association of American Medical Colleges (AAMC or Association) welcomes the opportunity to comment on the Department of Health and Human Services (HHS' or the Agency's) proposed rule titled *Protecting Statutory Conscience Rights in Health Care, HHS, 83 Fed. Reg. 3880* (January 26, 2018).

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Our members are all 151 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, we serve the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. As will be described in detail below, should the rule be finalized as proposed, it will result in harm to patients, undermine standards of medical professionalism, and raise serious concerns regarding individuals' rights that are protected by other federal and state laws. **Therefore, we urge the Department to withdraw the proposed regulation.**

### **The Needs of Patients Should Be Put First**

Ethical and moral issues within the context of health care are among the most challenging that we face. They require a careful balance between the rights of the health care professional to avoid behavior that violates his/her moral or ethical code, and the rights of a patient to receive lawful health care services that are safe and medically appropriate. In some circumstances, it is difficult to maintain this balance. When that happens, the health and the rights of the patient, who is in the more vulnerable position, must be given precedence. Those who choose the profession of medicine are taught repeatedly during their medical school and residency training that, in the end, their duty to care for the patient must come first, before self. For example, the American Medical Association *Principles of Medical Ethics* state, "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." This does not mean that a physician or other health care provider must act in violation of his or her own moral code,

but it does mean that a physician has the duty to provide information and to refer the patient to other caregivers without judgment.<sup>1</sup>

Julie Cantor wrote about the need for a balance towards professionalism in her article, “Conscientious Objection Gone Awry – Restoring Selfless Professionalism in Medicine” (New England Journal of Medicine, April 9, 2009), which is cited in this proposed rule instead as evidence of rampant discrimination against those who wish to practice women’s health. Rather than promote discrimination against health care professionals, Dr. Cantor calls on those who “freely choose their field” to evaluate their beliefs in relation to their specialties and whether they are able to provide all legal options for care. “As gatekeepers to medicine, physicians and other health care providers have an obligation to choose specialties that are not moral minefields for them. . . . Conscience is a burden that belongs to that individual professional; patients should not have to shoulder it.”

### **There Is No Demonstrable Need for the Proposed Rule**

As we stated when we commented on the original 2008 Federal Health Care Conscience Rule, no individual or entity in this country has the option to pick and choose the laws to which he/she will adhere. Every health care provider and entity already has the obligation to comply with all applicable federal laws. The Department has offered little evidence that this has not been the case. The Office of Civil Rights has received just forty-four complaints since it was designated with authority to enforce the Church, Coats-Snow, and Weldon Amendments. The paucity of complaints does not provide compelling evidence of a need for the expansion of OCR’s authority, or the need for changes in the current regulations.

### **Accreditation Organizations Require Medical Students and Residents to Be Taught to Respond to the Many Health Care Needs of a Diverse Patient Population and Respect a Medical Student or Resident’s Decision to Not Receive Training in Abortions**

Starting with undergraduate medical education and continuing through residency training, physicians are taught that they will be practicing medicine in a multi-cultural, multi-ethnic world in which patients and their families hold diverse viewpoints on many complex ethical issues that affect health care. Their education also occurs in an atmosphere that acknowledges that as health care providers, physicians themselves bring a diversity of religious and moral views on health care issues to their work. Such disparate views are examined during the educational process during a physician’s initial training and throughout the individual’s professional development.

Belying the concern that medical schools and training program are discriminating against medical students and residents for their religious views are the accreditation requirements of the Liaison Committee for Medical Education (LCME), which accredits all US medical education programs leading to the MD degree, and the Accreditation Council for Graduate Medical Education (ACGME), which accredits residency programs that seek to attract a wide variety of individuals into medicine. Both organizations have standards that are designed to ensure that the education of physicians provides an environment that embraces diversity of views and values for both health care providers and patients. For instance, the LCME requires that “[t]he selection of individual [medical] students must not be influenced by any political or financial factors.”

---

<sup>1</sup> American Medical Association Council on Ethical & Judicial Affairs, “Code of Medical Ethics Opinion 1.1.7” <https://www.ama-assn.org/delivering-care/physician-exercise-conscience>

Additional requirements include the following:

A medical school does not discriminate on the basis of age, creed, gender identity, national origin, race, sex, or sexual orientation.

A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, develop and conduct appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

A medical school develops effective written policies that address violations of the code, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing inappropriate behavior. Mechanisms for reporting violations of the code of professional conduct are understood by medical students, including visiting medical students, and ensure that any violations can be registered and investigated without fear of retaliation. (Standards, Publications, & Notification Forms. LCME. [lcme.org/publications](http://lcme.org/publications). Accessed March 2018).

Further, the LCME's June 2017 Rules of Procedure regarding medical school accreditation state that:

Medical education programs are reviewed solely to determine compliance with LCME accreditation standards. LCME accreditation standards and their related elements are stated in terms that respect the diversity of mission of U.S. medical schools, including religious missions.

The LCME also recognizes the need for medical students to learn how to care for a diverse patient population. For example,

The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction regarding the following:

- The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments
- The basic principles of culturally competent health care
- The recognition and development of solutions for health care disparities
- The importance of meeting the health care needs of medically underserved populations
- The development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society

Similarly, the ACGME states that:

Residents are expected to demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.



Clinical learning environments (CLEs) need to ensure that their residents and fellows learn to recognize health care disparities and strive for optimal outcomes for all patients, especially those in potentially vulnerable populations. As front-line caregivers, residents and fellows are a valuable resource for formulating strategies on these matters. They can assist the CLEs in addressing not only low-income populations, but also those that experience differences in access or outcome based on gender, race, ethnicity, sexual orientation, health literacy, primary language, disability, geography, and other factors.

The diverse, often vulnerable, patient populations served by CLEs also provide an important opportunity for teaching residents and fellows to be respectful of patients' cultural differences and beliefs, and the social determinants of health.

In considering patient outcomes, it is important to note that patients at risk for disparities are likely to require differences in care that are tailored to their specific needs—based not only on their biological differences, but also on other social determinants of health (e.g., personal social support networks, economic factors, cultural factors, safe housing, local food markets, etc.).

The ACGME's Common Program Requirements state that "Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Standard VI.B.6)

In regard to women's healthcare, both accrediting organizations are clear that a program cannot require training in abortion procedures. The ACGME's Program requirements specific to obstetrics and gynecology state "Residents who have a religious or moral objection may opt-out and must not be required to participate in training in or performing induced abortions." The profession of medicine seeks to embrace within its ranks individuals from diverse racial/ethnic, cultural, religious and socioeconomic backgrounds. Such diversity of backgrounds helps to ensure that physicians will understand and be sympathetic to the traditions, values, and beliefs of their patients and provide competent care.

### **The Proposed Rule Is Overly Expansive In Its Reach and Is Incongruous with Medical Professionalism**

The proposed rule is overly expansive, allowing physicians and others to avoid engaging in any activity "with an articulable connection" to the objectionable procedure, "include[ing] counseling, referral, training, and other arrangements for the procedure." It then proposes a definition of referral that expands the general understanding of referral to include "the provision of *any* information...when the entity or health care entity making the referral sincerely understands that particular health care service, activity, or procedure to be a purpose or *possible outcome of the referral*." (emphasis added). The refusal of a physician or other health care professional to provide a patient with information, or to give a patient a referral to a provider where the desired care is available, risks limiting the patient's access to health care. Allowing health care professionals to engage in behavior that could harm patients is incongruous with the standards of medical professionalism that are the core of a physician's education and the practice of medicine.

Similarly, the proposed regulation would interpret the term "assist in the performance" to include "any activity with an articulable connection to a procedure, health service, or research activity[.]" The proposed regulation states that this definition is intended to be broad, and not limited to direct involvement with a procedure, health service, or research activity. For example, this broader definition could apply to an employee whose task is to clean a room where a particular procedure took place. Such a

broad view is unnecessary particularly since the employee has the option to seek employment elsewhere while the patient may have only one place where he/she can receive care.

### **The Proposed Rule Will Do Harm to Lower Income Americans, Racial and Ethnic Minorities, the LGBTQ Community, and Patients in Rural Areas**

The proposed rule would allow physicians and others to avoid engaging in any activity “with an articulable connection” to the objectionable procedure, “includ[ing] counseling, referral, training, and other arrangements for the procedure.” This broad reach will create or exacerbate inequities in health care access for Americans whose access may already be limited due to their geographic residence or financial means. For rural- and frontier-dwelling Americans who reside in a health professional shortage area, access to certain services might functionally cease to exist as a result of this proposed rule: seeking care in distant locales might be too burdensome or expensive. This holds, too, for lower income Americans who lack the financial means to seek out care for procedures when their primary physicians decline to provide services.

Racial and ethnic minority women have reported experiencing race-based discrimination when receiving family planning care.<sup>2</sup> The proposed rule may exacerbate this problem and the consequences that follow for women and their children. Research has associated unintended pregnancy with several adverse maternal and child health outcomes, such as delayed prenatal care, tobacco and alcohol use during pregnancy, delivery of low birthweight babies<sup>3</sup>, and poor maternal mental health.<sup>4</sup> These negative health outcomes are more prevalent in racial and ethnic minority communities likely would worsen under the proposed rule.

For the lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities, the proposed rule may further exacerbate health care access disparities. It is well documented that LGBTQ Americans currently experience discrimination in health care settings, erecting a barrier to accessing health care services.<sup>5</sup> This proposed rule would codify what many within and beyond the LGBTQ communities will view as state-sanctioned discrimination, and allow providers to refuse care or appropriate referrals solely on the basis of their patients’ sexual orientation or gender identity. This stands in stark opposition to OCR’s stated goal to “protect fundamental rights of nondiscrimination.”

### **The Proposed Rule Adds Burdensome Requirements That Have No Commensurate Benefit**

The Department and this Administration have undertaken major efforts to reduce regulatory burden, such as “Reducing Regulation and Controlling Regulatory Costs” (Executive Order 13771, issued January 30, 2017), “Enforcing the Regulatory Reform Agenda” (Executive Order 13777, issued February 24, 2017), the Centers for Medicare & Medicaid’s “Patient over Paperwork” initiative (launched October 2017, in an effort to reduce unnecessary burden), and several Requests for Information regarding administrative burden. The burden associated with complying with the proposed rule runs counter to this goal. Moreover, the investment in resources that would be required for a large teaching health care system to

---

<sup>2</sup> Thorburn S, Bogart LM. “African American women and family planning services: perceptions of discrimination,” *Women Health*. 2005;42(1):23–39.

<sup>3</sup> Institute of Medicine (US) Committee on Unintended Pregnancy; Brown SS, Eisenberg L, editors. “The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families. National Academies Press (US); 1995. 3, *Consequences of Unintended Pregnancy*. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK232137/>

<sup>4</sup> Herd P et al., “The implications of unintended pregnancies for mental health in later life,” *American Journal of Public Health*, 2016, 106(3):421–429.

<sup>5</sup> Cahill, S. “LGBT Experiences with Health Care,” *Health Affairs* Vol. 36, No.4. 2017. Available from: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0277>

March 26, 2018

Page 6

ensure compliance and monitoring of all of the proposed requirements would be even more onerous and reduce funds available for the core missions of teaching, patient care, and research.

The Department proposes to modify existing civil rights clearance forms (or develop similar forms in the future), and notes that it might require submission of these documents annually and incorporate by reference in all other applications submitted that year. The receipt of any federal funds already requires the compliance with all federal laws and regulations; assurances and attestations to compliance are routine. OCR has not made clear why there is a need for additional assurance and certification.

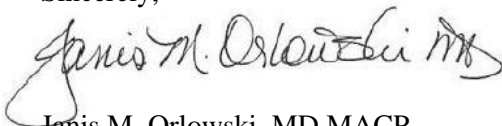
The Department also proposes notice requirements, which includes notice on the funding recipient's website, in prominent and conspicuous physical locations where other notices to the public and notices to the recipient's workforce are customarily posted. The notice is to be posted by April 26, 2018, or for new recipients, within 90 days of becoming a recipient. Even if the rule is finalized by April 26, and no changes are made in the notice requirement, it is unreasonable to expect current recipients to comply by that date.

The rule also proposes that if a sub-recipient is found to have violated federal health care conscience and associated anti-discrimination laws, the recipients "shall be subject to the imposition of funding restrictions and other appropriate remedies." Requiring the imposition of funding restrictions should be dependent on the facts and circumstances of a particular case; however, by using the word "shall" there seems to be no discretion in whether this penalty is appropriate. If the rule is finalized, the AAMC asks that OCR clearly make the penalty optional by using "may" instead of "shall."

The AAMC strongly urges the Department to withdraw the proposed rule. Alternatively, the rule should be re-proposed and narrowed in scope to, at a minimum, appropriately balance the needs of patients with the needs of health care providers who have freely chosen their profession.

If you would like additional information, please contact Ivy Baer, Senior Director and Regulatory Counsel, at 202-828-0499 or [ibaer@aamc.org](mailto:ibaer@aamc.org).

Sincerely,



Janis M. Orlowski, MD MACP  
Chief, Health Care Affairs

**EXHIBIT N**

NHeLP Draft as of March 22, 2018

U.S. Department of Health and Human Services  
Office for Civil Rights  
Attention: Conscience NPRM  
RIN 0945-ZA03  
Hubert H. Humphrey Building, Room 209F  
200 Independence Avenue SW  
Washington, DC 20201

## Introduction

On behalf of National Association of Councils on Developmental Disabilities, we submit these comments to the federal Department of Health and Human Services (“Department”) and its Office for Civil Rights (“OCR”) in opposition to the proposed regulation entitled “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.”<sup>1</sup>

The regulations as proposed 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 regulations purport to provide clarity and guidance in implementing existing federal religious exemptions, in reality they are vague and confusing. The proposed rule creates the potential for exposing patients to medical care that fails to comply with established medical practice guidelines, negating long-standing principles of informed consent, and undermines the ability of health facilities to provide care in an orderly and efficient manner.

Most important, the regulations fail to account for the significant burden that will be imposed on patients, a burden that will fall disproportionately and most harshly on women, people of color, people living with disabilities, and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals. These communities already experience severe health disparities and discrimination, conditions that will be exacerbated by the proposed rule, possibly ending in poorer health outcomes. By issuing the proposed rule along with the newly created “Conscience and Religious Freedom Division,” the Department seeks to use OCR’s 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. For these reasons, the National Health Law Program calls on the Department and OCR to withdraw the proposed rule in its entirety.

### **I. Under the guise of civil rights, the proposed rule seeks to deny medically necessary care**

Civil rights laws and Constitutional guarantees, such as due process and equal protection, are designed to ensure full participation in civil society. The proposed rule,

---

<sup>1</sup> U.S. Dept. of Health and Human Serv., Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880-3931 (Jan. 26, 2018) (hereinafter “proposed rule”).

NHeLP Draft as of March 22, 2018

while cloaked in the language of non-discrimination, is designed to deny care and exclude disadvantaged and vulnerable populations. The adverse consequences of health care refusals and other forms of discrimination are well documented. As the Department 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.”<sup>2</sup>

The Department and OCR have an important role to play in ensuring equal health opportunity and ending discriminatory practices that contribute to health disparities. Yet, 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.<sup>3</sup> As an outcome of this 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.<sup>4</sup> The proposed rule will not achieve these outcomes. Instead, the proposed rule 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. The expansion of religious refusals under the proposed rule will disproportionately harm communities who already lack access to care**

Women, individuals living with disabilities, LGBTQ persons, 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. 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.<sup>5</sup> Women of color experience health care disparities such as high rates of cervical cancer and are disproportionately impacted by HIV.<sup>6</sup>

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

<sup>3</sup> 83 Fed. Reg. 3917.

<sup>4</sup> *Id.*

<sup>5</sup> 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>.

<sup>6</sup> In 2014, Latinas 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



NHeLP Draft as of March 22, 2018

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-Latino/a counties designated by the federal Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

The expansion of refusals as proposed under this rule will exacerbate these disparities and undermine the ability of these individuals to access comprehensive and unbiased health care, including 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.

- a. *The proposed rule will block access to care for low-income women, including immigrant women and African American 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,<sup>7</sup> 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.<sup>8</sup> Notably, immigrant, Latina women have far higher rates of uninsurance than Latina women born in the United States (48 percent versus 21 percent, respectively).<sup>9</sup>

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.<sup>10</sup> 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.<sup>11</sup>

---

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>.

<sup>7</sup> 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>.

<sup>8</sup> 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).

<sup>9</sup> *Id.* at 8, 16.

<sup>10</sup> 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](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](http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf).

<sup>11</sup> *Reproductive Injustice*, *supra* note 10, at 16-17.

NHeLP Draft as of March 22, 2018

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.<sup>12</sup> In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.<sup>13</sup> 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.<sup>14</sup> 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.<sup>15</sup> The proposed rule will give health care providers a license, such as Catholic hospitals, to opt out of evidence-based care that the medical community endorses. If this rule were to be implemented, more women, particularly women of color, will be put 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 will negatively impact rural communities*

The ability to refuse care to patients will leave many individuals in rural communities with no health care options. Medically underserved areas already exist in every state,<sup>16</sup> with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.<sup>17</sup> 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.<sup>18</sup> 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

---

<sup>12</sup> 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>.

<sup>13</sup> *Id* at 12.

<sup>14</sup> *Id* at 9.

<sup>15</sup> 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/>.

<sup>16</sup> 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).

<sup>17</sup> 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/>.

<sup>18</sup> 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>.

NHeLP Draft as of March 22, 2018

quality roads, and have less access to reliable public transportation.<sup>19</sup> 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.<sup>20</sup> 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.<sup>21</sup>

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.<sup>22</sup> 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.<sup>23</sup> Individuals with Hepatitis C infection find few providers in rural areas with the specialized knowledge to manage the emerging treatment options, drug toxicities and side effects.<sup>24</sup> All of these barriers will worsen if providers are allowed to refuse care to particular patients.

Meanwhile, immigrant, Latina women and their families often face cultural and linguistic barriers to care, especially in rural areas.<sup>25</sup> These women often lack access to transportation and may have to travel great distances to get the care they need.<sup>26</sup> 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.

---

<sup>19</sup> 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/>.

<sup>20</sup> 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/>.

<sup>21</sup> *Id.*

<sup>22</sup> 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>.

<sup>23</sup> 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/>.

<sup>24</sup> 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>.

<sup>25</sup> 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>.

<sup>26</sup> 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>.

NHeLP Draft as of March 22, 2018

c. *The proposed rule would harm LGBTQ Communities who continue to face rampant discrimination and health disparities*

The proposed rule will compound the barriers to care that LGBTQ individuals face, particularly the effects of ongoing and pervasive discrimination by potentially allowing providers to refuse to provide services and information vital to LGBTQ health.

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. The Department's Healthy People 2020 initiative recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."<sup>27</sup> LGBTQ people still 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.<sup>28</sup> 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.<sup>29</sup> 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.<sup>30</sup>

i. Discrimination against the transgender community

Discrimination based on gender identity, gender expression, gender transition, transgender status, or sex-based stereotypes is necessarily a form of sex discrimination.<sup>31</sup> Numerous federal courts have found that federal sex discrimination

<sup>27</sup> *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).

<sup>28</sup> 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>.

<sup>29</sup> 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.

<sup>30</sup> *Id.*

<sup>31</sup> 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.



NHeLP Draft as of March 22, 2018

statutes reach these forms of gender-based discrimination.<sup>32</sup> 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.”<sup>33</sup>

Twenty-nine percent of transgender individuals were refused to be seen 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.<sup>34</sup> 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.<sup>35</sup> Data obtained by Center for American Progress (CAP) under a FOIA request indicates the Department’s 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 the Department 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.”

---

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 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).

<sup>32</sup> 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).

<sup>33</sup> *Macy v. Holder*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, \*12 (Apr. 20, 2012).

<sup>34</sup> 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](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).

<sup>35</sup> 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].

NHeLP Draft as of March 22, 2018

- “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.”<sup>36</sup>

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

ii. Discrimination Based Upon Sexual Orientation

Many LGBTQ people lack insurance and providers are not competent in health care issues and obstacles that the LGBTQ community experiences.<sup>37</sup> LGBTQ people still face discrimination. According to one survey, 8 percent of lesbian, gay, bisexual, and queer individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and 7 percent experienced unwanted physical contact and violence from a health care provider.<sup>38</sup>

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.<sup>39</sup> Almost ten percent of LGB respondents reported that they had been denied necessary health care expressly because of their sexual orientation.<sup>40</sup> 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:

---

<sup>36</sup> 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/>.

<sup>37</sup> Medical schools often do not provide instruction about LGBTQ health concerns that are not related to HIV/AIDS. Jen Kates et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.*, KAISER FAMILY FOUND.12 (2017), <http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US>.

<sup>38</sup> Mirza, *supra* note 34.

<sup>39</sup> 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](http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf).

<sup>40</sup> *Id.*



NHeLP Draft as of March 22, 2018

- LGB individuals are more likely than heterosexuals to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities.<sup>41</sup>
- Lesbian and bisexual women report poorer overall physical health than heterosexual women.<sup>42</sup>
- 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.<sup>43</sup>
- 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.<sup>44</sup>
- Bisexual people face significant health disparities, including increased risk of mental health issues and some types of cancer.<sup>45</sup>

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 family or them [identifying as LGBTQ]”.<sup>46</sup> 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.<sup>47</sup>

The proposed rule allowing providers to deny needed care would reverse recent gains in combatting discrimination and health care disparities for LGBT persons. Refusals also implicate standards of care that are vital to LGBTQ health. Medical professionals are expected to provide LGBTQ individuals with the same quality of care as they would anyone else. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and competency with LGBTQ issues as they pertain to any health services provided.<sup>48</sup> The World Professional

<sup>41</sup> 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/>.

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> 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>.

<sup>45</sup> 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>.

<sup>46</sup> HUMAN RIGHTS WATCH, *supra* note 28.

<sup>47</sup> Mirza, *supra* note 34.

<sup>48</sup> *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, GAY LESBIAN BISEXUAL & TRANSGENDER HEALTH ACCESS PROJECT, <http://www.glbthealth.org/CommunityStandardsofPractice.htm> (last visited Jan. 26, 2018, 12:59 PM); *Creating an LGBTQ-friendly Practice*, A.M.A., <https://www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice#Meet a Standard of Practice> (last visited Jan. 26, 2018, 12:56 PM).

NHeLP Draft as of March 22, 2018

Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.<sup>49</sup> The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.<sup>50</sup> LGBTQ individuals already experience significant health disparities, and denying medically necessary care on the basis of sexual orientation or gender identity exacerbates these disparities.

In addition, LGBTQ individuals face disparities in medical conditions that may implicate the need for reproductive health services. For example, lesbian and bisexual women report heightened risk for and diagnosis of some cancers and higher rates of cardiovascular disease.<sup>51</sup> The LGBTQ community is significantly at risk for sexual violence.<sup>52</sup> Eighteen percent of lesbian, gay, bisexual students have reported being forced to have sex.<sup>53</sup> Transgender women, particularly women of color, face high rates of HIV.<sup>54</sup>

Refusals to treat individuals according to medical standards of care put patients' health at risk, particularly for women and LGBTQ individuals. Expanding religious refusals will further put needed care, including reproductive health care, out of reach for many. Given the broadly-written and unclear language of the proposed rule, if implemented, some providers may misuse this rule to deny services to LGBTQ individuals on the basis of perceived or actual sexual orientation and gender identity. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care impairs the ability of patients to make a health decision that expresses their self-determination.

Finally, the proposed rule threatens to turn back the clock to the darkest days of the AIDS pandemic when same-sex partners were routinely denied hospital visitation and health care providers scorned sick and dying patients.

*d. The proposed rule will hurt 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,

<sup>49</sup> *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, WORLD PROF. ASS'N FOR TRANSGENDER HEALTH (2011), [https://s3.amazonaws.com/amo\\_hub\\_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf).

<sup>50</sup> *Committee Opinion 512: Health Care for Transgender Individuals*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Dec. 2011), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals>.

<sup>51</sup> Kates, *supra* note 37, at 4.

<sup>52</sup> Forty-six percent of bisexual women have been raped and 47 percent of transgender people are sexually assaulted at some point in their lifetime. This rate is particularly higher for transgender people of color. Kates, *supra* note 37, at 8.; *2015 U.S. Transgender Survey*, *supra* note 35, at 5.

<sup>53</sup> *Health Risks Among Sexual Minority Youth*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/healthyyouth/disparities/smy.htm> (last updated May 24, 2017).

<sup>54</sup> More than 1 in 4 transgender women are HIV positive. Kates, *supra* note 37, at 6.

NHeLP Draft as of March 22, 2018

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.<sup>55</sup> 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.<sup>56</sup> Given these and other experiences, the extremely broad proposed language at 45 C.F.R. § 88.3(a)(2)(vi) that would allow any individual or entity with an “articulable connection” to a service, referral, or counseling described in the relevant statutory language to deny assistance due to a moral or religious objection is extremely alarming and could seriously compromise the health, autonomy, and well-being of people with disabilities.

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 this broad new proposed language, 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 case manager might refuse to set up a routine appointment with a gynecologist because contraceptives might be discussed. A personal home health aide could refuse to help someone take a contraceptive. An interpreter for a deaf individual could refuse to mediate a conversation with a doctor about abortion. In these cases, a denial based on someone’s personal moral objection can potentially impact every facet of life for a person with disabilities – including visitation rights, autonomy, and access to the community.

Finally, 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.<sup>57</sup> Finding providers competent to treat people with certain disabilities can increase the challenge. Add in the possibility of a case manager or personal care attendant who

---

<sup>55</sup> 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).

<sup>56</sup> 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](https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf).

<sup>57</sup> 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>.

NHeLP Draft as of March 22, 2018

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 receive (or even know about) accommodations.

### **III. The proposed rule undermines longstanding ethical and legal principles of informed consent**

The proposed rule threatens informed consent, a necessary principle of patient-centered decision-making. Informed consent relies on disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.<sup>58</sup> This right relies on two factors: access to relevant and medically-accurate information about treatment choices and alternatives, and provider guidance based on generally accepted standards of practice. Both factors make trust between patients and health care professionals a critical component of quality of care.

The proposed rule purports to improve communication between patients and providers, but instead, will deter open, honest conversations that are vital to ensuring that a patient is able to be in control of their medical circumstances. For example, the proposed rule suggests that someone could refuse to offer information, if that information might be used to obtain a service to which the refuser objects. Such an attenuated relationship to informed consent could result in withholding information far beyond the scope of the underlying statutes, and would violate medical standards of care.

In recent decades, the U.S. medical community has primarily looked to informed consent as key to assuring patient autonomy in making decisions.<sup>59</sup> Informed consent is intended to help balance the unequal balance of power between health providers and patients and ensure patient-centered decision-making. Moreover, consent is not a yes or no question but rather is dependent upon the patient's understanding of the procedure that is to be conducted and the full range of treatment options for a patient's medical condition. Without informed consent, patients will be unable to make medical decisions that are grounded in agency, their beliefs and preferences, and that meet their personal needs. This is particularly problematic as many communities, including women of color and women living with disabilities, have disproportionately experienced abuse and trauma at the hands of providers and institutions.<sup>60</sup> In order to ensure that patient

---

<sup>58</sup> TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).

<sup>59</sup> BEAUCHAMP & CHILDRESS, *supra* note 58; Robert Zussman, *Sociological perspectives on medical ethics and decision-making*, 23 ANN. REV. SOC. 171-89 (1997).

<sup>60</sup> Gutierrez, E. R. *Fertile Matters: The Politics of Mexican Origin Women's Reproduction*, 35-54 (2008) (discussing coercive sterilization of Mexican-origin women in Los Angeles); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 411-12 (2000) (referencing one 1974 study indicating that Indian Health Services would have coercively sterilized approximately 25,000 Native American Women by 1975); Alexandra Minna Stern, *Sterilized in the Name of Public Health*, 95 AM. J. PUB. H. 1128, 1134 (July 2005) (discussing African-American women forced



NHeLP Draft as of March 22, 2018

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.

According to the American Medical Association: “The physician’s obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient’s care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.”<sup>61</sup> The American Nursing Association similarly requires that patient autonomy and self-determination are core ethical tenets of nursing. “Patients have the moral and legal right to determine what will be done with their own persons; to be given accurate, complete and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens and available options in their treatment.”<sup>62</sup> Similarly, pharmacists are called to respect the autonomy and dignity of each patient.<sup>63</sup>

Various state and federal laws require that health care professionals inform and counsel patients on specific issues such as preventing the spread of HIV/AIDS, non-directional information on family planning and abortion options, and emergency contraception to prevent pregnancy from rape.<sup>64</sup> In *Brownfield v. Daniel Freeman Marina Hospital*, a California court addressed the importance of patients’ access to information in regard to emergency contraception. The court found that:

“The duty to disclose such information arises from the fact that an adult of sound mind has ‘the right, in the exercise of control over [her] own body, to determine whether or not to submit to lawful medical treatment.’ [citation omitted] Meaningful exercise of this right is possible only to the extent that patients are provided with adequate information upon which to base an intelligent decision with regard to the option available.”<sup>65</sup>

---

to choose between sterilization and medical care or welfare benefits and Mexican women forcibly sterilized). See also *Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding state statute permitting compulsory sterilization of “feeble-minded” persons); Vanessa Volz, *A Matter of Choice: Women With Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 WOMEN RTS. L. REP. 203 (2006) (discussing sterilization reform statutes that permit sterilization with judicial authorization).

<sup>61</sup> *The AMA Code of Medical Ethics’ Opinions on Informing Patients: Opinion 9.09 – Informed Consent*, 14 AM. MED. J. ETHICS 555-56 (2012), <http://journalofethics.ama-assn.org/2012/07/coet1-1207.html>.

<sup>62</sup> *Code of ethics for nurses with interpretive statements, Provision 1.4 The right to self-determination*, AM. NURSES ASS’N (2001),

[https://www.truthaboutnursing.org/research/codes/code\\_of\\_ethics\\_for\\_nurses\\_US.html](https://www.truthaboutnursing.org/research/codes/code_of_ethics_for_nurses_US.html).

<sup>63</sup> *Code of Ethics for Pharmacists*, AM. PHARMACISTS ASS’N (1994).

<sup>64</sup> See, e.g., *State HIV Laws*, CTR. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/hiv/policies/law/states/index.html> (last visited Nov. 13, 2017, 1:22PM); *Emergency Contraception*, GUTTMACHER INST. (Oct. 1, 2017), <https://www.guttmacher.org/state-policy/explore/emergency-contraception>.

<sup>65</sup> *Brownfield v. Daniel Freeman Marina Hospital*, 256 Cal. Rptr. 240 (Ct. App. 1989).

NHeLP Draft as of March 22, 2018

In addition, the proposed rule does not provide any protections for health care professionals who want to provide, counsel, or refer for health care services that are implicated in this rule, for example, reproductive health or gender affirming care. Due to the rule's aggressive enforcement mechanisms and its vague and confusing language, providers may fear to give care or information. The inability of providers to give comprehensive, medically accurate information and options that will help patients make the best health decisions violates medical principles such as, beneficence, nonmaleficence, respect for autonomy, and justice. In particular, the principle of beneficence "requires that treatment and care do more good than harm; that the benefits outweigh the risks, and that the greater good for the patient is upheld."<sup>66</sup> In addition, the proposed rule undermines principles of quality care. Health care should be safe, effective, patient-centered, timely, efficient, and equitable.<sup>67</sup> Specifically, the provision of the care should not vary due to the personal characteristics of patients and should ensure that patient values guide all clinical decisions.<sup>68</sup> The expansion of religious refusals as envisioned in the proposed rule may compel providers to furnish care and information that harms the health, well-being, and goals of patients.

In particular, the principles of informed consent, respect for autonomy, and beneficence are important when individuals are seeking end of life care. These patients should be the center of health care decision-making and should be fully informed about their treatment options. Their advance directives should be honored, regardless of the physician's personal objections. Under the proposed rule, providers who object to various procedures could impose their own religious beliefs on their patients by withholding vital information about treatment options— including options such as voluntarily stopping eating and drinking, palliative sedation or medical aid in dying. These refusals would violate these abovementioned principles by ignoring patient needs, their desires, and autonomy and self-determination at a critical time in their lives. Patients should not be forced to bear the brunt of their provider's religious or moral beliefs regardless of the circumstances.

#### **IV. The regulations fail to consider the impact of refusals on persons suffering from substance use disorders (SUD)**

The over breadth of this proposed rule could be devastating to people with Substance Use Disorder (SUD). Rather than promoting the evidence-based standard of care, the rule could 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.

---

<sup>66</sup> Amy G. Bryant & Jonas J. Schwartz, *Why Crisis Pregnancy Centers Are Legal but Unethical*, 20 AM. MED. ASS'N J. ETHICS 269, 272 (2018).

<sup>67</sup> INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21<sup>ST</sup> CENTURY 3 (Mar. 2001), available at <http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>.

<sup>68</sup> *Id.*



NHeLP Draft as of March 22, 2018

The opioid epidemic continues to claim too many lives. According to the Centers for Disease Control and Prevention (CDC), over 63,000 people in the U.S. died from drug overdose in 2016.<sup>69</sup> 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.<sup>70</sup>

The clear, evidence-based treatment standard for opioid use disorder (OUD) is medication-assisted treatment (MAT).<sup>71</sup> 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.”<sup>72</sup> 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.<sup>73</sup> 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.<sup>74</sup> 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.

However, stigma associated with drug use stands in the way of saving lives.<sup>75</sup> 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 of care. For example, a needle exchange program designed to protect injection drug users from contracting blood

---

<sup>69</sup> Holly Hedegaard M.D., et al. *Drug Overdose Deaths in the United States, 1999-2016*, NAT’L CTR. FOR HEALTH STATISTICS 1-8 (2017).

<sup>70</sup> *Vital Signs*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vitalsigns/opioid-overdoses/>.

<sup>71</sup> 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>.

<sup>72</sup> World Health Organization, 19th WHO Model List of Essential Medicines (April 2015), [http://www.who.int/medicines/publications/essentialmedicines/EML2015\\_8-May-15.pdf](http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf)

<sup>73</sup> 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].

<sup>74</sup> See James M. Chamberlain & Bruce L. Klein, *A Comprehensive Review of Naloxone for the Emergency Physician*, 12 AM. J. EMERGENCY MED. 650 (1994).

<sup>75</sup> 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>.

NHeLP Draft as of March 22, 2018

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.<sup>76</sup> 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.<sup>77</sup>

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.”<sup>78</sup> This belief is so common that even the former Secretary of the Department 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.”<sup>79</sup> 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.<sup>80</sup> 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.”<sup>81</sup>

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.<sup>82</sup> 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.<sup>83</sup> 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.<sup>84</sup> The current Secretary of the

<sup>76</sup> 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>.

<sup>77</sup> 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-cbcc2e7bfbf\\_story.html?utm\\_term=.4184c42f806c](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-cbcc2e7bfbf_story.html?utm_term=.4184c42f806c).

<sup>78</sup> Lopez, *supra* note 75.

<sup>79</sup> 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](https://www.wvgazette.com/news/health/trump-officials-look-for-opioid-solutions-in-wv/article_52c417d8-16a5-59d5-8928-13ab073bc02b.html).

<sup>80</sup> 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>.

<sup>81</sup> 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](https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf)

<sup>82</sup> 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>

<sup>83</sup> 42 C.F.R. §8.610.

<sup>84</sup> 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),

NHeLP Draft as of March 22, 2018

Department 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 standard of care.<sup>85</sup> This rule, which allows misinformation and personal feelings to get in the way of science and lifesaving treatment, will not help achieve the goals of the administration; it will instead trigger countless numbers of deaths.

**V. The proposed rule permits health care professionals to opt out of providing medical care that the public expects by allowing them to disregard evidence-based standards of care**

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 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.<sup>86</sup> The expansion of these refusals as outlined in the proposed rule will put women, particularly women of color, who experience these medical conditions at greater risk for harm.

Moreover, a 2007 survey of physicians working at religiously-affiliated hospitals found that nearly one in five (19 percent) experienced a clinical conflict with the religiously-based policies of the hospital.<sup>87</sup> While some of these physicians might refer their patients to another provider who could provide the necessary care, one 2007 survey found that as many as one-third of patients (nearly 100 million people) may be receiving

---

<https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/plenary-address-to-national-governors-association.html>.

<sup>85</sup> Azar, *supra* note 84.

<sup>86</sup> For example, Black women are three times more likely to be diagnosed with lupus than white women. Latinas 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 Latina 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>.

<sup>87</sup> Debra B. Stulberg M.D. M.A., et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, J. GEN. INTERN. MED. 725-30 (2010) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881970/>.

NHeLP Draft as of March 22, 2018

care from physicians who do not believe they have any obligations to refer their patients to other providers.<sup>88</sup> Meanwhile, the number of Catholic hospitals in the United States has increased by 22 percent since 2001, and now own one in six hospital beds across the country.<sup>89</sup> The increase of Catholic hospitals poses a danger for women seeking reliable access to medical services, many of whom do not understand the full range of services that may be denied them. One public opinion survey found that, among the less than one-third of women who understood that a Catholic hospital might limit care, only 43 percent expected limited access to contraception, and a mere 6 percent expected limited access to the morning-after pill.<sup>90</sup>

*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.<sup>91</sup> Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant.<sup>92</sup>

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.<sup>93</sup> 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.<sup>94</sup> The Institute of Medicine has

<sup>88</sup> Farr A. Curlin M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, NEW ENG. J. MED. 593–600 (2007) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2867473/>.

<sup>89</sup> Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, AM. CIVIL LIBERTIES UNION 22 (2017), available at [https://www.aclu.org/sites/default/files/field\\_document/healthcaredenied.pdf](https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf).

<sup>90</sup> Nadia Sawicki, *Mandating Disclosure Of Conscience-Based Limitations On Medical Practice*, 42 AM. J. OF LAW & MED. 85-128 (2016) available at <http://journals.sagepub.com/doi/pdf/10.1177/0098858816644717>.

<sup>91</sup> 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](http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf)

<sup>92</sup> *Id.* at S114.

<sup>93</sup> *Unintended Pregnancy in the United States*, Guttmacher Inst. (Sept. 2016), <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>.

<sup>94</sup> Lawrence B. Finer & Stanley K. Henshaw, *Disparities in rates of unintended pregnancy in the United*



NHeLP Draft as of March 22, 2018

documented negative health effects of unwanted pregnancy for mothers and children. Unwanted pregnancy is associated with maternal morbidity and risky health behaviors as well as low-birth weight babies and insufficient prenatal care.<sup>95</sup>

*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.<sup>96</sup> 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.<sup>97</sup>

*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.<sup>98</sup> For example, the rate of preeclampsia is 61% higher for Black women than for white women, and 50% higher than women overall.<sup>99</sup> The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics guidelines state

---

*States, 1994 and 2001*, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90-6 (2006).

<sup>95</sup> 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).

<sup>96</sup> *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](https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf).

<sup>97</sup> 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](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](https://www.unicef.org/aids/files/2009_position_paper_condoms_en.pdf).

<sup>98</sup> 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>.

<sup>99</sup> 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>.

NHeLP Draft as of March 22, 2018

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.<sup>100</sup> ACOG and American Heart Association recommend that a pregnancy be avoided or ended for certain conditions such as severe pulmonary hypertension.<sup>101</sup> 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.<sup>102</sup> In addition, some medical guidelines counsel patients to end a pregnancy if they are taking certain medications for thyroid disease.<sup>103</sup>

*d. Emergency contraception*

The proposed rule will magnify the harm in circumstances where women are already denied the standard of care. Catholic hospitals have a record of providing substandard care or refusing care altogether to women for a range of medical conditions and crises that implicate reproductive health. For example, in a 2005 study of Catholic hospital emergency rooms by Ibis Reproductive Health for Catholics for Choice, it was found that 55 percent would not dispense emergency contraception under any circumstances.<sup>104</sup> Twenty three percent of the hospitals limited EC to victims of sexual assault.<sup>105</sup>

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.<sup>106</sup> At the bare

<sup>100</sup> AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).

<sup>101</sup> 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>.

<sup>102</sup> 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).

<sup>103</sup> For example, the American College of Obstetricians and Gynecologists specifically recommends that if a woman taking Iodine 131 becomes pregnant, her physician should caution her 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).

<sup>104</sup> 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)

<sup>105</sup> *Id.* at 105.

<sup>106</sup> *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>.



NHeLP Draft as of March 22, 2018

minimum, survivors should be given comprehensive information regarding emergency contraception.<sup>107</sup>

*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 Nursing Society.<sup>108</sup> 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 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.<sup>109</sup> Under the proposed rule, an insurance company could refuse to cover PrEP or PEP

<sup>107</sup> *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>.

<sup>108</sup> 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](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).

<sup>109</sup> *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>.

NHeLP Draft as of March 22, 2018

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 violates the Establishment Clause**

The Establishment Clause of the First Amendment bars the government from granting religious and moral exemptions that would harm any third party.<sup>110</sup> It requires the Department to “take adequate account of the burdens” that an exemption “may impose on nonbeneficiaries” and must ensure that any exemption is “measured so that it does not override other significant interests.”<sup>111</sup>

The Supreme Court acknowledged the limitations imposed by the Establishment Clause in *Burwell v. Hobby Lobby Stores, Inc.*, declaring the effect on employees of an accommodation provided to employers under the Religious Freedom Restoration Act (RFRA) “would be precisely zero.”<sup>112</sup> Justice Kennedy emphasized that an accommodation must not “unduly restrict other persons, such as employees, in protecting their own interests.”<sup>113</sup> The proposed exemptions clearly impose burdens on and harm others and thus, violate the clear mandate of the Establishment Clause.

## **VII. The regulations are overly broad, vague, and will cause confusion in the health care delivery system**

The regulations dangerously expand the application of the underlying statutes by offering an extremely broad definition who can refuse and what they can refuse to do. Under the proposed rule, any one engaged in the health care system could refuse services or care. The proposed rule defines workforce to include “volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity.”<sup>114</sup> Under this definition, could any member of the health care workforce refuse to serve a patient in any way – could a nurse assistant refuse to serve lunch to a transgender patient, could a billing specialist refuse to help a patient who had sought contraceptive counseling?

---

<sup>110</sup> E.g., *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Cutter v. Wilkinson*, 544 U.S.709, 720, 726 (2005); *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 18 n.8 (1989).

<sup>111</sup> *Cutter*, 544 U.S. at 720, 722; see also *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709-10 (1985).

<sup>112</sup> *Hobby Lobby*, 134 S. Ct. 2751, 2760 (2014).

<sup>113</sup> *Id.* at 2786-87 (Kennedy, J., concurring).

<sup>114</sup> 83 Fed. Reg. 3894.

NHeLP Draft as of March 22, 2018

*a. Discrimination*

The failure to define the term “discrimination” will cause confusion for providers, and as employers, expose them to liability. Title VII already requires that employers accommodate employees’ religious beliefs to the extent there is no undue hardship on the employer.<sup>115</sup> The regulations make no reference to Title VII or current EEOC guidance, which prohibits discrimination against an employee based on that employee’s race, color, religion, sex, and national origin.<sup>116</sup> The proposed rule should be read to ensure that the long-standing balance set in Title VII between the right of individuals to enjoy reasonable accommodation of their religious beliefs and the right of employers to conduct their businesses without undue interference is to be maintained.

If this balance is not maintained, the language in the proposed rule could force health care providers to hire people who intend to refuse to perform essential elements of a position. For example, the proposed rule lacks clarity about whether a Title X-funded health center’s decision not to hire a counselor or clinician who objected to provide non-directive options counseling as an essential job function of their position would be deemed discrimination under the rule. Furthermore, the proposed rule does not provide guidance on whether it is impermissible “discrimination” for a Title X-funded state or local health department to transfer such a counselor or clinician to a unit where pregnancy counseling is not done.

By failing to define “discrimination,” supervisors in health care settings will be unable to proceed in the orderly delivery of health care services, putting women’s health at risk. The proposed rule impermissibly muddies the interpretation of Title VII and current EEOC guidance. If implemented, health care entities may be forced to choose between complying with a fundamentally misguided proposed rule and long-standing interpretation of Title VII.

Finally, the proposed rule’s lack of clarity regarding what constitutes discrimination, may undermine non-discrimination laws. Because of the potential harm to individuals if religious refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.<sup>117</sup> Instead, courts have held that the government has a compelling interest in ending discrimination

---

<sup>115</sup> 42 U.S.C. § 2000e-2.; *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>.

<sup>116</sup> *Id.*

<sup>117</sup> See e.g., *Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government’s interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that “the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family”); *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

NHeLP Draft as of March 22, 2018

and that anti-discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a “shield” to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a “compelling interest in providing an equal opportunity to participate in the workforce without regard to race,” and are narrowly tailored to meet that “critical goal.”<sup>118</sup> The uncertainty regarding how the proposed rule will interact with non-discrimination laws is extremely concerning.

*b. Assist in the performance*

The definition of “assist in the performance” greatly expands the types of services that can be refused beyond any reasonable stretch of the imagination. The proposed rule defines “assistance” to include participation “in any activity with an *articulable connection* to a procedure, health service or health service program, or research activity.”<sup>119</sup> In addition, the Department includes activities such as “making arrangements for the procedure.”<sup>120</sup> If workers in very tangential positions, such as schedulers, are able to refuse to do their jobs based on personal beliefs, the ability of any health system or entity to plan, to properly staff, and to deliver quality care will be undermined. Employers and medical staff may be stymied in their ability to establish protocols, policies and procedures under these vague and broad definitions. The proposed rule creates the potential for a wide range of workers to interfere with and interrupt the delivery of health care in accordance with the standard of care.

The regulations also leave unclear whether a worker can assert his or her moral belief in refusing to treat patients on the basis of their identity or deny care for reasons outside of religious or moral beliefs. Even though women living with disabilities report engaging in sexual activities at the same rate as women who do not live with disabilities, they often do not receive the reproductive health care they need for multiple reasons, including lack of accessible provider offices and misconceptions about their reproductive health needs.<sup>121</sup> Biased counseling can contribute to unwanted health outcomes and exacerbate health disparities.<sup>122</sup> The proposed rule is especially alarming as it does not articulate a definition of moral beliefs. The prejudices of a health care professional could easily inform their beliefs and consequently, serve as the basis of denying care to an individual based on characteristics alone. The proposed rule will foster discriminatory health care settings and interactions between patients and

<sup>118</sup> *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, slip op. at 46 (2014).

<sup>119</sup> 83 Fed. Reg. 3892.

<sup>120</sup> *Id.*

<sup>121</sup> RM Haynes et al., *Contraceptive Use at Last Intercourse Among Reproductive-Aged Women with Disabilities: An Analysis of Population-Based Data from Seven States*, CONTRACEPTION (2017), <https://www.ncbi.nlm.nih.gov/pubmed/29253580>; See generally Alex Zielinski, *Why Reproductive Health Can Be A Special Struggle for Women with Disabilities*, THINKPROGRESS, Oct. 1, 2015, <https://thinkprogress.org/why-reproductive-health-can-be-a-special-struggle-for-women-with-disabilities-73eacea23c4/>.

<sup>122</sup> In one study in Massachusetts, women living with intellectual and developmental disabilities, including those who were Black and Latina, faced increased risks of preterm delivery and very low and low birth weight babies. M. Mitra et al., *Pregnancy Outcomes Among Women with Intellectual and Developmental Disabilities*, AM. J. PREV. MED. (2015), <https://www.ncbi.nlm.nih.gov/pubmed/25547927>.

NHeLP Draft as of March 22, 2018

providers that are informed by bias instead of medically accurate, evidence-based, patient-centered care.

Moreover, in the preamble, the proposed rule states that the exemptions that Weldon provides is not limited to refusals of abortion care on the basis of religious or moral beliefs.<sup>123</sup> Due to this, health care professionals may think they can deny abortion care and other health services just because they do not want to provide the service. The preamble uses language such as “those who choose not to provide” or “Would rather not” as justification for a refusal. This is more concerning because the proposed rule contains no mechanism to ensure that patients receive the care they need if their provider refuses to furnish a service. The onus will be on the patient to question whether her hospital, medical doctor, or health care professional has religious, moral, or other beliefs that would lead them to deny services or if services were denied, the basis for refusal. This is likely to occur as the proposed rule does not have any provisions that stipulate that patients must be given notice that they may be refused certain health care services on the basis of religious or moral beliefs.

*c. Referral*

The definition of “referral” similarly goes beyond any understanding of the term, allowing refusals to provide any information based on which an individual could get the care they need. Any information distributed by any method, including online or print, regarding any service, procedure, or activity could be refused by an entity if the information given would lead to a service, activity, or procedure that the entity or health care entity objects. Under this definition, could a medical doctor refuse to provide a website describing the medical conditions which contraception treats? Or could an entity refuse to provide a list of LGBTQ-friendly providers? In addition, the Department states that the underlying statutes of the proposed rule permits entities to deny help to anyone who is likely to make a referral for an abortion or for other services.<sup>124</sup> The breadth and vagueness of this definition will possibly lead providers to refrain from providing information vital to patients out of anxiety and confusion of what the proposed rule permits them to do.

*d. Health Care Entity*

The proposed rule's definition of “health care entity” conflicts with Federal religious refusal laws such as the Coats and Weldon Amendments, thus fostering confusion regarding which entities are required to comply with the proposed rule and existing Federal religious refusals. Specifically, under the Coats and Weldon Amendments a “health care entity” is defined to encompass a limited and specific range of individuals and entities involved in health care delivery. Under the proposed rule, a plan sponsor “not primarily engaged in the business of health care” would be deemed a “health care entity.”<sup>125</sup> This definition would mean that an employer acting as a third party administrator or sponsor could count as a “health care entity” and deny coverage. In

---

<sup>123</sup> 83 Fed. Reg. 3890-91.

<sup>124</sup> *Id.* at 3895.

<sup>125</sup> *Id.* at 3893.



NHeLP Draft as of March 22, 2018

2016, OCR found that religiously affiliated employers were not health care entities under the Weldon amendment.<sup>126</sup>

Moreover, the Department states that their definition of “health care entity” is “not an exhaustive list” for concern that the Department would “inadvertently omit[ting] certain types of health care professionals or health care personnel.”<sup>127</sup> Additionally, the proposed rule incorporates entities as defined in 1 USC 1 which includes corporations, firms, societies, etc.<sup>128</sup> States and public agencies and institutions are also deemed to be entities.<sup>129</sup> The Department’s inclusion of entities who are primarily not engaged in the health care delivery system highlights the true purpose of the proposed rule, to permit a greater number of entities to interfere in the provider-patient relationship and deter a patient from making the best decision based on their circumstances, preferences, and beliefs.

## Conclusion

National Association of Councils on Developmental Disabilities opposes the proposed rule as it expands religious refusals to the detriment of patients’ health and well-being. We are concerned that these regulations, if implemented, will interfere in the patient-provider relationship by undermining informed consent. The proposed rule will allow anyone in the health care setting to refuse health care that is evidence-based and informed by the highest standards of medical care. The outcome of this regulation will harm communities who already lack access to care and endure discrimination.

Thank you for your attention to our comments. If you have any questions, please reach out to Erin Prangle, Public Policy Director at [EPrangle@nacdd.org](mailto:EPrangle@nacdd.org).

---

<sup>126</sup> Office for Civil Rights, Decision Re: OCR Transaction Numbers: 14-193604, 15-193782 & 15-195665, 4 (Jun. 21, 2016) (letter on file with NHeLP-DC office).

<sup>127</sup> 83 Fed. Reg. 3893.

<sup>128</sup> *Id.*

<sup>129</sup> *Id.*



# **EXHIBIT O**

March 27, 2018

U.S. Department of Health and Human Services

Office for Civil Rights

Attention: Conscience NPRM, RIN 0945-ZA03

Hubert H. Humphrey Building

Room 509F

200 Independence Avenue, S.W.

Washington, D.C. 20201

**RE: Public Comment in Response to the Proposed Regulation, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03**

To Whom It May Concern:

I am writing on behalf of the Oregon Foundation for Reproductive Health in response to the request for public comment on the proposed rule entitled, “Protecting Statutory Conscience Rights in Health Care” published January 26.<sup>1</sup> The Oregon Foundation for Reproductive Health (OFRH) is a non-profit advocacy organization located in Portland, that provides a channel for Oregon women’s voices from all over the state to be heard, particularly those historically under-served. We believe that all people should have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction for themselves and their families without fear of discrimination, exclusion, or harm. We will work to break down barriers to health care so that all people have the opportunity to thrive. Our mission is to improve access to comprehensive reproductive health care, such as preventing unintended pregnancy and planning healthy families, and we are committed to advancing reproductive rights and advocating for reproductive health equity in all Oregon communities.

This proposed regulation would exacerbate the challenges that many patients—especially women, LGBTQ people, people of color, immigrants and low-income people—already face in getting the health care they need in a timely manner and at an affordable cost. The rule would expose vulnerable patients to increased discrimination and denials of medically-indicated care by broadening religious health care provider exemptions beyond the existing limited circumstances allowed by law. Moreover, while protecting health providers who deny care, the rule would provide *no protections for patients who are being denied care—even in emergencies*. As drafted, the rule would not even require that patients be informed of all their potential treatment options or referred to alternative providers of needed care.

---

<sup>1</sup> Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88) [*hereinafter* Rule].

Indeed, this proposal runs in the opposite direction of everything the American health system is striving to achieve in the pursuit of “patient-centered care.” We urge the administration to put patients first, and withdraw the proposed regulation because of the serious problems enumerated below.

**1. The rule improperly seeks to expand on existing religious refusal exemptions to potentially allow denial of any health care service based on a provider’s personal beliefs or religious doctrine.**

Existing refusal of care laws (such as those for abortion and sterilization services) are already being used across the country to deny patients the care they need.<sup>2</sup> The proposed rule attempts to expand on these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. Specifically, the Department and its Office for Civil Rights (OCR) are attempting to require a broad swath of entities to allow individuals to refuse “any lawful health service or activity based on religious beliefs or moral convictions (emphasis added).”<sup>3</sup>

This expansive interpretation could lead to provider denials based on personal beliefs that are biased and discriminatory, such as objections to providing care to people who are transgender or in same-sex relationships. We are aware of cases in which this type of unjust denial of care has occurred, such as a California physician’s denial of donor insemination to a lesbian couple, even though the doctor routinely provided the same service to heterosexual couples.<sup>4</sup>

We are also concerned about potential enabling of care denials by providers based on their non-scientific personal beliefs about other types of health services. For example, certain religiously-affiliated hospitals and individual clinicians have refused to provide rape victims with emergency contraception to prevent pregnancy<sup>5</sup> based on the belief that it can cause an abortion, even though there is no scientific evidence that this is the case.

**2. The rule would protect refusals by anyone who would be “assisting in the performance of” a health care service to which they object, not just clinicians.**

The rule seeks to protect refusals by any “member of the workforce” of a health care institution whose actions have an “articulable connection to a procedure, health services or health service program, or research activity.” The rule includes examples such as “counseling, referral, training and other arrangements for the procedure, health service or research activity.”

An expansive interpretation of “assist in the performance of” thus *could conceivably allow an ambulance driver to refuse to transport a patient to the hospital for care he/she finds objectionable.* It

---

<sup>2</sup> See, e.g., *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT’L WOMEN’S L. CTR. (2017), <https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/>; Uttley, L., et al, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), <https://www.aclu.org/report/miscarriage-medicine>.

<sup>3</sup> See Rule *supra* note 1, at 12.

<sup>4</sup> Hardaway, Lisa, *Settlement Reached in Case of Lambda Legal Lesbian Client Denied Infertility Treatment by Christian Fundamentalist Doctors*, Lambda Legal, September 29, 2009, accessed at [https://www.lambdalegal.org/news/ca\\_20090929\\_settlement-reached](https://www.lambdalegal.org/news/ca_20090929_settlement-reached).

<sup>5</sup> Erdely, Sabrina, *Doctors’ beliefs can hinder patient care*, SELF magazine, June 22, 2007, accessed at <http://www.nbcnews.com/id/19190916/print/1/displaymode/1098/>

could mean a hospital admissions clerk could refuse to check in a patient for treatment the clerk finds objectionable or a technician could refuse to prepare surgical instruments for use in a service.

On an institutional level, the right to refuse to “assist in the performance of” a service could mean a religiously-affiliated hospital or clinic could deny care, and *then also refuse to provide a patient with a referral or transfer to a willing provider* of the needed service.

The proposed rule thus could be read as allowing health providers to refuse to inform patients of all potential treatment options. A 2010 publication of the National Health Law Program, “Health Care Refusals: Undermining Quality of Care for Women,” noted that “refusal clauses and institutional restrictions can operate to deprive patients of the complete and accurate information necessary to give informed consent.”<sup>6</sup>

### **3. The rule does not address how a patient’s needs would be met in an emergency situation.**

There have been reported instances in which pregnant women suffering medical emergencies—including premature rupture of membranes (PPROM) and ectopic pregnancies<sup>7</sup>—have gone to hospital emergency departments and been denied prompt, medically-indicated care because of institutional religious restrictions.<sup>8</sup> 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 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.<sup>9</sup> Under EMTALA, every hospital is required to comply – even those that are religiously affiliated.<sup>10</sup> 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.

---

<sup>6</sup> The NHeLP publication noted (at page 21) that the Ethical and Religious Directives for Catholic Healthcare Services, which govern care at Catholic hospitals, limit the information a patient can be given about treatment alternatives to those considered “morally legitimate” within Catholic religious teachings. (Directive No. 26).

<sup>7</sup> Foster, AM, and Smith, DA, *Do religious restrictions influence ectopic pregnancy management? A national qualitative study*, Jacob Institute for Women’s Health, Women’s Health Issues, 2011 Mar-Apr; 21(2): 104-9, accessed at <https://www.ncbi.nlm.nih.gov/pubmed/21353977>

<sup>8</sup> Stein, Rob, *Religious hospitals’ restrictions sparking conflicts, scrutiny*, The Washington Post, January 3, 2011, accessed at [https://www.washingtonpost.com/health-environment-science/religious-hospitals-restrictions-sparking-conflicts-scrutiny/2011/01/03/ABVVxmD\\_story.html?utm\\_term=.cc34abcbb928](https://www.washingtonpost.com/health-environment-science/religious-hospitals-restrictions-sparking-conflicts-scrutiny/2011/01/03/ABVVxmD_story.html?utm_term=.cc34abcbb928)

<sup>9</sup> 42 U.S.C. § 1295dd(a)-(c) (2003).

<sup>10</sup> 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 (3<sup>rd</sup> Cir. 2000); *In re Baby K*, 16 F.3d 590, 597 (4<sup>th</sup> 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).

**4. Health care institutions would be required to notify employees that they have the right to refuse to provide care, but would not be required to notify patients about the types of care they will not be able to receive at that hospital, pharmacy, clinic or doctor's office.**

The rule sets forth extensive requirements for health care institutions, such as hospitals, to notify employees about their refusal rights, including how to file a discrimination complaint with OCR. The rule requires posting of such notices on the employer's website and in prescribed physical locations within the employer's building. The rule also sets forth the expectation that OCR would investigate or conduct compliance reviews of whether health care institutions are following the posting rule.<sup>11</sup>

By contrast, the rule contains no requirement that patients be notified of institutional restrictions on provision of certain types of care. Such notification is essential because research has found that patients often are unaware of service restrictions at religiously-sponsored health care institutions.<sup>12</sup>

**5. The rule conflicts with other existing federal laws, including the Title VII framework for accommodation of employees' religious beliefs.**

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals of care it would create. For example, the proposed rule makes no mention of Title VII,<sup>13</sup> the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.<sup>14</sup> 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.<sup>15</sup> 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.

**5. There is no provision protecting the rights of health care providers with religious or moral convictions to provide (not deny) services their patients need.**

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. The

---

<sup>11</sup> The notice requirement is spelled out in section 88.5 of the proposed rule.

<sup>12</sup> See, for example, Freedman, Lori R., Luciana E. Hebert, Molly F. Battistelli, and Debra B. Stulberg, *Religious hospital policies on reproductive care: what do patients want to know?* American Journal of Obstetrics & Gynecology 218, no. 2 (2018): 251-e1, accessed here: [http://www.ajog.org/article/S0002-9378\(17\)32444-4/fulltext](http://www.ajog.org/article/S0002-9378(17)32444-4/fulltext); also Guiahi, Maryam, Jeanelle Sheeder, and Stephanie Teal, *Are women aware of religious restrictions on reproductive health at Catholic hospitals? A survey of women's expectations and preferences for family planning care*, Contraception and Stulberg, D., et al, accessed here: [http://www.contraceptionjournal.org/article/S0010-7824\(14\)00358-8/fulltext](http://www.contraceptionjournal.org/article/S0010-7824(14)00358-8/fulltext); *Do women know when their hospital is Catholic and how this affects their care? Restrictions in Catholic Hospitals (PARRCH) national survey*, Contraception, Volume 96, Issue 4, 268-269, accessed here: [http://www.contraceptionjournal.org/article/S0010-7824\(17\)30235-4/fulltext](http://www.contraceptionjournal.org/article/S0010-7824(17)30235-4/fulltext); a

<sup>13</sup> 42 U.S.C. § 2000e-2 (1964).

<sup>14</sup> *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>.

<sup>15</sup> See *id.*

rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.<sup>16</sup>

Doctors are, in effect, forced to abandon their patients when they are prevented by health care institutions from providing a service they believe is medically-indicated. This was the case for a doctor in Sierra Vista, Arizona, who was prevented from ending a patient's wanted, but doomed, pregnancy after she suffered premature rupture of membranes. The patient had to be sent to the nearest non-objecting hospital, which was 80 miles away, far from her family and friends. The physician described the experience as "a very gut wrenching thing to put the staff through and the patient, obviously."<sup>17</sup>

## **6. The proposed rule carries severe consequences for patients and will exacerbate 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.<sup>18</sup> 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.<sup>19</sup> Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.<sup>20</sup> In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.<sup>21</sup> 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.<sup>22</sup> 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.<sup>23</sup>

### *b. Refusals of care are especially dangerous for those already facing barriers to care*

Refusals of care based on personal beliefs already make it difficult for many individuals to 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

<sup>16</sup> See The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).

<sup>17</sup> Uttley, L, et al, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), p. 16, <https://www.aclu.org/report/miscarriage-medicine>.

<sup>18</sup> See, e.g., *supra* note 2.

<sup>19</sup> 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>.

<sup>20</sup> 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](https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf).

<sup>21</sup> See Kira Shepherd, et al., *supra* note 19, at 29.

<sup>22</sup> See *The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf>; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), [https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2\\_story.html?utm\\_term=.8c022b364b75](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).

<sup>23</sup> See Kira Shepherd, et al., *supra* note 19, at 27.



location, refusals bar access to necessary care.<sup>24</sup> 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.<sup>25</sup> In rural areas there may be no other sources of health and life preserving medical care.<sup>26</sup> 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 In 19 states, women of color are more likely than white women to give birth in Catholic hospitals.<sup>27</sup> Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provide guidance on a wide range of hospital matters, including reproductive health care, and can keep providers from offering the standard of care.<sup>28</sup> The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.<sup>29</sup>

## 7. The Department is abdicating its responsibility to patients

If finalized, the proposed rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care and eliminate health disparities

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. For example, Black women are three to four times more likely than white women to die during or after childbirth.<sup>30</sup> Lesbian, gay, bisexual and transgender individuals also encounter high rates of discrimination in health care.<sup>31</sup> Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.<sup>32</sup> OCR must work to address these disparities, yet the proposed rule is antithetical to OCR's mission.

---

<sup>24</sup> 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>.

<sup>25</sup> 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>.

<sup>26</sup> 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/>.

<sup>27</sup> See Kira Shepherd, et al., *supra* note 19, at 12.

<sup>28</sup> See *id.* at 10-13.

<sup>29</sup> 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>.

<sup>30</sup> 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>.

<sup>31</sup> 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](https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf).

<sup>32</sup> 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](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf).

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

The proposed rule will have a chilling effect on the enforcement and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. 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.<sup>33</sup>

### **Conclusion**

The proposed rule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The proposed rule is discriminatory, violates multiple federal statutes and the Constitution, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons the Oregon Foundation for Reproductive Health calls on the Department to withdraw the proposed rule in its entirety.

---

<sup>33</sup> See, e.g., Rule, *Supra* note 1, at 3888-89.

# **EXHIBIT P**



March 27, 2018

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

**RE: Public Comment in Response to the Proposed Regulation, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03**

To Whom It May Concern:

I am writing on behalf of the North Carolina Justice Center in response to the request for public comment on the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26.<sup>1</sup>

The North Carolina Justice Center advocates for the social, political, economic, and healthful well-being of all North Carolinians. Our mission is to eliminate poverty by ensuring that every household has access to the resources, services and fair treatment it needs to enjoy economic security and participate equally in the opportunities available in the state. A project of the NC Justice Center, the Health Advocacy Project works to ensure that all North Carolinians, especially underserved populations, including racial and ethnic minorities and rural communities, have meaningful access to high quality, affordable, equitable, and comprehensive health care so that children, adults, and families have better health outcomes and live productive lives. In addition, each of the undersigned organizations joining to support these comments also advocates for policies that would improve access to health care for North Carolinians.

This proposed regulation would exacerbate the challenges that many patients -- especially women, LGBTQ people, people of color, immigrants and low-income people -- already face in getting the health care they need in a timely manner and at an affordable cost. The rule would expose vulnerable patients to increased discrimination and denials of medically-indicated care by broadening religious health care provider exemptions beyond the existing limited circumstances allowed by law. Moreover, while protecting health providers who deny care, the rule would provide *no protections for patients who are being denied care – even in emergencies*. As drafted, the rule would not even require that patients be informed of all their potential treatment options and referred to alternative providers of needed care.

---

<sup>1</sup> Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88) [hereinafter Rule].

Indeed, this proposal runs in the opposite direction of everything the American health system is striving to achieve in the pursuit of “patient-centered care.” We urge the administration to put patients first, and withdraw the proposed regulation because of the serious problems enumerated below.

**1. The rule improperly seeks to expand on existing religious refusal exemptions to potentially allow denial of any health care service based on a provider’s personal beliefs or religious doctrine.**

Existing refusal of care laws (such as for abortion and sterilization services) are already being used across the country to deny patients the care they need.<sup>2</sup> The proposed rule attempts to expand on these laws in numerous ways that are directly contrary to the stated purpose of the existing laws. Specifically, the Department and its Office for Civil Rights (OCR) are attempting to require a broad swath of entities to allow individuals to refuse “any lawful health service or activity based on religious beliefs or moral convictions (emphasis added).”<sup>3</sup>

This expansive interpretation could lead to provider denials based on personal beliefs that are biased and discriminatory, such as objections to providing care to people who are transgender or in same-sex relationships. We are aware of cases in which this type of unjust denial of care has occurred, such as a California physician’s denial of donor insemination to a lesbian couple, even though the doctor routinely provided the same service to heterosexual couples.<sup>4</sup>

We are also concerned about potential enabling of care denials by providers based on their non-scientific personal beliefs about other types of health services. For example, certain religiously-affiliated hospitals and individual clinicians have refused to provide rape victims with emergency contraception to prevent pregnancy<sup>5</sup> based on the belief that it can cause an abortion, even though there is no scientific evidence that this is the case.

**2. The rule would protect refusals by anyone who would be “assisting in the performance of” a health care service to which they object, not just clinicians.**

The rule seeks to protect refusals by any “member of the workforce” of a health care institution whose actions have an “articulable connection to a procedure, health services or health service program, or research activity.” The rule includes examples such as “counseling, referral, training and other arrangements for the procedure, health service or research activity.”

An expansive interpretation of “assist in the performance of” thus *could conceivably allow an ambulance driver to refuse to transport a patient to the hospital for care he/she finds objectionable.* It

---

<sup>2</sup> See, e.g., *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT’L WOMEN’S L. CTR. (2017), <https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/>; Uttley, L., et al, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), <https://www.aclu.org/report/miscarriage-medicine>.

<sup>3</sup> See Rule *supra* note 1, at 12.

<sup>4</sup> Hardaway, Lisa, *Settlement Reached in Case of Lambda Legal Lesbian Client Denied Infertility Treatment by Christian Fundamentalist Doctors*, Lambda Legal, September 29, 2009, accessed at [https://www.lambdalegal.org/news/ca\\_20090929\\_settlement-reached](https://www.lambdalegal.org/news/ca_20090929_settlement-reached).

<sup>5</sup> Erdely, Sabrina, *Doctors’ beliefs can hinder patient care*, SELF magazine, June 22, 2007, accessed at <http://www.nbcnews.com/id/19190916/print/1/displaymode/1098/>

could mean a hospital admissions clerk could refuse to check a patient in for treatment the clerk finds objectionable or a technician could refuse to prepare surgical instruments for use in a service.

On an institutional level, the right to refuse to “assist in the performance of” a service could mean a religiously-affiliated hospital or clinic could deny care, and *then also refuse to provide a patient with a referral or transfer to a willing provider* of the needed service.

The proposed rule thus could be read as allowing health providers to refuse to inform patients of all potential treatment options. A 2010 publication of the National Health Law Program, “Health Care Refusals: Undermining Quality of Care for Women,” noted that “refusal clauses and institutional restrictions can operate to deprive patients of the complete and accurate information necessary to give informed consent.”<sup>6</sup>

### **3. The rule does not address how a patient’s needs would be met in an emergency situation.**

There have been reported instances in which pregnant women suffering medical emergencies – including premature rupture of membranes (PPROM) and ectopic pregnancies<sup>7</sup> -- have gone to hospital emergency departments and been denied prompt, medically-indicated care because of institutional religious restrictions.<sup>8</sup> 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 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.<sup>9</sup> Under EMTALA every hospital is required to comply – even those that are religiously affiliated.<sup>10</sup> Because the proposed rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA’s requirements. This could result in patients in emergency circumstances not receiving necessary care.

### **4. Health care institutions would be required to notify employees that they have the right to refuse to provide care, but would not be required to notify patients about the types of care they will not be able to receive at that hospital, pharmacy, clinic or doctor’s office.**

<sup>6</sup> The NHeLP publication noted (at page 21) that the Ethical and Religious Directives for Catholic Healthcare Services, which govern care at Catholic hospitals, limit the information a patient can be given about treatment alternatives to those considered “morally legitimate” within Catholic religious teachings. (Directive No. 26).

<sup>7</sup> Foster, AM, and Smith, DA, *Do religious restrictions influence ectopic pregnancy management? A national qualitative study*, Jacob Institute for Women’s Health, Women’s Health Issues, 2011 Mar-Apr; 21(2): 104-9, accessed at <https://www.ncbi.nlm.nih.gov/pubmed/21353977>

<sup>8</sup> Stein, Rob, *Religious hospitals’ restrictions sparking conflicts, scrutiny*, The Washington Post, January 3, 2011, accessed at [https://www.washingtonpost.com/health-environment-science/religious-hospitals-restrictions-sparking-conflicts-scrutiny/2011/01/03/ABVVxmD\\_story.html?utm\\_term=.cc34abcbb928](https://www.washingtonpost.com/health-environment-science/religious-hospitals-restrictions-sparking-conflicts-scrutiny/2011/01/03/ABVVxmD_story.html?utm_term=.cc34abcbb928)

<sup>9</sup> 42 U.S.C. § 1295dd(a)-(c) (2003).

<sup>10</sup> 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 (3<sup>rd</sup> Cir. 2000); *In re Baby K*, 16 F.3d 590, 597 (4<sup>th</sup> 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).



The rule sets forth extensive requirements for health care institutions, such as hospitals, to notify employees about their refusal rights, including how to file a discrimination complaint with OCR. The rule requires posting of such notices on the employer's website and in prescribed physical locations within the employer's building. The rule also sets forth the expectation that OCR would investigate or do compliance reviews of whether health care institutions are following the posting rule.<sup>11</sup>

By contrast, the rule contains no requirement that patients be notified of institutional restrictions on provision of certain types of care. Such notification is essential because research has found that patients often are unaware of service restrictions at religiously-sponsored health care institutions.<sup>12</sup>

**5. The rule conflicts with other existing federal laws, including the Title VII framework for accommodation of employee's religious beliefs.**

The Proposed Rule generates chaos through its failure to account for existing laws that conflict with the refusals of care it would create. For example, the proposed rule makes no mention of Title VII,<sup>13</sup> the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.<sup>14</sup> 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.<sup>15</sup> 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.

**5. There is no provision protecting the rights of health care providers with religious or moral convictions to *provide* (not deny) services their patients need.**

The proposed rule ignores those providers with deeply held moral convictions that motivate them to provide patients with health care, including abortion, transition-related care and end-of-life care. The rule fails to acknowledge the Church Amendment's protection for health care professionals who support or participate in abortion or sterilization services, which OCR has a duty to enforce.<sup>16</sup>

Doctors are, in effect, forced to abandon their patients when they are prevented by health care institutions from providing a service they believe is medically-indicated. This was the case for a doctor in Sierra Vista, Arizona, who was prevented from ending a patient's wanted, but doomed, pregnancy after

<sup>11</sup> The notice requirement is spelled out in section 88.5 of the proposed rule.

<sup>12</sup> See, for example, Freedman, Lori R., Luciana E. Hebert, Molly F. Battistelli, and Debra B. Stulberg, *Religious hospital policies on reproductive care: what do patients want to know?* American Journal of Obstetrics & Gynecology 218, no. 2 (2018): 251-e1, accessed here: [http://www.ajog.org/article/S0002-9378\(17\)32444-4/fulltext](http://www.ajog.org/article/S0002-9378(17)32444-4/fulltext); also Guiahi, Maryam, Jeanelle Sheeder, and Stephanie Teal, *Are women aware of religious restrictions on reproductive health at Catholic hospitals? A survey of women's expectations and preferences for family planning care*, Contraception and Stulberg, D., et al, accessed here: [http://www.contraceptionjournal.org/article/S0010-7824\(14\)00358-8/fulltext](http://www.contraceptionjournal.org/article/S0010-7824(14)00358-8/fulltext); *Do women know when their hospital is Catholic and how this affects their care? Restrictions in Catholic Hospitals (PARRCH) national survey*, Contraception, Volume 96, Issue 4, 268-269, accessed here: [http://www.contraceptionjournal.org/article/S0010-7824\(17\)30235-4/fulltext](http://www.contraceptionjournal.org/article/S0010-7824(17)30235-4/fulltext); a

<sup>13</sup> 42 U.S.C. § 2000e-2 (1964).

<sup>14</sup> *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>.

<sup>15</sup> See *id.*

<sup>16</sup> See The Church Amendments, 42 U.S.C. § 300a-7(c) (2018).

she suffered premature rupture of membranes. The patient had to be sent to the nearest non-objecting hospital, which was 80 miles away, far from her family and friends. The physician described the experience as “a very gut wrenching thing to put the staff through and the patient, obviously.”<sup>17</sup>

**6. The proposed rule carries severe consequences for patients and will exacerbate 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.<sup>18</sup> 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.<sup>19</sup> Another woman experiencing pregnancy loss was denied care for 10 days at a religiously affiliated hospital outside Chicago, Illinois.<sup>20</sup> In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.<sup>21</sup> 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.<sup>22</sup> 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.<sup>23</sup>

*b. Refusals of care are especially dangerous for those already facing barriers to care*

Refusals of care based on personal beliefs already make it difficult for many individuals to 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.<sup>24</sup> 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.<sup>25</sup> In rural

<sup>17</sup> Uttley, L, et al, *Miscarriage of Medicine*, MergerWatch and the ACLU (2013), p. 16, <https://www.aclu.org/report/miscarriage-medicine>.

<sup>18</sup> See, e.g., *supra* note 2.

<sup>19</sup> 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>.

<sup>20</sup> 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](https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf).

<sup>21</sup> See Kira Shepherd, et al., *supra* note 19, at 29.

<sup>22</sup> See *The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT’L WOMEN’S L. CTR. (2017), <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf>; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), [https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2\\_story.html?utm\\_term=.8c022b364b75](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).

<sup>23</sup> See Kira Shepherd, et al., *supra* note 19, at 27.

<sup>24</sup> 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>.

<sup>25</sup> 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 &

areas there may be no other sources of health and life preserving medical care.<sup>26</sup> 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 in 19 states, women of color are more likely than white women to give birth in Catholic hospitals.<sup>27</sup> Catholic-affiliated hospitals must follow the Ethical and Religious Directives (ERDs) which provide guidance on a wide range of hospital matters, including reproductive health care, and can keep providers from offering the standard of care.<sup>28</sup> The reach of this type of religious refusal of care is growing with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously affiliated entities that provide health care and related services.<sup>29</sup>

## 7. The Department is abdicating its responsibility to patients

If finalized, the proposed rule will represent a radical departure from the Department's mission to combat discrimination, protect patient access to care, and eliminate health disparities

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. For example, Black women are three to four times more likely than white women to die during or after childbirth.<sup>30</sup> Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care.<sup>31</sup> Eight percent of lesbian, gay, bisexual, and queer people and 29 percent of transgender people reported that a health care provider had refused to see them because of their actual or perceived sexual orientation or gender identity in the year before the survey.<sup>32</sup> OCR must work to address these disparities, yet the proposed rule is antithetical to OCR's mission.

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

The proposed rule will have a chilling effect on the enforcement and passage of state laws that protect access to health care and prevent discrimination against individuals seeking medical care. 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.<sup>33</sup>

---

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>.

<sup>26</sup> 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/>.

<sup>27</sup> See Kira Shepherd, et al., *supra* note 19, at 12.

<sup>28</sup> See *id.* at 10-13.

<sup>29</sup> 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>.

<sup>30</sup> 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>.

<sup>31</sup> 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](https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf).

<sup>32</sup> 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](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf).

<sup>33</sup> See, e.g., Rule, *Supra* note 1, at 3888-89.

## **Conclusion**

The proposed rule will allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The proposed rule is discriminatory, violates multiple federal statutes and the Constitution, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons, the North Carolina Justice Center calls on the Department to withdraw the proposed rule in its entirety.

Thank you for this opportunity to comment. If you have any questions, please contact Brendan Riley at [Brendan@ncjustice.org](mailto:Brendan@ncjustice.org).

North Carolina Justice Center

**EXHIBIT Q**



NATIONAL CENTER FOR LESBIAN RIGHTS

WASHINGTON DC OFFICE  
1776 K Street NW, Suite 852  
Washington, D.C. 20006

March 26, 2018

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

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

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

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

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

**I. The Proposed Rule disregards HHS's core mission**

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



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

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

The HHS web site states: “It is the mission of the U.S. Department of Health & Human Services (HHS) to enhance and protect the health and well-being of all Americans. We fulfill that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services” (emphasis added).<sup>1</sup> The Proposed Rule departs significantly from that vision as well as the Office for Civil Rights (OCR’s) mission to address health disparities and discrimination that harm patients.<sup>2</sup> Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended, proposing a regulatory scheme that would be affirmatively harmful to many patients seeking care.

HHS, through OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.<sup>3</sup> If finalized, however, the Proposed Rule will undermine HHS’s mission of combating discrimination, protecting patient access to care, and eliminating health disparities. Through enforcement of civil rights laws, OCR has in the past worked to reduce discrimination in health care by ending discriminatory practices such as segregation in health care facilities based on race or disability, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.<sup>4</sup>

---

<sup>1</sup> See <https://www.hhs.gov/about/index.html>.

<sup>2</sup> *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.”).

<sup>3</sup> As one of its first official acts in 1967, the Office of Equal Health Opportunity undertook the massive effort of inspecting 3,000 hospitals to ensure they were complying with Title VI’s prohibition against discrimination on the basis of race, color, or national origin. 42 U.S.C. § 2000d (1964). After this auspicious start, the Office of Equal Health Opportunity, which would eventually become OCR, would go on to ensure that health programs and activities it regulated complied with key anti-discrimination laws, including Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1973), Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 (1972), the Age Discrimination Act of 1976, 42 U.S.C. § 6101 (1976), and Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116 (2010), among others. Through robust enforcement of these laws, OCR has in the past worked to reduce discrimination in health care.

<sup>4</sup> See, e.g., *Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead*, DEP’T OF HEALTH AND HUMAN SERVS. (2018), <https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html>; *Protecting the Civil Rights and Health Information Privacy*

Despite this past progress, there is still much work to be done, and the Proposed Rule would divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.<sup>5</sup> Black women are three to four times more likely than are white women to die during or after childbirth.<sup>6</sup> And the disparity in maternal mortality is growing rather than decreasing,<sup>7</sup> which in part may be due to the reality that women have long been the subject of discrimination in health care and the resultant health disparities. Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care (we discuss this further below).

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

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

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

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

---

*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>.

<sup>5</sup> 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>.

<sup>6</sup> 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>.

<sup>7</sup> See *id.*

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

### 1. Discrimination against LGBT people in health care is pervasive

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

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

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

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

---

<sup>8</sup> See, e.g., Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2018), <https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care>; Sandy E. James et al., *The Report of the U.S. Transgender Survey* 93–126 (2016), [www.ustranssurvey.org/report](http://www.ustranssurvey.org/report); Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), <http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx>; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), <http://www.lambdalegal.org/publications/when-health-care-isnt-caring>.

<sup>9</sup> See <http://www.nclrights.org/cases-and-policy/cases-and-advocacy/case-prescott-v-rchsd/>.

<sup>10</sup> *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).

<sup>11</sup> 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>.

<sup>12</sup> 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.

<sup>13</sup> *Id.*

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

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

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

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

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

---

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

<sup>15</sup> 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>.

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

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

When LGBT patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In the CAP study, nearly one in five LGBT people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBT people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.<sup>18</sup> For these patients, being turned away by a medical provider is not just an inconvenience: it often means being denied care entirely with nowhere else to go.

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

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

---

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> Cathleen E. Willging, Melina Salvador, and Miria Kano, “Pragmatic Help Seeking: How Sexual and Gender Minority Groups Access Mental Health Care in a Rural State,” *Psychiatric Services* 57, no. 6 (June 2006): 871–4, <http://doi.org/10.1176/ps.2006.57.6.871>.

<sup>20</sup> Colleen S. Poon and Elizabeth M. Saewyc, “Out Yonder: Sexual-Minority Adolescents in Rural Communities in British Columbia,” *American Journal of Public Health* 99, no. 1 (January 2009): 118–24, <http://doi.org/10.2105/AJPH.2007.122945>.

<sup>21</sup> Trish Williams et al., “Peer Victimization, Social Support, and Psychosocial Adjustment of Sexual Minority Adolescents,” *Journal of Youth and Adolescence* 34, no. 5 (October 2005): 471–82, <https://doi.org/10.1007/s10964-005-7264-x>.



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

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

Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women's care was delayed or they were transferred to other facilities at great risk to their health.<sup>28</sup> The reach of this type of religious refusal of care is growing with the proliferation of religiously affiliated entities that provide health care and related services.<sup>29</sup> New research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than are white women to give birth in Catholic hospitals.<sup>30</sup>

---

<sup>22</sup> 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/>.

<sup>23</sup> 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).

<sup>24</sup> 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/>.

<sup>25</sup> 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>.

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

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

<sup>28</sup> 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/>.

<sup>29</sup> 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>.

<sup>30</sup> See Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), <https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf>.



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

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

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

The lack of clarity in the Proposed Rule could lead a hospital or an individual provider to refuse to provide ART to same-sex couples based on religious belief. For some couples, this

---

<sup>31</sup> 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](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).

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

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

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

<sup>35</sup> *Id.*

discrimination would increase the cost and emotional toll of family building. In some parts of the country, however, these refusals would be a complete barrier to parenthood. More broadly, these refusals deny patients the human right and dignity to be able to decide to have children, and cause psychological harm to patients who are already vulnerable because of their health status or their experience of health disparities.

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

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

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

- I and many of my community members struggle to afford healthcare as it is, even with full time jobs. I live in a rural area and even if you do have health insurance, access to healthcare is very difficult. I do not see how my sexual orientation, religion, or other parts of me that one might disagree with at a personal level has anything to do with my right to receive healthcare. This regulation, whatever its intentions, will give those who are discriminatory the ability to act on this in a way that can harm the community and disproportionately provide support based on personal differences. I fear this will only further drive people apart.
- As a retired nurse educator I find this proposed rule unethical, immoral, unconscionable & inhumane. All health professionals essentially take an oath to treat & or take care of any person regardless of their race/religion/age/sexual orientation/ethnic background. And women have a right to choose their own reproduction health care. I strongly oppose this rule which promotes discrimination & urge HHS to withdraw it.

---

<sup>36</sup> This incident was reported to NCLR Legal Help Line attorneys; the name has been changed to protect the caller's privacy.

<sup>37</sup> Some have been edited slightly for length and clarity.

- If this rule is allowed to exist, it will allow emergency room staff to turn away people maimed by car accidents, mass shootings and terrorist attacks. Do you really want to be waiting for life saving care as you are interviewed (interrogated) to determine that you are the "right" sort of person who aligns with a hospital staff member's religious beliefs? You could easily die as you try to prove that you are "worthy" of their care.
- I happen to be a health care provider and I see LGBT people in my practice regularly. I understand the disadvantages they face every day as they go to work, to school, and even at home in their families and communities. Access to health care is a critical problem for many people, and HHS should not be making the problem worse by inviting health care institutions and providers to turn people away based on religious or moral reasons.
- I am a US citizen, I am also Romani Hindu. I am an intersex female and lesbian. I greatly oppose any rules or laws that would allow any person to establish their personal religious views as a means to hold others as a lesser person. This archaic way of thinking does not create a peaceful and free nation. I live in America that is said to be a free nation. Yet I am not free simply because of who I am. I have a difficult time finding the health care I need because of discrimination. I am a senior citizen of America and have been denied medical care. Giving any person the right to discriminate for any purpose does great harm to an entire country.
- I am an LBGTX woman, married and the mother of two adult children. I travel frequently for work and have paid into my company's health insurance system for over 40 years. While I'm fairly confident that wouldn't be refused treatment locally, the thought that I might be refused treatment during an emergency while I'm traveling because I am a gay woman is both appalling and frightening.
- I am a 75 year-old lesbian living in San Francisco. As an R.N. and an LCSW, I have worked in the healthcare field for my entire adult life. The proposed rule entitled "Protecting Statutory Conscience Rights in Health Care" would give permission to mistreat or not treat an entire group of citizens. This is outrageous! This would be against any oath that a healthcare provider has taken to provide healthcare to all - without exception. An individual's personal opinions or biases have no place in the healthcare field. HHS should not promote discrimination of any kind. I am sure this proposed rule would prove to be unconstitutional if tested in our courts - and it surely would be. This proposed rule should be withdrawn immediately! It's shocking that it's even been suggested.
- In many small communities there is a limited number of health care providers. Allowing this kind of bigotry and prejudice could be life-threatening to any number of people. I know of no religion that preaches withholding life-saving care from anyone. The whole idea of government sponsored bigotry is outrageous and about as un-American as you can get.
- In the last year alone, I had to be taken by ambulance to Emergency Rooms in Northern and Southern California due to a heart issue. I also had to go to an Emergency Room in

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

- I fear we will return to the days where we could be refused health care because of who we love. In 2008, I had to carry legal papers with me to the emergency room so that my partner, before marriage was legal, could be informed about my illness and be involved in making decisions. We were lucky to have a nurse who was also lesbian and while she was on duty I had excellent care. One of my care givers was not happy that I had a female partner and excused himself from the room to send in another therapist a few hours later. We cannot go back, lives are at stake.
- I have personally known people who have come within inches of death from complications due to HIV/AIDS because of the neglect of a doctor based on that doctor's personal beliefs. Discrimination and personal beliefs should not factor in to medical treatment, ever.
- In our community there is a shortage of health care providers to begin with, and if you reduce the number of providers that LGBT people can use, people will die.
- My children (one of whom is still a minor) are part of the LGBTQ community, and your rule would allow physicians to deny them lifesaving medical treatment, should they fall ill or have a medical emergency, such as a car accident or appendicitis, because they are gay or trans. They could die in the waiting area of the ER while someone who would be willing to treat them is located, and brought to the hospital, or in transit to a hospital where someone would treat them. It would allow doctors providing preventative care like pap smears to turn away my trans son, so that he wouldn't be able to find out if he had ovarian cancer until it was too late. Or to deny them vaccines for preventable diseases, or even just the flu. It would allow pharmacists to deny my children a prescription for antibiotics, because they feel morally or religiously opposed to their "lifestyle choices." It could have allowed one of my best friends to die from the heart attack he had a few years ago, because he's married to another man - because he was taken to a Catholic hospital by the ambulance crew. If it happened again, and your rule is in place, that hospital, one of the largest and most comprehensive in coverage in our area, could start turning people away en mass, for simply not being Catholic. In a predominantly Mormon state, that means about half the population.

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

## **2. The Proposed Rule fits a troubling pattern at HHS**

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

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

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

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

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care.<sup>38</sup> The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions to bind the hands of providers and attempt to limit the types of care they can provide. This has profound implications for the core medical ethical precept of informed consent, and for the ability of health care providers to follow accepted standards of care for their patients.

#### 1. Informed consent

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making. Informed consent relies on disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their medical treatment.<sup>39</sup> This right relies on two factors: access to relevant and medically-accurate information about treatment choices and alternatives, and provider guidance based on generally

---

<sup>38</sup> See, e.g., Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1 (2018), <https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf>; *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), <https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/>; Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1 (2016), [https://www.aclu.org/sites/default/files/field\\_document/healthcaredenied.pdf](https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf); Catherine Weiss, et al., *Religious Refusals and Reproductive Rights*, AM. CIVIL LIBERTIES UNION (2002), <https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report>;

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



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

According to the American Medical Association: “The physician’s obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient’s care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.”<sup>40</sup> The American Nursing Association similarly maintains that patient autonomy and self-determination are core ethical tenets of nursing. “Patients have the moral and legal right to determine what will be done with their own persons; to be given accurate, complete and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens and available options in their treatment.”<sup>41</sup> Pharmacists are also expected to respect the autonomy and dignity of each patient.<sup>42</sup>

The Proposed Rule purports to improve communication between patients and providers,<sup>43</sup> but in reality it will have the opposite effect, deterring open, honest conversations that are vital to ensuring that a patient is able to be in control of their medical circumstances. Informed consent is intended to address the unequal balance of power between health providers and patients and ensure patient-centered decision-making. Moreover, consent is not a “yes or no” question but rather is dependent upon the patient’s understanding of the procedure that is to be conducted and the full range of treatment options for a patient’s medical condition.<sup>44</sup> Without informed consent, patients will be unable to make medical decisions that are grounded in agency, their beliefs and preferences, and that meet their personal needs. This is particularly problematic as many communities, including women of color and women living with disabilities, have disproportionately experienced abuse and trauma at the hands of providers and institutions.<sup>45</sup>

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

---

<sup>40</sup> *The AMA Code of Medical Ethics’ Opinions on Informing Patients: Opinion 9.09 – Informed Consent*, 14 AM. MED. J. ETHICS 555-56 (2012), <http://journalofethics.ama-assn.org/2012/07/coet1-1207.html>.

<sup>41</sup> *Code of ethics for nurses with interpretive statements, Provision 1.4 The right to self-determination*, AM. NURSES ASS’N (2001), [https://www.truthaboutnursing.org/research/codes/code\\_of\\_ethics\\_for\\_nurses\\_US.html](https://www.truthaboutnursing.org/research/codes/code_of_ethics_for_nurses_US.html).

<sup>42</sup> *Code of Ethics for Pharmacists*, AM. PHARMACISTS ASS’N (1994).

<sup>43</sup> 83 Fed. Reg. 3917.

<sup>44</sup> BEAUCHAMP & CHILDRESS, *supra* note 39; Robert Zussman, *Sociological perspectives on medical ethics and decision-making*, 23 ANN. REV. SOC. 171-89 (1997).

<sup>45</sup> Gutierrez, E. R. *Fertile Matters: The Politics of Mexican Origin Women’s Reproduction*, 35-54 (2008) (discussing coercive sterilization of Mexican-origin women in Los Angeles); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 411-12 (2000) (referencing one 1974 study indicating that Indian Health Services would have coercively sterilized approximately 25,000 Native American Women by 1975); Alexandra Minna Stern, *Sterilized in the Name of Public Health*, 95 AM. J. PUB. H. 1128, 1134 (July 2005) (discussing African-American women forced to choose between sterilization and medical care or welfare benefits and Mexican women forcibly sterilized). *See also* *Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding state statute permitting compulsory sterilization of “feeble-minded” persons); Vanessa Volz, *A Matter of Choice: Women With Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 WOMEN RTS. L. REP. 203 (2006) (discussing sterilization reform statutes that permit sterilization with judicial authorization).



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

## 2. Standards of care

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are not only important services in their own right, they are also part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.<sup>46</sup> Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them. It is alarming that a public health agency would actively encourage compromising patient health by facilitating departures from accepted standards of care.

A 2007 survey of physicians working at religiously-affiliated hospitals found that nearly one in five (19 percent) experienced a clinical conflict with the religiously-based policies of the hospital.<sup>47</sup> While some of these physicians might refer their patients to another provider who could provide the necessary care, another survey found that as many as one-third of patients (nearly 100 million people) may be receiving care from physicians who do not believe they have any obligations to refer their patients to other providers.<sup>48</sup> Meanwhile, the number of Catholic hospitals in the United States has increased by 22 percent since 2001, and they now control one in six hospital beds across the country.<sup>49</sup> The increase of Catholic hospitals poses a danger for women seeking reliable access to medical services, many of whom do not understand the full range of services that may be denied them. One public opinion survey found

---

<sup>46</sup> For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant. AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE § 114-15, S117 (2017), available at [http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement\\_1.DC1/DC\\_40\\_S1\\_final.pdf](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).

<sup>47</sup> Debra B. Stulberg M.D. M.A., et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, J. GEN. INTERN. MED. 725-30 (2010) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881970/>.

<sup>48</sup> Farr A. Curlin M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, NEW ENG. J. MED. 593-600 (2007) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2867473/>.

<sup>49</sup> Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, AM. CIVIL LIBERTIES UNION 22 (2017), available at [https://www.aclu.org/sites/default/files/field\\_document/healthcaredenied.pdf](https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf).

that, among the less than one-third of women who understood that a Catholic hospital might limit care, only 43 percent expected limited access to contraception, and a mere 6 percent expected limited access to the morning-after pill.<sup>50</sup>

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

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

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

### **A. HHS has exceeded its rulemaking authority**

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

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

<sup>50</sup> Nadia Sawicki, *Mandating Disclosure Of Conscience-Based Limitations On Medical Practice*, 42 AM. J. OF LAW & MED. 85-128 (2016) available at <http://journals.sagepub.com/doi/pdf/10.1177/0098858816644717>.

<sup>51</sup> *Gonzales v. Oregon*, 546 U.S. 243, 274–75 (2006); *United States v. Mead*, 533 U.S. 218, 229–30 (2001); *Motion Picture Ass'n of Am., Inc. v. FCC*, 309 F.3d 796, 801 (D.C. Cir. 2002); *Amalgamated Transit Union v. Skinner*, 894 F.2d 1362, 1371 (D.C. Cir. 1990) *Pharm. Research & Mfrs. of Am. v. U.S. Dep't of Health & Human Servs.*, 43 F. Supp. 3d 28, 39–40 (D.D.C. 2014).

<sup>52</sup> See 83 Fed. Reg. at 3928–30.

<sup>53</sup> *Id.* at 3930–31.

<sup>54</sup> 83 Fed. Reg. 3904.

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

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

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

---

<sup>55</sup> *Id.* at 3903.

<sup>56</sup> 42 U.S.C. 2000d *et seq.*

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

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

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

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

<sup>61</sup> *See* 42 U.S.C. § 18113.

<sup>62</sup> *Id.*

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

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

## **B. The Proposed Rule violates the Administrative Procedure Act**

Even if HHS could promulgate a rule such as this based on its general authority to engage in rulemaking, that authority is not without limits. Under the Administrative Procedure Act (APA), “agency action, findings, and conclusions found to be... arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,” “contrary to a constitutional right,” or “in excess of statutory jurisdiction, authority, or limitations” shall be held unlawful and set aside.<sup>64</sup> 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.”<sup>65</sup> In addition, an agency can only change an existing policy if it provides a “reasoned explanation” for disregarding or overriding the basis for the prior policy.<sup>66</sup>

### **1. The Proposed Rule is arbitrary and capricious**

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

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

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

---

<sup>64</sup> 5 U.S.C. § 706(2)(A), (B), (C).

<sup>65</sup> *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)).

<sup>66</sup> *Id.* at 2125-26.

<sup>67</sup> Executive Order 12866 on Regulatory Planning and Review (September 30, 1993).

potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity).”<sup>68</sup>

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

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

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

<sup>68</sup> Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Sec. 1 (b).

<sup>69</sup> Executive Order 12866, at Sec. 4(b),(c).

<sup>70</sup> *Id.* at Sec. 6(b).

<sup>71</sup> “Removing Barriers for Religious and Faith-Based Organizations To Participate in HHS Programs and Receive Public Funding,” 82 Fed. Reg. 49300 (Oct. 25, 2017).

<sup>72</sup> 42 U.S.C. § 2000e-2 (1964).

<sup>73</sup> *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP’T. OPPORTUNITY COMM’N (2018), <https://www.eeoc.gov/laws/statutes/titlevii.cfm>.



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

Furthermore, the language in the Proposed Rule could put health care entities in the untenable position of being forced to hire people who intend to refuse to perform essential elements of the job for which they are being hired. For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling. It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

The Proposed Rule also conflicts with the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.<sup>76</sup> Under EMTALA every hospital is required to comply – even those that are religiously affiliated.<sup>77</sup> Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances – such as those experiencing an ectopic pregnancy or miscarriage - not receiving necessary care. The Proposed Rule fails to explain how entities will be able to comply with the new regulatory requirements in a manner consistent with the statutory requirements of EMTALA, making the Proposed Rule unworkable.

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

---

<sup>74</sup> *See id.*

<sup>75</sup> 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](https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html).

<sup>76</sup> *See* 42 U.S.C. s 1295dd(a)-(c)

<sup>77</sup> *See, e.g., Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3<sup>rd</sup> Cir. 2000); *In re Baby K*, 16 F.3d 590, 597 (4<sup>th</sup> Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, 93 Fair Empl. Prac. Cas. (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).



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

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

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

The Proposed Rule is also not in accordance with law because much of its language exceeds the plain parameters and intent of the underlying statutes it purports to enforce. It defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. Therefore, the Proposed Rule violates the APA and should be withdrawn.

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

---

<sup>78</sup> U.S. Const. amend. I; *Cutter v. Wilkinson*, 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts “must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries” and must ensure that the accommodation is “measured so that it does not override other significant interests”) (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 18 n.8 (1989); see also *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).

<sup>79</sup> *Cutter*, 544 U.S. at 720, 722; see also *Thornton*, 472 U.S. at 709-10.

<sup>80</sup> 42 USC 300a-7.

<sup>81</sup> 83 Fed. Reg. 3892.

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

If workers in very tangential positions, such as schedulers, are able to refuse to do their jobs based on personal beliefs, the ability of any health system or entity to plan, to properly staff, and to deliver quality care will be undermined. Employers and medical staff may be stymied in their ability to establish protocols, policies and procedures under these vague and broad definitions. The Proposed Rule creates the potential for a wide range of workers to interfere with and interrupt the delivery of health care in accordance with applicable standards of care.

The definition of “referral” similarly goes beyond any understanding of the term, allowing refusals to provide any information based on which an individual could get the care they need.<sup>83</sup> Any information distributed by any method, including online or print, regarding any service, procedure, or activity could be refused by an individual or entity if the information given would lead to a service, activity, or procedure to which the provider objects.

Under the Coats and Weldon Amendments, “health care entity” is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.<sup>84</sup> 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.<sup>85</sup> Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but contravenes congressional intent. By expressly defining the term “health care entity” Congress implicitly rejected the inclusion of the other terms HHS now attempts to insert.<sup>86</sup>

The Proposed Rule defines workforce to include “volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity.”<sup>87</sup> Under this definition, virtually any member of the health care workforce could ostensibly refuse to serve a patient in any way.

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

---

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

<sup>83</sup> 83 Fed. Reg. 3895.

<sup>84</sup> 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).

<sup>85</sup> 83 Fed. Reg. 3893.

<sup>86</sup> The doctrine of *expressio unius est exclusio alterius* (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.

<sup>87</sup> 83 Fed. Reg. 3894.

or employment as well as an unspecified catch-all phrase “any activity reasonably regarded as discrimination.”<sup>88</sup> Such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion and undermining non-discrimination laws. Because of the potential harm to individuals if religious refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.<sup>89</sup> Instead, courts have held that the government has a compelling interest in ending discrimination and that anti-discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a “shield” to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a “compelling interest in providing an equal opportunity to participate in the workforce without regard to race,” and are narrowly tailored to meet that “critical goal.”<sup>90</sup> In seeking to craft a regulatory scheme mirroring “other civil rights laws,” HHS is in fact hampering enforcement of the very civil rights laws it claims to be emulating.

Moreover, the Proposed Rule states that the exemptions that Weldon provides is not limited to refusals of abortion care on the basis of religious or moral beliefs – the denial may be for any reason at all.<sup>91</sup> The preamble uses language such as “those who choose not to provide” or “would rather not” as justification for a refusal. This unbounded license to deny care is made more dangerous by the fact that the Proposed Rule contains no mechanism to ensure that patients receive the care they need if their provider refuses to furnish a service. The onus will be on the patient to question whether her hospital, medical doctor, or health care professional has religious, moral, or other beliefs that would lead them to deny services, or if services were denied, the basis for refusal. The Proposed Rule does not have any provisions that stipulate that patients must be given notice that they may be refused certain health care services on the basis of religious or moral beliefs.

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

---

<sup>88</sup> 83 Fed. Reg. 3892.

<sup>89</sup> *See, e.g., Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government’s interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that “the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family”); *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

<sup>90</sup> *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, slip op. at 46 (2014).

<sup>91</sup> 83 Fed. Reg. 3890-91.

<sup>92</sup> 83 Fed. Reg. 3898.

## **Conclusion**

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

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

National Center for Lesbian Rights

**EXHIBIT R**





**BY E-MAIL**

March 26, 2018

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

**Re: Docket HHS-OCR-2018-0002**

On behalf of the Anti-Defamation League, we are writing to offer our comments on the proposed 45 CFR Part 88, “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority,” as outlined at 83FR 3880 (“Proposed Rule” or “Part 88”).

For more than a century, the Anti-Defamation League (ADL) has been an active advocate for religious freedom for all Americans – whether in the majority or minority. Among ADL’s core beliefs is strict adherence to the separation of church and state effectuated through both the Establishment Clause and the Free Exercise Clause of the First Amendment. We believe a high wall of separation between government and religion is essential to the continued flourishing of religious practice and belief in America, and to the protection of all religions and their adherents.

ADL believes that true religious freedom is best achieved when all individuals are able to practice their faith or choose not to observe any faith; when government neutrally accommodates religion, but does not favor any particular religion; and when religious belief is not used to harm or infringe on the rights of others by government action or others in the public marketplace.

The “play in the joints” between the Establishment Clause and Free Exercise Clause allows and, in many instances, mandates government to accommodate the religious beliefs and observances of citizens. Religious accommodation, however, has its limitations. The United States government should not sanction discrimination or harm in the name of religion. The right to individual religious belief and practice is fundamental. But there should be no license to discriminate or to do harm with government authority.

As noted in the background for this Proposed Rule, healthcare providers – whether individuals or entities – already have robust statutory religious or moral exemptions from performing abortions or sterilization procedures, or complying with advanced directives, and in certain international programs, they have even broader exemptions (“Statutory Exemptions”).<sup>1</sup> Provided that the health and safety of patients are safeguarded, such

<sup>1</sup> See The Church Amendments, 42 U.S.C. 300a-7; The Coats-Snowe Amendment, 42 U.S.C. 238n; Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. H, Tit. V, sec. 507(d) (the Weldon Amendment) and at Div. H, Tit. II, sec. 209; Patient Protection and Affordable Care Act related to assisted suicide 42 U.S.C. 18113; 42 U.S.C. 1395cc(f), 1396a(w)(3), and 14406; 22 U.S.C. 7631(d); Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. J, Tit. VII, sec. 7018 (Helms Amendment).

Officers of the National Commission  
 National Chair  
 Marvin D. Nathan  
 CEO and National Director  
 Jonathan A. Greenblatt  
 Past National Chairs  
 Barbara B. Balsler  
 Howard P. Berkowitz  
 Kenneth J. Bialkin  
 Barry Curtiss-Lushner  
 Burton S. Levinson  
 Glen S. Levy  
 David H. Strassler  
 Robert G. Sugarman  
 Glen A. Tobias  
 Vice Chairs  
 Martin Budd  
 Meyer Eisenberg  
 Esta Gordon Epstein  
 James Grosfeld  
 Charles Kriser  
 Steven Lyons  
 Ruth Moss  
 George Stark  
 Mark Wilf  
 Christopher Wolf  
 Honorary Vice Chairs  
 Rudy Boschwitz  
 Yossie Hollander  
 Geri M. Joseph  
 Bernard Marcus  
 Cynthia Marks  
 Samuel H. Miller  
 Haim Saban  
 Michael Steindhardt  
 Gerald Stempler  
 Treasurer  
 Milton S. Schneider  
 Honorary Treasurer  
 Robert H. Nafaty  
 Secretary  
 Thomas C. Hornburger  
 Assistant Secretary  
 Stanford Baratz  
 Standing Committee Chairs  
 Administration  
 Lawrence Rosenbloom/  
 Pamela Schwartz  
 Audit  
 Shelley Parker  
 Budget  
 Mitchell Wesseley  
 Civil Rights  
 Elizabeth A. Price  
 Development  
 Ben Sax  
 Education  
 Miriam Weisman  
 Information Technology  
 Arthur Reidel  
 International Affairs  
 Eric Horodas  
 Leadership  
 Tracey Grossman/Tracy Treger  
 Funding for The Future  
 Lawrence Miller  
 Marketing & Communications  
 Joseph Goldblum  
 Outreach & Interfaith Affairs  
 Martin L. Budd  
 Planning  
 Milton S. Schneider  
 Regional Operations  
 Esta Gordon Epstein  
 Washington Affairs  
 Michael Sheetz  
 Senior Management Team  
 Deputy National Director  
 Kenneth Jacobson  
 Growth  
 Frederic L. Bloch, SVP  
 Chief of Staff  
 Emily Bromberg  
 Finance & Administration  
 Michael A. Kellman, SVP  
 International Affairs  
 Sharon Nazarian, SVP  
 Technology  
 Rafail Portnoy, SVP  
 Programs  
 George Selim, SVP  
 Talent & Knowledge  
 Tom Ruderman, SVP  
 General Counsel, Privacy & Security  
 Steven C. Sheinberg, SVP  
 Communications & Digital  
 Betsaida Alcantara, VP  
 Brand & Marketing  
 Amy Aronoff Blumkin, VP  
 Law Enforcement, Extremism  
 & Community Security  
 David Friedman, VP  
 Regional Operations  
 & Advancement  
 David S. Waren, VP  
 Anti-Defamation League  
 Foundation  
 President  
 Glen S. Levy  
 National Director Emeritus  
 Abraham H. Foxman



accommodations are appropriate for doctors, nurses, and others, who actually may be called on to perform these medical procedures or services.

The Proposed Rule, however, crosses the line from providing appropriate accommodations to allowing individuals or entities with incidental or tangential relationships to such procedures or services to detrimentally impose their religious or moral beliefs on patients and other third parties. It does so in two ways. First, Part 88 provides excessively broad and vague definitions of persons, entities, and activities covered by Statutory Exemptions. Second, it includes an excessively broad interpretation of Statutory Exemptions the enforcement of which is delegated to the Office of Civil Rights (“OCR”).

As a result, Part 88 would impede access to federally-supported healthcare and in particular have a disparate impact on women, LGBTQ people and religious minorities. It thereby would undermine the mission of OCR, which is to “... enforce laws against discrimination based on race, color, national origin, disability, age, sex, and religion by certain health care and human services.” Moreover, the Proposed Rule and the accompanying creation of a new OCR division to implement it convey the distinct message that enforcement of civil rights protections for such groups is secondary.

#### **The Proposed Rule Provides Excessively Broad Definitions of Persons and Entities Covered by Statutory Exemptions**

The “Descriptions of the Proposed Rule” (“Rule Descriptions”) advise that the term “Entity” means a person or any legal entity whether private or public, and the definition of “Health Care Entity” is not definitive. Rather, it includes examples of covered persons or entities such as “...an individual physician or other health care professional, health care personnel, ... a hospital, a laboratory, an entity engaging in biomedical or behavioral research, ... a or health insurance plan ... , or any other kind of health care organization.” However, these examples are “... an illustrative, not an exhaustive list.” Additionally, while Part 88 contains a definition of “Health Program or Activity,” which will be discussed, *infra*, it does not appear to contain a definition of “health care.”

With respect to employees of or other persons associated with Entities or Health Care Entities, the Rule Descriptions provide the following definitions for the terms “Workforce” and “Individual.” Workforce means:

*employees, volunteers, trainees, contractors, and other persons whose conduct in the performance of work for an entity or health care entity is under the direct control of such entity or health care entity, whether or not they are paid by the entity or health care entity, as well as health care providers holding privileges with the entity or health care entity.*

The term “Individual” means “a member of the workforce of an entity or health care entity,” including “... volunteers, trainees, or other members or agents of a covered entity, broadly defined, when the conduct of the person is under the control of such entity” (emphasis added).

The Statutory Exemptions are intended to cover persons, who actually may be called on to perform medical procedures. Yet, based on these definitions, virtually any person, including volunteers, who work, for example, at a federally-funded or supported hospital, pharmacy, medical or nursing school, nursing home, or “any other kind of health care organization” would be covered by Statutory Exemptions. Simply put, any person performing work for such a facility

– whether paid or unpaid – would be encompassed by the Proposed Rule irrespective of their non-medical job description or role. That unnecessarily-inclusive definition would compromise and harm the rights of third parties.

### **The Proposed Rule Provides Excessively Broad Definitions of Activities Covered by Statutory Exemptions**

The Rule Descriptions advise that term “Healthcare Program or Activity ... include the provision or administration of any health-related services, health service programs and research activities, health-related insurance coverage, health studies, or any other service related to health or wellness whether directly, through payments, grants, contracts, or other instruments, through insurance, or otherwise” (emphasis added). Part 88 does not define the meaning of “health-related services” or “service related to health or wellness.”

These terms must be read in conjunction with two other definitions: “Assist in the Performance” and “Referral or Refer for.” The Rule Descriptions advise that the Department of Health and Human Services (“HHS”) intends Assist in the Performance to “... to provide broad protection for individuals, consistent with the plain meaning of the statutes ...” because “[t]he Department believes that a more narrow definition of the statutory term ‘assist in the performance,’ such as a definition restricted to those activities that constitute direct involvement with a procedure, health service, or research activity, would fall short of implementing the protections Congress provided (emphasis added). To this end, the term applies “... to activities with an articulable connection to the procedure, health service, health service program, or research activity in question.”

Furthermore, “Referral or Refer for” includes

*... the provision of any information (including but not limited to name, address, phone number, email, or website) by any method (including but not limited to notices, books, disclaimers, or pamphlets online or in print) pertaining to a service, activity, or procedure, including related to availability, location, training, information resources, private or public funding or financing, or direction that could provide any assistance in a person obtaining, assisting, training in, funding, financing, or performing a particular health care service, activity, or procedure, when the entity or health care entity making the referral sincerely understands that particular health care service, activity, or procedure to be a purpose or possible outcome of the referral.*

Based on these definitions a person who performs work for a federally-supported healthcare facility could refuse, without penalty, to perform their responsibilities for any service related to health or wellness that has an indirect or possible articulable connection to a statutorily-covered procedure, including providing any information about or how to obtain a procedure.

### **Application of the Proposed Rule’s Definitions to 45 CFR Part 88’s Interpretation of Statutory Exemptions Will Impede Access to Healthcare**

The Proposed Rule’s definitions operating in conjunction with its interpretation of substantive Statutory Exemptions could impede access to or deny federally-funded or supported healthcare. And the harm caused by enforcement of the Proposed Rule would disparately impact women, LGBT people, and religious minorities.

For example, with respect to federally supported healthcare within the United States, here are some examples of the harms that could result:



- An administrator at the only healthcare provider in a rural area could refuse to perform intake or process paperwork for a woman who must terminate her pregnancy due to an ectopic pregnancy or who is getting a tubal ligation. Similarly, the administrator could refuse to do the same for a transgender person, who is undergoing gender reassignment surgery because the surgery requires a hysterectomy. At the same provider, the only administrator or receptionist on shift could refuse to provide a referral to or any information about a health clinic that provides abortions.
- An administrator at a healthcare provider, even one that does not provide abortions or sterilization procedures, could refuse to disclose the provider's policy on these procedures based on the sincerely-held belief that the person seeking the information will either obtain the procedure at the contacted provider or at an alternative provider, which offers these procedures.
- A lab technician could refuse to perform any tests for a patient who will undergo an abortion, sterilization procedure, hysterectomy, or gender reassignment surgery.
- A hospital maintenance worker or contractor directed by the healthcare provider could refuse to perform any upkeep or construction work on an operating room or other facility that is used for abortions, sterilization procedures or hysterectomies.
- A hospital orderly could refuse to provide wheelchair service to a patient who is getting a hysterectomy or gender reassignment surgery.
- An administrator or employee of an insurance company that provides federally funded Medicare or Medicaid insurance policies could refuse to disclose to a prospective purchaser of insurance whether policies cover sterilization, gender reassignment surgery or services related to advance directives.
- At a federally supported medical school, an administrator could refuse to register students based on the sincerely-held belief that they will obtain medical training on abortion, sterilization, gender reassignment surgery, or advance directives, and will perform or assist with such procedures or services during or after their training. Or an employee of such a school's bookstore could refuse to sell medical books to students that provide information on abortion, sterilization or advance directives based on the sincerely-held belief that providing these books will train students to prospectively perform such procedures or services.

In the international arena, Part 88 could have an even wider detrimental impact. Pursuant to the Proposed Rule “[a]ny entity” that receives federal financial assistance for HIV/AIDS prevention, treatment or care under section 104A of the Foreign Assistance Act of 1961 shall not “endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the applicant has a religious or moral objection, as a condition of assistance” (emphasis added).

Thus, with respect to programs funded under section 104A, a health care organization, doctor, nurse or administrator, for example, could not be penalized for refusing, based on religious or moral objection, to treat or offer services to LGBT people, Muslims or other religious minorities, or sex workers.

### **The Proposed Rule Raises Significant Constitutional Issues**

The U.S. Supreme Court “has long recognized that government may (and sometimes must) accommodate religious practices.” See *Corp. of Presiding Bishop v. Amos*, 483 U.S. 327, 334. (1987) (citations omitted). However, it cautioned that “[a]t some point, accommodation may devolve into “an unlawful fostering of religion.” *Id* at 334-35.

Indeed, religious accommodations that unduly burden third parties violate the Establishment Clause. See *Sherbert v. Verner*, 374 U.S. 398 (1963); see also *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985). More recently, the Court has found that for statutory exemptions under the Religious Land Use and Institutionalized Persons Act, 42 U.S.C. § 2000cc et seq., to comport with the Establishment Clause, reviewing courts “must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries.” See *Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005).

Furthermore, in *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014), every member of the Court authored or joined an opinion recognizing that detrimental effects on nonbeneficiaries must be considered when evaluating requests for accommodations under the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb et seq. See *Hobby Lobby*, 134 S. Ct. at 2760 (“Nor do we hold \* \* \* that \* \* \* corporations have free rein to take steps that impose ‘disadvantages . . . on others’ or that require ‘the general public to pick up the tab.’” (brackets omitted)); *id.* at 2781 n.37 (“It is certainly true that in applying RFRA ‘courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries.’”); *id.* at 2787 (Kennedy, J., concurring) (religious exercise must not “unduly restrict other persons \* \* \* in protecting their own interests”); *id.* at 2790 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ., dissenting) (“Accommodations to religious beliefs or observances \* \* \* must not significantly impinge on the interests of third parties.”); see also *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., joined by Sotomayor, J., concurring) (Court’s recognition of right to accommodation under RLUIPA was constitutionally permissible because “accommodating petitioner’s religious belief in this case would not detrimentally affect others who do not share petitioner’s belief”).

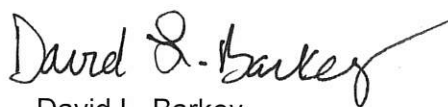
The Proposed Rule goes well beyond a religious accommodation that safeguards the health and safety of patients while exempting doctors, nurses, and medical professionals, who actually may be called on to perform abortions, sterilization, or other medical procedures, or to comply with advance directives. Rather, as detailed above, Part 88 broadly allows a wide swath of non-medical personnel far removed from these procedures or services to detrimentally impose their particular religious beliefs about them on innocent third parties. The Proposed Rule therefore raises serious constitutional issues because the broad exemptions provide a license to discriminate and would unduly burden – or, in some instances – deny patient access to federally-supported healthcare services.

We urge you to recall the Proposed Rule for modifications in light of these serious policy and constitutional arguments.

Sincerely,



Jonathan A. Greenblatt  
CEO



David L. Barkey  
Southeastern & National  
Religious Freedom Counsel



Michael Lieberman  
Washington Counsel

**EXHIBIT S**



# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

March 27, 2018

Submitted electronically via regulations.gov

U.S. Department of Health & Human Services  
Office for Civil Rights  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

**Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority Notice of Proposed Rule Making (RIN 0945-ZA03; Docket No. HHS-OCR-2018-0002)**

Justice in Aging appreciates the opportunity to respond to the Department of Health and Human Services (HHS) Notice of Proposed Rule Making entitled “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.” For the reasons below, we strongly urge HHS not to finalize the proposed rule. This submission supplements the comments of the Leadership Conference on Civil and Human Rights, which we also support.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Ensuring that all consumers are protected from discrimination in health care is integral to the mission of the HHS Office for Civil Rights (OCR). This mission cannot be carried out without also ensuring that providers, whatever their religious beliefs or moral convictions, adhere to nondiscrimination laws and the medical and health-related standard of care. The proposed rule would greatly expand current “conscience” protections and religious refusals, and we are deeply concerned that it would allow employees in health care settings to discriminate against and deny care to older adults and people with disabilities. Existing law already provides ample protection for health care providers to refuse to participate in a health care service to which they have religious or moral objections. As proposed, the rule will harm consumers by increasing barriers to care, allowing health care professionals to ignore established medical guidelines, and undermining open communication between providers and patients.

## WASHINGTON

1444 Eye Street, NW, Suite 1100  
Washington, DC 20005  
202-289-6976

## LOS ANGELES

3660 Wilshire Boulevard, Suite 718  
Los Angeles, CA 90010  
213-639-0930

## OAKLAND

1330 Broadway, Suite 525  
Oakland, CA 94612  
510-663-1055



**I. The proposed rule’s expansion of conscience protections and religious refusals could seriously compromise the health, autonomy, and well-being of older adults and people with disabilities.**

The extremely broad language proposed in the rule 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. The rule’s definitions could both undermine nondiscrimination laws that are meant to protect consumers and even foster health care settings and interactions between patients and providers that are informed by bias instead of medically accurate, evidence-based, person-centered care. This would seriously jeopardize the health, autonomy, and well-being of older adults and people with disabilities.

We are concerned that the rule’s proposed definitions and applicability, which HHS repeatedly states are meant to be “broadly defined” and “illustrative, not exhaustive,” could allow any member of the health care workforce to refuse to serve a patient in any way. Under the proposed rule’s definitions, any individual who is a member of an entity’s workforce could refuse to assist in the performance of any services or activities that have any “articulable connection”<sup>1</sup> to a procedure they object to. This includes “volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity.”<sup>2</sup> Also, the definition of “referral”<sup>3</sup> would allow an entity to refuse to provide any information distributed by any method, including online or print, regarding any service, procedure, or activity if that information would lead to a service, activity, or procedure that the entity objects to.

The proposed rule does not articulate a definition of moral beliefs. This opens the door to a provider’s own prejudices serving as the basis of denying services or care based on an individual’s characteristics. For example, could a nurse assistant refuse to serve lunch to a transgender patient? Could office staff refuse to schedule an appointment for a person whom they believe to be from another country or who does not speak English well?

**II. The expansion of religious refusals under the proposed rule is contrary to the mission of HHS and OCR and would disproportionately harm communities that already lack access to care**

HHS OCR has worked for decades to ensure that the health programs and activities it regulated comply with vital nondiscrimination laws, including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act (ACA). HHS has enforced these laws by ending overtly discriminatory practices such as race segregation and segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for gender transition related services, and insurance benefit designs that

---

<sup>1</sup> 83 Fed. Reg. 3880, 3892 (Jan 26, 2018).

<sup>2</sup> *Id.* at 3894 (Jan 26, 2018).

<sup>3</sup> *Id.*

discriminate against people who are HIV positive. OCR has also sought to ensure compliance with civil rights statutes by requiring covered entities to provide auxiliary aids and services to ensure effective communication for individuals with disabilities and taking steps to ensure that individuals with limited English proficiency have meaningful access to health facilities, such as providing interpreters free of charge. These actions have gone a long way towards combating discrimination and disparities in health care.

Nevertheless, further work is needed to address discrimination and reduce these disparities. Older adults are no exception to the stark health disparities that persist across race, national origin, gender, sexual orientation, and poverty lines. For example, a larger share of Black and Hispanic Medicare beneficiaries report fair or poor health status than white beneficiaries.<sup>4</sup> Similarly, Black and Hispanic adults age 65 and older are almost twice as likely as white older adults to develop diabetes.<sup>5</sup> Older adults who are limited English proficient (LEP), including over four million Medicare beneficiaries,<sup>6</sup> face difficulties finding providers, especially for in-home supports and services, who speak their preferred language and often are forced to rely on family members to interpret for them. Lesbian, gay and bisexual older adults face higher rates of disability and mental health challenges; older bisexual and gay men face higher rates of physical health challenges; bisexual and lesbian older women have higher obesity rates and higher rates of cardiovascular disease; and transgender older adults face greater risk of suicidal ideation, disability, and depression compared to their peers.<sup>7</sup> HIV disproportionately impacts the LGBTQ community, and it is affecting an increasing number of older adults.<sup>8</sup>

However, the expansion of religious refusals under the proposed rule would only make these disparities worse by disproportionately harming communities that already face barriers to care: women, people of color, people living with disabilities, people with limited English proficiency, and Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) individuals, as well as people living in rural communities. The harmful effects would be compounded for individuals who hold multiple disadvantaged identities. For example, an older adult who is gay might also have limited English proficiency, or a physical or mental disability, and may not have a choice of providers and therefore nowhere to go if they are refused care in the rural community where they live.

---

<sup>4</sup> Kaiser Family Foundation, *Profile of Medicare Beneficiaries by Race and Ethnicity*, (March 9, 2016), available at <http://kff.org/medicare/report/profile-of-medicare-beneficiaries-by-race-and-ethnicity-a-chartpack/>.

<sup>5</sup> Centers for Disease Control and Prevention, *The State of Aging and Health in America*, (2013) at Figure 2, available at [www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf](http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf)

<sup>6</sup> CMS Office of Minority Health, *Understanding Communications and Language Needs of Medicare Beneficiaries*, at 8 (April 2017), available at [www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf](http://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf)

<sup>7</sup> Fredriksen-Goldsen et al., *The Aging And Health Report: Disparities And Resilience Among Lesbian, Gay, Bisexual, And Transgender Older Adults* (Nov. 2011), available at [www.lgbtagingcenter.org/resources/resource.cfm?r=419](http://www.lgbtagingcenter.org/resources/resource.cfm?r=419)

<sup>8</sup> See Ctrs. for Disease Control & Prevention, *HIV in the United States: At a Glance* (June 2017), available at [www.cdc.gov/hiv/statistics/overview/ataglance.html](http://www.cdc.gov/hiv/statistics/overview/ataglance.html); Ctrs. for Disease Control & Prevention, *HIV and Transgender Communities* (2016), [www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf](http://www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf).

A. *The proposed rule would harm LGBTQ older adults who continue to face widespread discrimination and health disparities.*

We are particularly concerned that the proposed rule would exacerbate the barriers to care that LGBTQ older adults face and the effects of ongoing and pervasive discrimination by potentially allowing providers to refuse to provide services and information vital to LGBTQ health. In addition to experiencing the health disparities described above, LGBT elders are more likely to be single, childless, estranged from their biological family, and reliant on families of choice, such as friends and other loved ones. Because they do not have traditional support systems in place, many LGBT elders rely on nursing homes or other long-term care facilities to receive needed services.<sup>9</sup> Results of a recent survey by AARP show that at least a third of LGBT adults are worried about having to hide their LGBT identity in order to have access to housing options that are suitable for older adults.<sup>10</sup> Over half of LGBT adults fear discrimination in health care as they age and are especially concerned about neglect, abuse, and verbal or physical harassment in long-term care facilities.<sup>11</sup> These concerns are even greater among Black and Latino LGBT adults and individuals who identify as non-binary.<sup>12</sup>

Unfortunately, these fears are a reality for many LGBT older adults. In a survey of LGBT seniors reported in our publication, *Stories from the Field*, we found numerous cases where LGBT older adults experienced discrimination in long-term care facilities ranging from verbal and physical harassment, to visiting restrictions and isolation, to being denied basic care such as a shower or being discharged or refused admission.<sup>13</sup> In addition to being denied care or provided inadequate care, LGBT older adults and their loved ones may be afraid to seek care because they are not treated with dignity and respect. Several LGBT older adults reported being “prayed over” without their consent or being told they would go to hell—violating their right to practice their own beliefs.<sup>14</sup> These discriminatory actions by facility staff could be protected under this ill-advised rule.

As proposed, the rule could allow individuals and facilities to not only refuse to provide treatment for LGBTQ individuals, but to also deny doctors and other professionals the ability to provide that treatment in their facilities. Such refusals implicate standards of care that are vital to LGBTQ health. Medical professionals are expected to provide LGBTQ individuals with the same quality of care as they would anyone else. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and

---

<sup>9</sup> SAGE (Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders) and Movement Advancement Project, *Improving the Lives of LGBT Older Adults*, (March 2010), available at [www.sageusa.org](http://www.sageusa.org), [www.lgbtmap.org](http://www.lgbtmap.org).

<sup>10</sup> Houghton, Angela, AARP, *Maintaining Dignity: Understanding and Responding to the Challenges Facing Older LGBT Americans*. (Mar. 2018), available at <https://doi.org/10.26419/res.00217.001>.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> Justice in Aging et al., *LGBT Older Adults In Long-Term Care Facilities: Stories from the Field* (updated June 2015), available at [www.justiceinaging.org.customers.tigertech.net/wp-content/uploads/2015/06/Stories-from-the-Field.pdf](http://www.justiceinaging.org.customers.tigertech.net/wp-content/uploads/2015/06/Stories-from-the-Field.pdf)

<sup>14</sup> *Id.* at 11.

competency with LGBTQ issues as they pertain to any health services provided.<sup>15</sup> The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions, when sought by transgender individuals, are medically necessary and part of the standard of care.<sup>16</sup> The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.<sup>17</sup> The proposed rule would interfere with the ability of providers to meet these standards since they would not be able to rely on the consistent support of the facilities and care teams where they practice.

*B. The proposed rule will harm older adults and people living with disabilities who rely on long-term services and supports.*

Many older adults and people with disabilities receive long-term services and supports, including home and community-based services (HCBS), from religiously-affiliated providers. However, some people who rely on these services have faced discrimination, exclusion, and a loss of autonomy due to provider objections to providing specified care. For example, 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 facilities before his family was finally forced to relocate him to a facility 80 miles away.<sup>18</sup>

Older adults and people with disabilities often live or spend much of their day in provider-controlled settings where they 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 this broad new proposed language, 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 that the service is available to them. In these cases, a denial based on a provider's personal moral objection can potentially impact every facet of life for an older adult or person with disabilities – including visitation rights, autonomy, and access to the community. For example,

---

<sup>15</sup> Gay Lesbian Bisexual & Transgender Health Access Project, *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, available at [www.glbthealth.org/documents/SOP.pdf](http://www.glbthealth.org/documents/SOP.pdf); A.M.A., *Creating an LGBTQ-friendly Practice*, available at [www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice](http://www.ama-assn.org/delivering-care/creating-lgbtq-friendly-practice).

<sup>16</sup> World Prof. Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (2011), available at [https://s3.amazonaws.com/amo\\_hub\\_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf).

<sup>17</sup> Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 512: Health Care for Transgender Individuals*, (Dec. 2011), available at [www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals](http://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals).

<sup>18</sup> 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](https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf).

could a case manager ignore an individual's request to see an HIV specialist? Could a group home refuse to allow a same-sex couple who are residents to live together in the group home?

Finally, due to limited provider networks, older adults and people with disabilities living in rural areas may have particular difficulty finding an alternate provider. 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.<sup>19</sup> Finding providers competent to treat people with certain disabilities increases the challenge, and adding in the possibility of a case manager or personal care attendant who objects to serving the individual under this proposed rule could make the barrier to accessing these services insurmountable. Moreover, older adults and 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 receive (or even know about) accommodations.

### **III. The proposed rule undermines longstanding ethical and legal principles of informed consent and would undermine effective provider-patient communication**

The proposed rule undermines informed consent, a necessary principle of person-centered decision making and a critical component of quality of care. Informed consent relies on providers disclosing medically accurate information so that patients can competently and voluntarily make decisions about their medical treatment or refuse treatment altogether.<sup>20</sup>

The proposed rule purports to improve communication between patients and providers, but instead, will deter open, honest conversations that are vital to ensuring that patients are able to be in control of their medical care. For example, the proposed rule suggests that a provider could refuse to offer information, if that information might be used to obtain a service to which the refuser objects. By undermining informed consent, the proposed rule could result in providers withholding information far beyond the scope of the underlying statutes and violate medical standards of care.

Additionally, while virtually every state already provides for a conscience objection and a provider's right to refuse to comply with a patient's directive, state laws also impose an obligation on providers to inform patients of their objection and to make some level of effort to transfer the patient to another provider or facility that will comply with the patient's wishes. This proposed rule appears to require neither and may even preempt these state laws which protect patients' rights. If this rule is finalized, which we oppose, HHS should clarify that state conscience rule procedural requirements are not preempted.

In particular, the principles of informed consent, respect for autonomy, and self-determination are important when individuals are seeking end-of-life care or have diminishing capacity. These

---

<sup>19</sup> 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>.

<sup>20</sup> Tom Beauchamp & James Childress, *PRINCIPLES OF BIOMEDICAL ETHICS* (4th ed. 1994); Charles Lidz et al., *INFORMED CONSENT: A STUDY OF DECISION MAKING IN PSYCHIATRY* (1984).

patients should be the center of health care decision-making and they or their representatives should be fully informed about their treatment options. Under the proposed rule, however, providers who object to various procedures could withhold vital information about treatment options— including options such as palliative sedation or declining artificial nutrition and hydration—and refuse to provide a referral to a provider who would honor the patient’s wishes. For patients who cannot currently make health care decisions, their advance directives should be honored, regardless of the physician’s personal objections, either through immediate assistance or through transfer to another facility. The blanket refusals permissible under this proposed rule would violate informed consent principles by ignoring patients’ needs, desires, and autonomy and self-determination at critical times in their lives.

#### **IV. Conclusion**

Justice in Aging is deeply concerned that the proposed rule’s expansion of conscience protections and religious refusals would be detrimental to older adults’ health and well-being and greatly harm communities who already lack access to care and endure discrimination. HHS must ensure that all consumers are protected from discrimination and that all providers treat every patient whom they serve with dignity and respect. The proposed rule would give carte blanche to any provider to withhold care on the basis of prejudice cloaked as “moral conviction.” Therefore, we strongly urge HHS not to finalize the proposed rule.

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at [jgoldberg@justiceinaging.org](mailto:jgoldberg@justiceinaging.org).

Sincerely,



Jennifer Goldberg  
Directing Attorney



# **EXHIBIT T**



March 27, 2018

Secretary Alex Azar  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: Comments on HHS proposed rule on Protecting Statutory Conscience Rights in Health Care, HHS–OCR–2018–0002, RIN 0945-ZA03**

Dear Secretary Azar:

The co-chairs of the Consortium for Citizens with Disabilities (CCD) Rights Task Force submit these comments in response to HHS’s proposed rule interpreting religious refusal laws. CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society.

As advocates for the rights of individuals with disabilities to full and equal participation in all aspects of our society, we have serious concerns about the vagueness and breadth of the proposed rule’s provisions and the potential impact that it may have on the application of disability and civil rights laws, such as the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. For example, the proposed provisions at 45 C.F.R. §§ 88.3(a)(2)(v) and 88.3(a)(2)(vi) seem to allow health care providers and staff extremely broad latitude in refusing to perform or assist in the provision of any lawful health service on the ground that doing so would be contrary to his or her religious beliefs. The proposed rule fails to discuss how these broad interpretations of religious refusal laws would interact with civil rights laws. To the extent that its provisions may be interpreted to limit the rights of people with disabilities under the ADA, Section 504, or other civil rights laws to receive health care services, however, we strongly object to them.

Congress provided a “broad mandate” in the ADA and Section 504 “to remedy widespread

discrimination against disabled individuals.”<sup>1</sup> The ADA was designed “to provide clear, strong, *consistent, enforceable* standards addressing discrimination against individuals with disabilities.”<sup>2</sup> Religious beliefs, regardless of the sincerity with which they are held, cannot be used as a shield for discrimination in contravention of disability rights mandates.

Discrimination in the provision of health care based on religious grounds presents particular concerns for people with disabilities because many people with disabilities rely heavily on religiously affiliated service providers for daily supports. In fact, many people with disabilities have little choice but to receive needed services from such service providers. And those service providers—particularly residential providers—are frequently responsible for assisting with many aspects of a person’s life.

People with disabilities have sometimes been excluded from needed services or faced barriers to receiving those services due to service provider objections. For example, group homes have sometimes refused to allow people with disabilities to live with their spouses or romantic partners - even in the case of a heterosexual married couple.<sup>3</sup> Recent federal regulations concerning Medicaid home and community-based services now more clearly require residential service providers for people with disabilities to allow choice of roommate and overnight visitors.<sup>4</sup> Allowing religiously-affiliated service providers to deny residential services to people with disabilities based on a religious objection such as this could dramatically undermine their clients' right to pursue relationships and exercise fundamental rights of association.

The broad language of the proposed rule might also be interpreted to mean that the service providers on whom people with disabilities rely to coordinate necessary services or to provide transportation, personal care services, or other key services could refuse to provide these services, even if the person is entitled to receive them through Medicaid, Medicare, or another program. For example, these provisions might permit a case manager to refuse to set up a medical appointment for a person with a disability to see a gynecologist if contraceptives might be discussed, might permit a personal care services provider to refuse to assist a person with a disability in performing parenting tasks because the person was married to someone of the same gender, might permit a mental health service provider to refuse to provide needed treatment to an individual based on the fact that the individual was transgender, and might permit a sign language interpreter to refuse to help a person communicate with a doctor about sexual health. As these examples demonstrate, a denial of service based on a provider’s personal moral

---

<sup>1</sup> *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 674 (2001).

<sup>2</sup> 42 U.S.C. § 12101(b)(2) (emphasis added). Section 504 contains virtually identical requirements.

<sup>3</sup> See *Forziano v. Independent Grp. Home Livin 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).

<sup>4</sup> 42 C.F.R. §§ 441.710(a)(vi)(B)(2), 441.710(a)(vi)(D).

objection can potentially impact every facet of life for a person with disabilities – including autonomy, parental rights, and access to the community.

In addition, individuals with particular disabilities have historically faced discrimination on the basis of religious beliefs.<sup>5</sup> Cases abound where religious scruples have been invoked to deny services to HIV-infected people; as recently as 2009, pharmacists unsuccessfully challenged a Washington law prohibiting pharmacies from refusing to deliver lawfully prescribed or approved medicines.<sup>6</sup> This is also an extremely relevant issue for the disability community since 4.6 percent of Deaf people are infected with HIV/AIDS, four times the rate for the African-American population,<sup>7</sup> the most at-risk racial group in the U.S.<sup>8</sup>

People with disabilities not only experience health disparities themselves, but those disparities are compounded by the health disparities that they face as members of other demographic groups such as women, people of color, and LGBTQ people. While disability affects people of all races, ethnicities, genders, languages, sexual orientations, and gender identities, disability does not occur uniformly among racial and ethnic groups. Disability prevalence is highest among African Americans, who report disability at 20.5 percent compared to 19.7 percent for non-Hispanic whites, 13.1 percent for Hispanics/Latinos and 12.4 percent of Asian Americans.<sup>9</sup> Disability prevalence among American Indians and Alaskan Natives is 16.3 percent.<sup>10</sup> An Institute of Medicine report has already observed that there are “clear racial differences in medical service utilization rates of people with disabilities that were not explained by socioeconomic variables,” and “persistent effects of race/ethnicity [in medical service utilization] could be the result of culture, class, and/or discrimination.”<sup>11</sup> These compounded disparities place people with disabilities at greater risk of denials of needed health care.

---

<sup>5</sup> National Women’s Law Center, *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](https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf).

<sup>6</sup> *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1116 n.7 (9th Cir. 2009)

<sup>7</sup> Disability Policy Consortium, Seth Curtis and Dennis Heaphy, *Disabilities and Disparities: Executive Summary* 3 (March 2009).

<sup>8</sup> *Id.*

<sup>9</sup> U.S. Census Bureau, Matthew Brault, *Americans With Disabilities: 2005, Current Population Reports* 117 (2008). Many of the differences between the disability rates by race and Hispanic origin can be attributed to differences in the age distributions of their populations. For example, Hispanics are predominantly younger than non-Hispanic whites.

<sup>10</sup> U.S. Census Bureau, *2009 American Community Survey, S1810, Disability Characteristics 1 year estimates* (2009) [http://factfinder.census.gov/servlet/STTable?\\_bm=y&-qr\\_name=ACS\\_2009\\_1YR\\_G00\\_S1810&-geo\\_id=01000US&-ds\\_name=ACS\\_2009\\_1YR\\_G00\\_&-lang=en&-format=&-CONTEXT=st](http://factfinder.census.gov/servlet/STTable?_bm=y&-qr_name=ACS_2009_1YR_G00_S1810&-geo_id=01000US&-ds_name=ACS_2009_1YR_G00_&-lang=en&-format=&-CONTEXT=st).

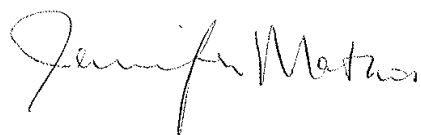
<sup>11</sup> Institute of Medicine, *The Future of Disability in America* 92 (2007).

Finally, we note that Title III of the ADA already exempts from coverage “religious entities or entities controlled by religious organizations, including places of worship.”<sup>12</sup> The sweeping language of the proposed rule has the potential to create conflicts with Title III and to preempt enforcement of similar state and local laws protecting people with disabilities.

For the foregoing reasons, we urge you to revise the proposed rule to ensure that the religious refusal provisions are not interpreted to preempt civil rights protections.

Sincerely,

CCD Rights Co-Chairs  
On behalf of CCD Rights Task Force



Jennifer Mathis  
Bazelon Center for Mental Health Law



Dara Baldwin  
National Disability Rights Network



Mark Richert  
American Foundation for the Blind



Heather Ansley  
Paralyzed Veterans of America



Samantha Crane  
Autistic Self Advocacy Network

---

<sup>12</sup> 42 U.S.C. § 12187.

**EXHIBIT U**





March 27, 2018

Via Electronic Submission ([www.regulations.gov](http://www.regulations.gov))

Secretary Alex Azar  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: Comments on HHS proposed rule on Protecting Statutory Conscience Rights in Health Care, HHS–OCR–2018–0002, RIN 0945-ZA03**

Dear Secretary Azar:

Disability Rights Education and Defense Fund (DREDF) thanks you for the opportunity to submit comments on the Department of Health and Human Services' proposed rule on Protecting Statutory Conscience Rights in Health Care (proposed rule). DREDF is a national cross-disability law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. We are committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives.

Healthcare is not simply a consumer good. Everyone needs some degree of healthcare at some point in their lives. Disabilities and health conditions that affect functional ability arise from every facet of human interaction, or the mere reality of aging. People with disabilities and chronic conditions require equal access to quality healthcare in their communities to exercise their civil right to fully participate in all aspects of American society. As longtime advocates for the disability community in the arena of healthcare, we are alarmed by the vagueness and potential reach of the proposed rule's provisions as they intersect with civil rights laws including the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504), and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557). The proposed broadly requirements and prohibitions of 45 C.F.R. § 88.3 prioritize the rights of personnel and entities involved with any health-related service, from research to insurance to third-party administration, to refuse to perform or assist with any lawful health service for "religious, moral, ethical or other reasons."

DREDF appreciates the proposed rule's argument on behalf of the conscience rights of

healthcare entities, but emphasizes that those rights must be read in concert with this country’s commitment to the right of people with disabilities, across a full range of race, ethnicity, age, sexual orientation and gender identity, to receive health care services free of discrimination. Congress provided a “broad mandate” in the ADA and Section 504 “to remedy widespread discrimination against disabled individuals.”<sup>1</sup> The ADA was designed “to provide clear, strong, *consistent, enforceable* standards addressing discrimination against individuals with disabilities.”<sup>2</sup> The ADA unquestionably applies to the private offices of healthcare providers, hospitals, and any state or locally operated healthcare entity, and Section 504 applies to all entities that receive federal financial assistance or are federally operated. Section 1557 broadly extended Section 504’s non-discrimination mandate to private insurers. Conscience rights, regardless of the sincerity with which they are held, cannot be used as a shield for discrimination that would deprive people with disabilities of equal access to healthcare.

Discrimination in the provision of health care based on religious grounds presents particular concerns for people with disabilities for both historic and practical reasons. Historically, people with disabilities have been subject to many stereotypes including religious beliefs that disability arises from demonic possession or a curse.<sup>3</sup> Those early stereotypes gave way to assumptions eugenic assumptions about who was “fit” to reproduce and many state laws that sterilized people with disabilities without their consent; California’s eugenics laws stayed on the books until 1979.<sup>4</sup> While hopefully few current healthcare providers may hold overt beliefs about demonic possession or eugenics, different religious beliefs can easily influence assumptions about the “childlike nature” and capacities of people with disabilities, their quality of life, their ambitions, and their freedom and capacity to make autonomous choices and take risks.

Practically, people with disabilities as a group are subject to higher unemployment and lower socio-economic status. Many people with disabilities rely heavily on religiously affiliated service providers for daily supports as well as ongoing healthcare services. In fact, many people with disabilities have little choice but to receive needed services from such service providers. And those service providers—particularly residential providers—are frequently responsible for assisting with many aspects of a person’s life and the activities to which they have access.

People with disabilities have sometimes been excluded from needed services or faced barriers to receiving those services due to service provider objections. For example, group homes have sometimes refused to allow people with disabilities to live with their spouses or romantic partners - even in the case of a heterosexual married couple.<sup>5</sup> Recent federal regulations concerning Medicaid home and community-based services now more clearly require residential service providers for people with disabilities that

---

<sup>1</sup> *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 674 (2001).

<sup>2</sup> 42 U.S.C. § 12101(b)(2) (emphasis added). Section 504 contains virtually identical requirements.

<sup>3</sup> Chomba Wa Munyi, “Past and Present Perceptions Towards Disability: A Historical Perspective,” *Disability Studies Quarterly* 32:2 (2012), available at: <http://dsq-sds.org/article/view/3197/3068>.

<sup>4</sup> A. M. Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America*, American Crossroads (2015).

<sup>5</sup> See *Forziano v. Independent Grp. Home Livin 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).

receive federal funds to allow choice of roommate and overnight visitors.<sup>6</sup> Allowing religiously-affiliated service providers to deny residential services to people with disabilities based on a religious objection such as this could dramatically undermine their clients' right to pursue relationships and exercise fundamental rights of association.

The breadth of application of the proposed rule might also be interpreted to mean that the service providers on whom people with disabilities rely to coordinate necessary services or to provide transportation, personal care services, or other key services could refuse to provide these services, even if the person is entitled to receive them through Medicaid, Medicare, or another program. For example, these provisions might permit a case manager to refuse to set up a medical appointment for a person with a disability to see a gynecologist if contraceptives might be discussed, might permit a personal care services provider to refuse to assist a person with a disability in performing parenting tasks because the person was married to someone of the same gender, might permit a mental health service provider to refuse to provide needed treatment to an individual based on the fact that the individual was transgender, and might permit a sign language interpreter to refuse to help a person communicate with a doctor about sexual health. As these examples demonstrate, a denial of service based on a provider's personal moral objection can potentially impact every facet of life for a person with disabilities – including autonomy, parental rights, and access to the community.

Since the proposed rule encompasses referral and the giving of information, people with disabilities can be denied both the option of assistance finding needed healthcare services somewhere else, or left not even knowing that they have been given incomplete information. In many rural areas, and even in some urban areas of the country that have a very high cost of living, it can be extremely difficult for people with disabilities to find personal care assistants. Will a personal care assistant, or a care agency, with sincerely held religious beliefs be able to refuse to assist their client with activities that the assistant disapproves of, such as watching certain movies or meeting with certain friends because they believe such activities are morally wrong? If a person with a disability attempts to find another care assistant, can the current assistant choose to simply not communicate the fact that other applicants are seeking the position? The department's failure to specify in the proposed rule that healthcare entities cannot exercise their conscience rights over a disabled person's right to receive healthcare services free of discrimination leaves people with disabilities in an extremely vulnerable situation, potentially unable to rely on the very agency, HHS Office for Civil Rights, that should be protecting them from discrimination.

In addition, individuals with particular disabilities have historically faced particular discrimination on the basis of religious beliefs.<sup>7</sup> Cases abound where religious scruples have been invoked to deny services to HIV-infected people; as recently as 2009, pharmacists unsuccessfully challenged a Washington law prohibiting pharmacies from refusing to deliver lawfully prescribed or approved medicines.<sup>8</sup> This is also an extremely

---

<sup>6</sup> 42 C.F.R. §§ 441.710(a)(vi)(B)(2), 441.710(a)(vi)(D).

<sup>7</sup> National Women's Law Center, *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>.

<sup>8</sup> *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1116 n.7 (9th Cir. 2009)

relevant issue for the disability community since 4.6 percent of Deaf people are infected with HIV/AIDS, four times the rate for the African-American population,<sup>9</sup> the most at-risk racial group in the U.S.<sup>10</sup>

People with disabilities not only experience health disparities themselves, but those disparities are compounded by the health disparities that they face as members of other demographic groups such as women, people of color, and LGBTQ people. While disability affects people of all races, ethnicities, genders, languages, sexual orientations, and gender identities, disability does not occur uniformly among racial and ethnic groups. Disability prevalence is highest among African Americans, who report disability at 20.5 percent compared to 19.7 percent for non-Hispanic whites, 13.1 percent for Hispanics/Latinos and 12.4 percent of Asian Americans.<sup>11</sup> Disability prevalence among American Indians and Alaskan Natives is 16.3 percent.<sup>12</sup> One Institute of Medicine report has already observed that there are “clear racial differences in medical service utilization rates of people with disabilities that were not explained by socioeconomic variables,” and “persistent effects of race/ethnicity [in medical service utilization] could be the result of culture, class, and/or discrimination.”<sup>13</sup> Another recent paper commissioned by the National Academies of Sciences, Engineering and Medicine found that “[c]onscious and unconscious biases and stereotypes among health care providers and public health practitioners about specific racial and ethnic groups, and people with disabilities, contribute to observable differences in the quality of health care and adverse health outcomes among individual within those groups.”<sup>14</sup> These compounded disparities place people with disabilities at greater risk of denials of needed health care.

Title III of the ADA already exempts from coverage “religious entities or entities controlled by religious organizations, including places of worship.”<sup>15</sup> The sweeping language of the proposed rule has the potential to create conflicts with Title III and to preempt enforcement of similar state and local laws protecting people with disabilities.

Finally, we note that the proposed rule provides HHS OCR with the following authority:

(c) Periodic compliance reviews. OCR may from time to time conduct compliance reviews or use other similar procedures as necessary to permit OCR to

---

<sup>9</sup> Disability Policy Consortium, Seth Curtis and Dennis Heaphy, *Disabilities and Disparities: Executive Summary* 3 (March 2009).

<sup>10</sup> *Id.*

<sup>11</sup> U.S. Census Bureau, Matthew Brault, *Americans With Disabilities: 2005, Current Population Reports* 117 (2008). Many of the differences between the disability rates by race and Hispanic origin can be attributed to differences in the age distributions of their populations. For example, Hispanics are predominantly younger than non-Hispanic whites.

<sup>12</sup> U.S. Census Bureau, *2009 American Community Survey, S1810, Disability Characteristics 1 year estimates* (2009) [http://factfinder.census.gov/servlet/STTable?\\_lang=en&-format=&-CONTEXT=st](http://factfinder.census.gov/servlet/STTable?_lang=en&-format=&-CONTEXT=st)

<sup>13</sup> Institute of Medicine, *The Future of Disability in America* 92 (2007).

<sup>14</sup> S. Yee, M. L. Breslin, T. D. Goode, S.M. Havercamp, W. Horner-Johnson, L. I. Iezzoni, G. Krahn, *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*, commissioned by the National Academy of Medicine of the National Academies of Sciences, Engineering and Medicine (2017).

<sup>15</sup> 42 U.S.C. § 12187.

investigate and review the practices of the Department, Department components, recipients, and subrecipients to determine whether they are complying with Federal health care conscience and associated antidiscrimination laws and this part. OCR may conduct these reviews in the absence of a complaint.

DREDF strongly submits that that HHS OCR's authority to conduct compliance reviews in the absence of a complaint must be available not only when OCR enforces conscience rights on behalf of providers and other healthcare entities, but equally available to those groups which are protected from non-discrimination in healthcare, including people with disabilities.

For the foregoing reasons, DREDF urges you to revise the proposed rule to ensure that the religious refusal provisions are not interpreted to preempt civil rights protections. Please feel free to contact me if you have any questions or comments concerning the above.

Sincerely,

A handwritten signature in cursive script, appearing to read "Silvia Yee", written in black ink. The signature is fluid and somewhat stylized, with a horizontal line underlining the name.

Silvia Yee  
Senior Staff Attorney

**EXHIBIT V**



## THE DISABILITY COALITION

*A Coalition of Persons with Disabilities, Family Members, and Advocates*

In Santa Fe:  
P.O. Box 8251  
Santa Fe, New Mexico 87504-8251  
Telephone: (505) 983-9637

In Albuquerque:  
3916 Juan Tabo Boulevard, NE  
Albuquerque, NM 87111  
Telephone: (505) 256-3100

Reply to: Santa Fe office

March 27, 2018

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

Re: Department of Health and Human Services, Office for Civil Rights RIN 0945–ZA03, Proposed Regulation on “Protecting Statutory Conscience Rights in Health Care”, Docket No. HHS-OCR-2018-0002

The Disability Coalition of New Mexico is a broad coalition of persons with disabilities, family members and advocates for the rights of people with disabilities of all kinds, including physical, mental, developmental, intellectual, and sensory. We submit these comments in opposition to the proposed rule on “Protecting Statutory Conscience Rights in Health Care” (“the Proposed Rule”) published in the Federal Register by the Department of Health and Human Services (DHHS) on January 26, 2018. 83 Fed.Reg. 3880.

Our central concern is that the Proposed Rule will allow or even promote discrimination specifically on the basis of disability. However, we note that persons with disabilities would also be subject to increased discrimination on non-disability-specific bases that they share with other individuals, such as discrimination related to reproductive health services or end-of-life care, or that based on sexual orientation or gender identity.

People with disabilities already face significant barriers to obtaining the health care they need, in the form of such obstacles as inaccessible medical offices and equipment, providers who do not understand or address the needs of persons living with disabilities, or those who do not value the lives of individuals with disabilities to the same degree as those of the “able-bodied”. The Proposed Rule would compound those problems by giving license to an extremely broad range of people involved – however tangentially – in the provision of health care services to impose their individual beliefs on patients, to the extent of entirely depriving them of access to necessary services.

Refusals to provide care are often based on subjective beliefs about the quality of life that a person with a disability experiences – or will experience if allowed to live. For example, life-saving care may be denied to a newborn because treating providers believe that the child’s quality of life as an individual with a disability is not worth saving. Or care may be withheld from someone who has been severely injured in an automobile accident based on the belief that his quality of life going forward does not merit providing life-saving services. Or a person with an intellectual disability may be denied services based on a belief that the person does not deserve the same access to services that a person with “normal” functional capacity would receive. The Proposed Rule would give free rein to providers to impose these beliefs on their patients, exacerbating the already difficult situation that people with disabilities face in obtaining health care services.

Health care providers already enjoy ample protection from being forced to participate in services that violate their religious beliefs. The Proposed Rule would constitute an enormous broadening of those protections, to the detriment of patients in need of care.

1. The Proposed Rule would allow any person’s individual belief to be the basis of an exemption from providing needed care to a patient, regardless of whether the belief is based on religious precepts.

2. The exemption would extend well beyond clinicians directly involved in the provision of health care services, and allow anyone with any “articulable connection” to service provision to refuse participation. 83 Fed.Reg. at 3892 (preamble) and 3923 (proposed 45 CFR §88.2). For example, a hospital administrator could refuse to process paperwork to admit a patient for a procedure disfavored by that employee, a cafeteria worker could refuse to bring a meal to a patient receiving services the worker does not agree with, or a technician could refuse to prepare equipment to be used in a procedure.

3. The “health care entities” protected under the Proposed Rule would include an extremely broad range of organizations beyond those directly engaged in the provision of health care services. The proposed definition expressly includes, for example, research organizations, insurance plans, and “plan sponsor[s]” such as employers, and goes on to state that the proposed list is intended to be merely illustrative and is not exhaustive. 83 Fed.Reg. at p. 3893 (preamble) and 3924 (proposed 45 CFR §88.2). The extent to which entities or individuals with only the most tangential tie to the care would be permitted to block provision of that care is breath-taking.

4. A provider refusing to participate would be under no obligation to give the patient information on or referral to alternate sources of care that would enable the individual to obtain needed services, or to facilitate the patient’s transfer to such a provider. Withholding such information from a patient is a gross violation of the trust relationship that should exist between provider and patient and could lead to serious harm to a patient who is thereby prevented from accessing needed care from an alternative source after a “conscience-based” refusal.

In addition to its extremely broad scope, we have many other concerns about the Proposed Rule, including the following:

1. The Proposed Rule would improperly give the religious, moral or ethical beliefs of health care providers (or other individuals distantly associated with the provision of care) primacy over those of the patient. The Proposed Rule goes well beyond protecting the religious

and moral beliefs of health care providers and allows those providers (and others with even a tenuous connection to provision of services) to impose their beliefs on their patients and other third parties.

2. The Proposed Rule would improperly give the religious, moral or ethical beliefs of providers primacy over medical standards of care. All patients have the right to expect that they will be treated in accordance with such generally accepted standards and should not be deprived of that appropriate treatment based on individual provider beliefs.

3. The Proposed Rule would protect the rights of providers to refuse to provide care, but does nothing to protect providers whose consciences call on them to provide services. For example, a physician would have the right to refuse to provide abortion services, but another physician whose moral convictions called for her to provide an abortion as a necessary service for a patient would not have the same protection for her beliefs and could be subjected to retaliation, disciplinary action or outright denial of her right to act on her beliefs by providing appropriate medical care. In so doing, the Proposed Rule appears to privilege some moral convictions as worthy of protection over others that are deemed to be unworthy of such safeguards.

4. The disclosure requirements in the Proposed Rule are inadequate. While it would require health care entities to notify patients of the provider's right to refuse services, it requires no notification of the types of care or services that will be denied. This could lead to a patient unknowingly finding herself in a position where she will be denied services, to her detriment. For example, a patient may mistakenly believe that a full-service hospital offers sterilization services, only to find out that she cannot obtain a tubal ligation at the time she delivers her baby but must instead undergo a second surgical procedure at a separate facility at another time.

5. The Proposed Rule goes beyond protecting the religious and moral beliefs of providers and would constitute government authorization for discrimination.

6. The Proposed Rule would conflict with existing law and does not clarify how its provisions would interact with those other provisions.

a) The Proposed Rule would create a conflict with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1295dd. That statute requires that a hospital must screen patients to determine the existence of an emergency condition and must provide necessary services to stabilize the individual's condition or, in appropriate cases, transfer the patient to another provider for care. The Proposed Rule appears to encourage providers to flout EMTALA by denying care, disregarding the requirements to screen and stabilize, and refusing to arrange for transfer to an appropriate provider. The Proposed Rule (including the preamble) published in the Federal Register makes neither any mention of EMTALA or any attempt to clarify the intended interaction of the Proposed Rule's provisions with statutory obligations under EMTALA.

b) Title VII of the 1964 Civil Rights Act requires reasonable accommodations for the religious beliefs or practices of employees, including those of health care entities, unless the accommodation imposes a undue burden on the entity's operations. The Proposed Rule would go well beyond such accommodations and thereby put employers in the position of operating within two different and inconsistent sets of rules. As with EMTALA, the Proposed Rule published in the Federal Register neither mentions nor addresses Title VII.

Finally, the Proposed Rule appears to authorize an unconstitutional establishment of religion. Freedom of religion, as enshrined in the U.S. Constitution, is the right to free exercise of one's own religion and is not a license to impose one's religious beliefs on others or to engage in

discrimination against others based on one's own beliefs. The U.S. Supreme Court has warned that accommodation of religious beliefs may, if taken too far, become an "unlawful fostering of religion", *Corp. of Presiding Bishop v. Amos*, 483 U.S. 327, 334-35 (1987), and that religious accommodations that unduly burden others are not protected by the Constitution's Establishment Clause. See *Sherbert v. Verner*, 374 U.S. 398 (1963); see also *Burwell v. Hobby Lobby*, 573 U.S. \_\_\_, 134 S. Ct. 2751 (2014). The Proposed Rule would authorize individuals and institutions involved in the provision of health care to impose their private beliefs on others who do not share those beliefs and thus unduly burden those other persons, and is therefore unconstitutional.

We strongly urge the Department to withdraw the Proposed Rule. Thank you for your consideration of these comments.

Sincerely,

Ellen Pinnes  
for The Disability Coalition  
EPinnes@msn.com

# **EXHIBIT W**

# National Organization for Women



March 27, 2018

U.S. Department of Health and Human Services  
Office for Civil Rights  
Hubert H. Humphrey Building, Room 509F  
200 Independence Avenue, SW  
Washington, D.C. 20201

ATTN: Conscience NPRM RIN 0945-ZA03

To Whom It May Concern:

The National Organization for Women (NOW) strongly believes that a health care provider's personal beliefs cannot be allowed to impede or alter the treatment of patients. For this reason, we oppose the Department of Health and Human Services' (the "Department") proposed rule ("Proposed Rule") and the establishment of the "Conscience and Religious Freedom Division" within the Office of Civil Rights (OCR). This Rule and this Division legalize discrimination in health care via the expansion of refusal procedures, including religious and moral convictions as reasonable bases for refusal of care.<sup>1</sup> Such an act undermines the separation of church and state, allowing any individuals and health care entities receiving federal funding to refuse *any* part of a health service or program to an individual based on subjective convictions, which additionally may be used to mask bigotry and prejudice. In this manner, the Department plans to utilize OCR resources to allow institutions, insurance companies, and anyone involved in patient care, including "volunteers, trainees, contractors...and providers holding admitting privileges" to use their personal beliefs to deny treatment to those desperately needing it. This opens the door to widespread discrimination based on a patient's race, gender identity, and/or sexual orientation. **For these reasons, NOW calls on the Department and OCR to withdraw the Proposed Rule.**

The Department and OCR specifically attempt to require a broad swath of entities to permit individuals to refuse "*any* lawful health service or activity based on religious beliefs or moral convictions (emphasis added)."<sup>2</sup> Read alongside the rest of the Proposed Rule, it is clear this allows any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care. Consequently, it is not only patient interactions with immediate providers that will be affected, but with any personnel involved, directly or indirectly, in their care.

By expanding the reach of existing refusal of care laws, which already harm those seeking care, and creating a right to new refusals, this Rule will exacerbate health inequities in the denial of critical services, such as abortion and transition-related care. Already, the Ethical and Religious Directives (ERDs) followed by Catholic and Catholic-affiliated hospitals allow providers to deny reproductive

---

<sup>1</sup> 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].

<sup>2</sup> *See id.* at 12.



health services to patients, with providers in one 2008 study disclosing that they could not provide the standard of care for managing miscarriages at Catholic hospitals.<sup>3</sup> As a result, women were delayed care or transferred to other facilities at great risk to their health<sup>4</sup>. One patient in Arkansas endured several pregnancy complications and, knowing she could not risk another pregnancy, requested a sterilization procedure at her Cesarean delivery which was refused by her Catholic hospital provider.<sup>5</sup> Under this proposed rule, similar denials of care, along with resulting emotional and physical distress, will become commonplace.

The Proposed Rule also broadens the Church Amendments, which in their current form, allow 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 related to the service or research activity to which they object.<sup>6</sup> The Proposed Rule expands this provision by allowing individuals to refuse to perform aspects of their jobs based on reference to religious or moral belief, whether or not the refusal relates to the specific biomedical, behavioral service, or research activity they are working on.<sup>7</sup> This expansion goes beyond the statute enacted by Congress.

Such overstepping, however, is a consistent theme with regards to this Proposed Rule. In addition to expanding the breadth of existing refusal laws, the Proposed Rule redefines phrases and words used in existing refusals of care laws and civil rights laws to further stretch and expand their intended meaning. For example, the definition of “assist in the performance” in the Proposed Rule indicates that the types of services which may be refused include “making arrangements for the procedure” no matter how tangential such arrangements are to the procedure.<sup>8</sup> As such, individuals not “assisting in the performance” of a procedure in the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, now possess a new “right” to refuse. The Proposed Rule’s definition of “referral” also goes beyond any recognized understanding, allowing providers and personnel to refuse to provide any additional information, including location or funding, that could help an individual to get the care they need, denying patients knowledge concerning their full and complete options for care.<sup>9</sup> Furthermore, the Proposed Rule’s newly expanded definitions often exceed, or are not in accordance with, existing definitions within the statutes the Proposed Rule seeks to enforce. 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.<sup>10</sup> The Proposed Rule, however, attempts to combine separate definitions of “health care entity” found in different statutes and applicable in different circumstances into one broad

<sup>3</sup> 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/>.

<sup>4</sup> *Id.*

<sup>5</sup> See *The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT’L WOMEN’S L. CTR. (2017), <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf>; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), [https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2\\_story.html?utm\\_term=.8c022b364b75](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).

<sup>6</sup> The Church Amendments, 42 U.S.C. § 300a-7 (2018).

<sup>7</sup> See Rule *supra* note 1, at 185.

<sup>8</sup> *Id.* at 180.

<sup>9</sup> *Id.* at 183.

<sup>10</sup> 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).

term.<sup>11</sup> This attempt to expand the meaning of a statutory term already defined by Congress fosters confusion and goes against congressional intent. By defining the term “health care entity” Congress implicitly rejected the inclusion of the other terms the Department now attempts to insert into the definition.<sup>12</sup>

When these broad definitions are combined with expansive interpretations of the underlying statutes, they expand refusals of care to allow more individuals and entities to refuse to provide access to health care. For example, another way the Weldon Amendment is expanded under the Proposed Rule is through the definition of “discrimination.”<sup>13</sup> The Proposed Rule defines “discrimination” against a health care entity broadly, including denying a grant or employment as well as an unspecified catch-all phrase “any activity reasonably regarded as discrimination.”<sup>14</sup> In a Rule that seeks to protect those who want to discriminate, such a broad definition is inappropriate. Furthermore, the definition itself is so vague that it provides no functional guidance on how to comply with its requirements, fostering confusion.

Refusals of care based on personal beliefs already make it difficult for many individuals to access health care and have potentially harmful consequences for those denied care. When women and families are uninsured, locked into managed care plans that do not meet their needs, or cannot afford to pay out of pocket and/or travel to another location, refusals bar access to care.<sup>15</sup> This is especially true for immigrants, who often lack transportation and may have to travel great distances to get required care.<sup>16</sup> In rural areas there may be no other sources of health and life preserving medical care.<sup>17</sup> When these individuals encounter refusals of care, they may have nowhere else to go. The same holds true for members of the LGBTQ+ community, who have often faced discrimination with regards to healthcare. This is evidenced by the fact that 8% of lesbian, gay, bisexual and queer respondents to a survey by the Center for American Progress indicated that a provider had refused to see them based on their sexual orientation, 16% reporting that they had experienced verbal, physical and/or sexual abuse at the hands of their providers<sup>18</sup>. For trans individuals, the statistics are still more alarming. 29% of trans people surveyed indicated that a healthcare provider had refused to see them and 50% stated that their providers

---

<sup>11</sup> See Rule *supra* note 1, at 182.

<sup>12</sup> 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.

<sup>13</sup> See Rule *supra* note 1, at 180.

<sup>14</sup> *Id.*

<sup>15</sup> 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>.

<sup>16</sup> 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>.

<sup>17</sup> 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/>.

<sup>18</sup> Percentages of those experiencing verbal, physical and/or sexual abuse are the result of the addition of percentages reporting verbal abuse and percentages reporting unwanted sexual/physical contact. For a summary of survey results, see: Shabab Ahmed Mirza and Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*. Center for American Progress (2018), <https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/>

had verbally, physically or sexually abused them as they sought care<sup>19</sup>. With such reported instances of discrimination and harm done while seeking treatment, it is sadly unsurprisingly that, according to the 2015 U.S. Transgender Survey, nearly 1 in 4 trans people avoided seeking necessary health care in the year prior due to a fear of discrimination, a fear, which given reported instances thereof, cannot be considered unreasonable<sup>20</sup>. And yet, like immigrant populations, the LGBTQ+ community often has nowhere else to go, those surveyed indicating in high amounts that it would be “very difficult” or “not possible” for them to find the services needed either at a different hospital, pharmacy or clinic, trans people once again reporting higher rates of difficulty as compared to cisgender LGBTQ+ individuals<sup>21</sup>. LGBTQ+ people living in non-metropolitan areas also report high rates of difficulty finding a new provider, a situation that is likely the result of increased transportation costs and distance<sup>22</sup>.

The Proposed Rule and the Division become still more troubling when one considers that individuals who face multiple and intersecting forms of discrimination may be more likely to encounter refusals. For example, research shows that women of color disproportionately receive their care at Catholic hospitals and that, (in) nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.<sup>23</sup> This puts them at greater risk of being denied appropriate reproductive healthcare, such as miscarriage management and treatment for pregnancy complications, relative to white women, simply due to the supposed religious preferences of these institutions.

In this manner, by expanding and creating new methods by which providers and personnel associated with healthcare services – however tangentially – may refuse to perform services for any patient, the Proposed Rule opens the doors to federally-sanctioned, legalized discrimination in healthcare, something that will cost lives and endanger the health and safety of many, especially those whose identities mark them as part of one or more marginalized populations. **For this reason, NOW reiterates, this Proposed Rule cannot be permitted to stand, and must be withdrawn, so as not to cause irreparable harm to prospective patients, all of whom are owed treatment in keeping with the recognized full and complete standard of care.**

Regards,



Toni Van Pelt, President  
National Organization for Women  
1100 H St., NW, Suite 300  
Washington, D.C.20005

---

<sup>19</sup> Id.

<sup>20</sup> Id.

<sup>21</sup> Id.

<sup>22</sup> Id.

<sup>23</sup> 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>.

**EXHIBIT X**

**OFFICE OF THE COUNTY COUNSEL  
COUNTY OF SANTA CLARA**

County Government Center  
70 West Hedding Street  
East Wing, 9<sup>th</sup> Floor  
San Jose, California 95110-1770

(408) 299-5900  
(408) 292-7240 (FAX)



James R. Williams  
COUNTY COUNSEL

Greta S. Hansen  
CHIEF ASSISTANT COUNTY COUNSEL

Winifred Botha  
Robert M. Coelho  
Steve Mitra  
ASSISTANT COUNTY COUNSEL

March 22, 2018

*Submitted electronically through [www.regulations.gov](http://www.regulations.gov)*

The Honorable Alex Azar  
Secretary of Health and Human Services  
U.S. Department of Health and Human Services  
Office for Civil Rights  
Hubert H. Humphrey Building, Room 509F  
200 Independence Avenue SW  
Washington, DC 20201

Attn: Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)  
Re: **Protecting Statutory Conscience Rights in Health Care**

Dear Secretary Azar:

The County of Santa Clara (“County”) submits these comments in response to the Department of Health and Human Services’ (HHS) proposed rule, Protecting Statutory Conscience Rights in Health Care.<sup>1</sup>

The County, established in 1850, is a charter county and political subdivision of the State of California. Its mission is to protect the health, safety, and welfare of 1.9 million County residents. The County owns and operates Santa Clara Valley Medical Center (“SCVMC”), a fully integrated and comprehensive public health care delivery system that provides critical health care to residents of Santa Clara County regardless of their ability to pay. SCVMC, which includes a 574-bed tertiary care hospital with a Level 1 trauma center and 11 ambulatory care clinics, is the only public safety-net health care provider in Santa Clara County, and the second largest such provider in California. SCVMC provides the vast majority of the health care services available to poor and underserved patients in the County. The County also owns and operates Valley Health Plan (“VHP”), which participates in California’s health insurance marketplace under the Affordable Care Act.

---

<sup>1</sup> 83 Fed. Reg. 3880 (proposed Jan. 26, 2018).

To: The Honorable Alex Azar, Secretary of Health and Human Services  
Re: Comment on Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)  
March 22, 2018  
Page 2 of 8

As set forth below, the proposed regulation: (1) improperly attempts to broaden the substantive scope of statutory conscience-based protections; (2) if adopted, may be improperly interpreted to invite discrimination against patients who face significant barriers to care; and (3) if adopted, will impose unnecessary burdens on safety-net providers such as the County.

**A. The Proposed Regulation Improperly Attempts to Broaden the Substantive Scope of Statutory Conscience-Based Protections**

Existing law provides an adequate framework for the enforcement of conscience-based protections, which protect under certain circumstances health care workers who refuse to participate in certain procedures or services based on their religious beliefs or “moral convictions.” In addition, Title VII of the Civil Rights Act of 1964 provides an employment law framework for religious accommodations. The proposed regulation is not only unnecessary in light of the current framework, but it also improperly attempts to legislate heightened conscience-based protections that Congress has not recognized. Through its “further definition of Federal health care conscience and associated anti-discrimination laws,” the proposed regulation seeks to vastly expand the scope of conscience-based protections in a way that substantially increases the likelihood that already-marginalized patients will face additional barriers in accessing health care.<sup>2</sup> Such an effect on patients seeking care undermines HHS’s mission “to enhance and protect the health and well-being of all Americans.”<sup>3</sup>

1. *The proposed regulation improperly broadens the meaning of “referral or refer for,” which may result in health care workers turning patients away from a facility when others at the facility are willing to provide care.*

The proposed regulation’s broad definitions of “assist in the performance” and “referral or refer to” in sections 88.3(a)(2)(v) and 88.2 sweep beyond the statutory language and may be improperly interpreted as permitting individual health care workers to turn patients away from a facility, without providing *any* information, when the objected-to services are in fact provided at that facility.<sup>4</sup> The definition in Section 88.2 of “refer or refer to” as including “the provision of any information . . . by any method” goes beyond the County’s understanding of what a referral is.<sup>5</sup> The County is concerned that individual health care workers might improperly interpret the proposed regulation as permitting them to refuse *any* form of patient assistance, including notifying them that such services are provided by the County at that facility. For example, a provider might interpret the proposed regulation as allowing her, based on “moral convictions,” to turn away, without providing *any* information, a patient at SCVMC experiencing abdominal pain related to an intra-uterine device, when there are many other providers at SCVMC who are

---

<sup>2</sup> *Id.* at 3891.

<sup>3</sup> *Introduction: About HHS*, HHS, <https://www.hhs.gov/about/strategic-plan/introduction/index.html>, attached as Exhibit 1.

<sup>4</sup> *Protecting Statutory Conscience Rights in Health Care*, 83 Fed. Reg. at 3925 (§ 88.3(a)(2)(v)); *id.* at 3924 (§ 88.2).

<sup>5</sup> *Id.*



To: The Honorable Alex Azar, Secretary of Health and Human Services  
Re: Comment on Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)  
March 22, 2018  
Page 3 of 8

willing to treat that patient. Health care professionals are obligated to provide their patients with complete and accurate information about their treatment options. Failure to do so could result in liability for the providers, incomplete or deficient treatment of patients, and violation of ethical and legal principles.

Nothing in the proposed regulation supports HHS's conclusion that Congress intended such a broad extension of statutory conscience-based protections. HHS contends in the commentary to the proposed regulation that because the statutes use the terms "make arrangements for" and "refer for" services, Congress intended a broad definition of "referrals."<sup>6</sup> But this is not persuasive evidence that Congress intended the definition of "referral or refer to" to be as broad as it is in the proposed regulation: "provision of *any information. . . by any method.*"<sup>7</sup> Stating that the County provides the requested services, even if the particular health care worker objects to providing them, is not "making arrangements for" a service that the provider has a religious objection to performing. In particular, the conscience-based protections must be read in light of Congress's robust, generally applicable non-discrimination statutes, including Section 1557 of the Affordable Care Act, Titles II and III of the Americans with Disabilities Act, and Title VI of the Civil Rights Act of 1964, that apply in certain health care settings.

Although HHS states that its proposed definition of "referral or refer to" will "address confusion the Department perceives among the public about what sorts of actions may be properly regarded as referrals for the purposes of protecting rights of conscience under the statutes at issue in this proposed rule,"<sup>8</sup> the substantive rewriting of statutory rights will result in greater confusion, because patients will not know whether they are getting complete information or a full range of treatment options. In delegating to the Office of Civil Rights (OCR) enforcement authority over the conscience-based protection statutes, Congress did not delegate the authority to transform the statutes into a broad license to discriminate and to provide patients with incomplete, deficient, or no treatment options based on a boundless array of "moral convictions," some of which may be contrary to non-discrimination statutes, and many more of which may conflict with HHS's mission to improve the health care of *all* Americans.

2. *The proposed regulation's reinterpretation of the Weldon Amendment is likely to limit access to comprehensive health insurance options.*

As applied to the Weldon Amendment,<sup>9</sup> the proposed regulation's definition of "health care entity" is likely to create additional barriers to accessing care, because it will likely limit

---

<sup>6</sup> *Id.* at 3895.

<sup>7</sup> *Id.* (emphasis added).

<sup>8</sup> *Id.*

<sup>9</sup> The Weldon Amendment, incorporated in the HHS appropriations acts, provides that "[n]one of the funds made available in this Act may be made available to a Federal agency or program, or to a state or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."

To: The Honorable Alex Azar, Secretary of Health and Human Services  
Re: Comment on Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)  
March 22, 2018  
Page 4 of 8

access to health insurance with comprehensive coverage of reproductive services. The proposed regulation adds “a plan sponsor” to the definition of “health care entity” under the Weldon Amendment.<sup>10</sup> This would greatly expand the universe of entities permitted to challenge a state’s requirement to “provide, pay for, provide coverage of, or refer for, abortion.”<sup>11</sup> HHS’s proposed justification for expanding the definition of “health care entity”—that “[t]he amendment’s broad and non-exhaustive definition indicates that the amendment takes an inclusive approach with respect to the health care entities it protects and should not be interpreted narrowly,”<sup>12</sup>—is not based on any legislative history, nor is it a license to go beyond the plain meaning of the statute. Congress did not delegate authority to HHS to expand the scope of the Weldon Amendment.

It is even more problematic that the proposed regulation attempts to reinterpret the Weldon Amendment to broadly allow health care entities to refuse to “provide, pay for, provide coverage of, or refer for abortions,”<sup>13</sup> regardless of whether entities have a conscience-based objection to doing so. HHS offers no evidence that refusals unrelated to conscience-based objections—such as financial or operational motivations—are intended to be protected under the Weldon Amendment. Rather, both the legislative history of the Weldon Amendment, and judicial interpretations of it, compel the contrary conclusion.<sup>14</sup> And even though economically or operationally driven refusals to provide abortion-related services or referrals have nothing to do with civil rights, the proposed regulation would make OCR’s enforcement authority available to entities that merely have an economic or operational objection to providing such services. Contrary to HHS’s mission, such a delegation would likely serve only to decrease the availability of health insurance options that provide comprehensive coverage of reproductive services.

## **B. The Proposed Regulation, If Adopted, May Be Improperly Interpreted as Inviting Discrimination Against Patients Who Already Face Significant Barriers to Care**

If adopted, the proposed regulation will likely invite discrimination against patients who already face significant barriers to accessing care, such as lesbian, gay, bisexual, transgender, or queer (LGBTQ) people. Although a full discussion of the myriad of health care consumers who may be affected by the proposed regulation is beyond the scope of this comment, the proposed

---

Consolidated Appropriations Act, 2017, Public Law 115-31, § 507(d)(1), 131 Stat. 135. It defines “health care entity” to include “an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.” *Id.* at § 507(d)(2).

<sup>10</sup> Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3890–91, 3924 (§ 88.2).

<sup>11</sup> *Id.* at 3925–26 (§ 88.3(c)(2)).

<sup>12</sup> *Id.* at 3890.

<sup>13</sup> *Id.* at 3925–26 (§ 88.3(c)(2)).

<sup>14</sup> See Letter from Jocelyn Samuels, Director, OCR, to Catherine W. Short, Vice President, Life Legal Def. Found., et al. (June 21, 2016) (citing *California ex rel. Lockyer v. United States*, 450 F.3d 436, 441 (9th Cir. 2006); 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004)).

To: The Honorable Alex Azar, Secretary of Health and Human Services  
Re: Comment on Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)  
March 22, 2018  
Page 5 of 8

regulation's likely effect on LGBTQ people, who frequently encounter discrimination and other barriers to accessing medical care, serves as an example of the harmful impact the regulation is likely to have.

Discrimination against LGBTQ people in health care settings is well documented. In one study, more than half of all respondents had experienced at least one of the following when seeking health care: refusals of needed care, providers refusing to touch them or using excessive precautions, harsh or abusive language, providers blaming them for their health status, or physically rough or abusive conduct.<sup>15</sup> In that study, eight percent of lesbian, gay, or bisexual respondents reported they had been refused needed health care because of their sexual orientation, and nearly 27 percent of transgender respondents reported being refused care because of their transgender status.<sup>16</sup> The percentages of LGBT people of color and low-income LGBT people who reported being refused care are much higher than the percentages for survey respondents as a whole.<sup>17</sup>

One respondent to a survey of transgender people reported, "I have been refused emergency room treatment even when delivered to the hospital by ambulance with numerous broken bones and wounds."<sup>18</sup> Another study, based on a review of complaints filed with OCR, describes a situation in which a transgender woman was recovering from an appendectomy, and the treating doctor, who "does not deal with 'these kinds' of patients," refused to call her by the correct pronouns.<sup>19</sup> Some medical providers have explicitly asserted religious-based reasons for denying care to LGBTQ people or their families, such as a pediatrician who refused to treat the newborn daughter of a lesbian couple.<sup>20</sup>

---

<sup>15</sup> Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 10 (2010), available at [https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report\\_when-health-care-isnt-caring.pdf](https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf), attached as Exhibit 2.

<sup>16</sup> *Id.*

<sup>17</sup> *Id.* at 12. The County generally uses the acronym LGBTQ but uses "LGBT" when referring to the cited study, which uses that acronym.

<sup>18</sup> Jaime Grant et al., Nat'l Center for Transgender Equality & Nat'l Gay and Lesbian Task Force, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* 73 (2011), available at [http://www.thetaskforce.org/static\\_html/downloads/reports/reports/ntds\\_full.pdf](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf), excerpt attached as Exhibit 3.

<sup>19</sup> Sharita Gruberg & Frank J. Bewkes, Ctr. for Am. Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (Mar. 7, 2018), available at <https://cdn.americanprogress.org/content/uploads/2018/03/06122027/ACAnondiscrimination-brief2.pdf>, attached as Exhibit 4.

<sup>20</sup> Abby Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents and There's Nothing Illegal about It*, Washington Post (Feb. 19, 2015), [https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it/?utm\\_term=.a59cf2f3df0a](https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it/?utm_term=.a59cf2f3df0a), attached as Exhibit 5.

To: The Honorable Alex Azar, Secretary of Health and Human Services  
Re: Comment on Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)  
March 22, 2018  
Page 6 of 8

Refusing to provide medical care to consumers based on sex, sexual orientation, or gender identity is a form of sex discrimination prohibited by federal law. As an entity covered by the Affordable Care Act, the County complies with the ACA's non-discrimination protections in Section 1557, 42 U.S.C. § 18116(a), which prohibits discrimination based on sex and other protected characteristics in health programs and activities. In addition, as a local government that seeks to ensure the health, safety, and welfare of its 1.9 million residents, the County has a significant interest in eliminating discrimination and barriers to health care for *all* of its residents. To understand the health needs of the County's LGBTQ residents, the County's Public Health Department performed an LGBTQ Health Assessment in 2013.<sup>21</sup> Among other things, the study showed that 12 percent of LGBTQ survey respondents were "denied or given lower quality health care" in the 12 months preceding the survey due to their sexual orientation and/or gender identity.<sup>22</sup>

The County is concerned that the proposed regulation, if adopted, will invite medical providers to discriminate against LGBTQ health care consumers, among others, in violation of federal non-discrimination law. Not only does the proposed regulation appear to invite discriminatory conduct by expanding the reach of statutory conscience-based protections as discussed above, but it also oversimplifies them in the language it proposes to use to raise awareness among providers. The Notice in Appendix A tells providers they "have the right to decline to participate in, refer for, undergo, or pay for certain health care-related treatments, research, or services . . . which violate your conscience, religious beliefs, or moral convictions under Federal law."<sup>23</sup> This is not limited to the types of procedures contemplated in the statutory provisions discussed in the proposed rule. Such notice might encourage a provider, for example, to refuse to treat a transgender patient who comes to the emergency room seeking care for a broken arm based on the provider's "moral convictions," even though such refusal of service would violate federal non-discrimination law and the Emergency Medical Treatment and Labor Act.<sup>24</sup> And, if the notice is seen by a patient, this might discourage open communication with the provider, for fear that services will be denied. If HHS adopts the proposed regulation, it must address the empirical evidence which strongly suggests that marginalized patients will face heightened barriers in accessing care. And the notice must be compliant with all other applicable laws.

---

<sup>21</sup> Santa Clara Cnty Pub. Health Dep't, *Status of LGBTQ Health: Santa Clara County 2013* (2013), available at <https://www.sccgov.org/sites/phd/hi/hd/Documents/LGBTQ%20Report%202012/LGBT%20Health%20Assessment.pdf>, attached as Exhibit 6.

<sup>22</sup> *Id.*

<sup>23</sup> Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3931.

<sup>24</sup> 42 U.S.C. § 18116(a); 42 U.S.C. § 1395dd.



To: The Honorable Alex Azar, Secretary of Health and Human Services  
Re: Comment on Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)  
March 22, 2018  
Page 7 of 8

**C. The Proposed Regulation, If Adopted, Would Be an Unnecessary Burden to Safety-Net Providers Such as the County of Santa Clara**

The proposed regulation's projected costs, which HHS states will be \$815 million over the course of five years, far outweigh any expected benefits that could possibly stem from the expected increase in the supply of health care providers who maintain conscience-based objections. As a result, the proposed regulation, if adopted, would be an unnecessary burden to safety-net providers such as the County, which rely on limited public funds to provide essential health care services to *all* patients on a non-discriminatory basis. As illustrated above, an effect of the proposed regulation will likely be increased discrimination against patients who already face barriers in accessing care.

The proposed regulation's discussion of "ancillary benefits for patients," such as "assist[ing] patients in seeking counselors who share their deepest held convictions,"<sup>25</sup> ignores the much more substantial harm that the proposed regulation will likely cause to patients who are refused medical services, referrals to services, information about such services or referrals, or even information about where such information might be obtained, based on the religious beliefs or "moral convictions" of providers. The proposed regulation asserts that "[f]acilitating open communication between providers and their patients also helps to eliminate barriers to care, particularly for minorities."<sup>26</sup> But providers may interpret the regulation as allowing them to refuse to communicate *any* information to patients based on the provider's "moral convictions."

Surprisingly, the proposed regulation's cost-benefit analysis does *not* consider the potential impact or costs directly impacting patients, including costs resulting from "health outcomes or other effects of protecting conscience rights."<sup>27</sup> Studies show that discrimination, and the potential for discrimination, deter marginalized populations such as LGBTQ people from seeking medical care.<sup>28</sup> And discrimination negatively impacts health outcomes. As HHS's HealthyPeople 2020 initiative has noted, LGBTQ people "face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."<sup>29</sup>

In addition, the proposed regulation vastly underestimates the costs of compliance for safety-net providers such as the County. Because the proposed regulation vastly expands the

---

<sup>25</sup> Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3916–17.

<sup>26</sup> *Id.* at 3917.

<sup>27</sup> *Id.* at 3916, 3918.

<sup>28</sup> Shabab Ahmed Mirza & Caitlin Rooney, Ctr. for Am. Progress, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018), available at <https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/>, attached as Exhibit 7.

<sup>29</sup> HHS Office of Disease Prevention & Health Promotion, *Lesbian, Gay, Bisexual, and Transgender Health*, HealthyPeople 2020, <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health>, attached as Exhibit 8.

To: The Honorable Alex Azar, Secretary of Health and Human Services  
Re: Comment on Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)  
March 22, 2018  
Page 8 of 8


substantive scope of statutory conscience-based protections, the projected estimate of *one* attorney hour to review the final rule<sup>30</sup> grossly underestimates the time that would be required to fully examine the rule's implications for existing County policies and practices related to conscience-based protections, as well as applicable non-discrimination policies at the federal, state, and local level. Similarly, the projected estimate for time required to post approximately five notices<sup>31</sup> ignores the reality of large health and hospital systems like the one operated by the County, which encompasses many facilities in many locations. The burden of this requirement is particularly unnecessary for entities like the County, which already ensures that employees are provided notice of their right to assert conscience-based protections through robust policies that allow employees to opt-out of participation in certain services in advance if those services conflict with a staff member's cultural values, ethics, or religious beliefs.<sup>32</sup>


#### D. Conclusion

As discussed above, the proposed regulation is an unlawful and unnecessary burden on providers and may invite discrimination against vulnerable populations who already face barriers to health care. The County urges HHS to rescind the proposed regulation.

Very truly yours,

JAMES R. WILLIAMS  
County Counsel

  
Julie Wilensky  
Deputy County Counsel

  
Adriana Benedict  
Social Justice and Impact Litigation Fellow

1741533

---

<sup>30</sup> Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3912.

<sup>31</sup> *Id.* at 3914.

<sup>32</sup> See, e.g., Memorandum from Paul Lorenz to SCVMC Employees, Non-Participation in Certain Patient Care (Aug. 9, 2017); Memorandum from Paul Lorenz to SCVMC Employees, Medically Ineffective Interventions, Requests Concerning (May 8, 2015); Agreement Between Cnty. of Santa Clara & Registered Nurses Prof'l Ass'n (Nov. 10, 2014 through Oct. 20, 2019).



# **EXHIBIT 1**

## Introduction: About HHS

- [Mission Statement](#)
  - [Organizational Structure](#)
  - [Cross-Agency Collaborations](#)
- 

### Mission Statement

The mission of the U.S. Department of Health and Human Services (HHS) is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

[Back to top](#)

### Organizational Structure

HHS is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS accomplishes its mission through programs and initiatives that cover a wide spectrum of activities, serving and protecting Americans at every stage of life, from conception. HHS is responsible for almost a quarter of all Federal outlays and administers more grant dollars than all other Federal agencies combined.

Eleven operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies, administer HHS's programs. While HHS is a domestic agency working to protect and promote the health and well-being of the American people, the interconnectedness of our world requires that HHS engage globally to fulfill its mission. In addition, staff divisions provide leadership, direction, and policy guidance to the Department.

The [organizational chart](#) for HHS and [a description of the Agencies and Offices](#) can be found on the Department's website at <http://www.hhs.gov/>.

[Back to top](#)

## Cross-Agency Collaborations

Improving health and human services outcomes cannot be achieved by the Department on its own; collaborations are critical to achieve our goals and objectives.

HHS collaborates closely with other Federal departments and agencies on cross-cutting topics. For example, through the President's Management Council, the Department engages with other Federal departments to identify and adopt best practices on performance and management initiatives. Another example, focused on mission-critical efforts, is the Federal Interagency Workgroup that led the Healthy People 2020 development effort, bringing together Federal staff from the Department with partners in the U.S. Departments of Agriculture and Education.

Federal Advisory Committees enable the Department to collaborate with other Federal departments and agencies, as well as members of the public, on high-priority issues. For example, the Interdepartmental Serious Mental Illness Coordinating Committee, established by the 21st Century Cures Act of 2016 (Pub. L. 114–255), convenes senior leaders from 10 Federal agencies including HHS; the Departments of Justice, Labor, Veterans Affairs, Defense, Housing and Urban Development, and Education; and the Social Security Administration, along with 14 non-Federal public members, to improve Federal coordination of efforts to address the needs of adults with serious mental illness and youth with serious emotional disturbance.

Importantly, the Federal Government has a unique legal and political government-to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments. Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, requires consultation with Indian Tribal governments when considering policies that affect Tribal communities. The Department's Tribal Consultation Policy - PDF, first developed with Tribal participation in 2004, was updated in 2010. HHS works with Tribal governments, Indian organizations, and other Tribal organizations to facilitate greater consultation and coordination between States and Tribes on health and human services issues.

HHS works closely with State, local, and U.S. territorial governments, providing funding for program operations and technical assistance. HHS also fosters critical global relationships, coordinates international engagement across HHS and the U.S. Government, and provides leadership and expertise in global health diplomacy and policy to contribute to a safer, healthier world.

In addition, HHS has strong partnerships with the private sector, academia, research institutions, and nongovernmental organizations, including religious and faith-based organizations. The Department partners with the private sector, such as regulated industries, academic institutions, trade organizations, and advocacy groups. The Department leverages resources from these organizations to enable HHS to

accomplish its mission through strategies that minimize the burden on, and increase the benefits to, the American public. This effort occurs through Tribes and faith-based and community initiatives as well as grantees in the private sector, such as academic and research institutions, and community-based nonprofit organizations, which provide many services at the local level.

The narrative and strategies listed under the Strategic Goals and Objectives in this document provide additional descriptions of how the Department collaborates with governmental and nongovernmental groups.

[Back to top](#)

---

Content created by Assistant Secretary for Planning and Evaluation (ASPE)

Content last reviewed on February 28, 2018

**EXHIBIT 2**



# When Health Care Isn't Caring

Lambda Legal's Survey on Discrimination Against  
LGBT People and People Living with HIV





## TABLE OF CONTENTS

### **Executive Summary 5**

Discrimination and Barriers to Care

Key Recommendations for Health Care Institutions, Governments and Individuals

About Lambda Legal and the Study

### **Health Care Fairness: A Personal Issue, A National Campaign 8**

### **What We Found: When Health Care Isn't Caring 9**

Discrimination and Substandard Care

Barriers to Care

### **The Path to Health Care Fairness: Recommendations for Providers, Policy-makers and Community Members 14**

The Critical Role of Cultural Competency

Our Recommendations

### **Methodology: How We Conducted the Survey 17**

### **Who Responded 18**

Sexual Orientation

Gender Identity

Race and Ethnicity

Other Demographics: Age, Employment Status, Income, Geography, HIV Status

### **Glossary: Explanation of Survey Terms 23**

### **Our Partners 25**

Lambda Legal is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those with HIV through impact litigation, education and public policy work.

*This project was directed by Lambda Legal's Director of Community Education and Advocacy Beverly Tillery*

*Research design and data analysis by Somjen Frazer Consulting ([www.somjenfrazer.com](http://www.somjenfrazer.com))*

*Additional drafting by Rhea Hirshman*

*For more information on the National Health Care Fairness Survey and to view the original survey, visit [www.lambdalegal.org/health-care-fairness](http://www.lambdalegal.org/health-care-fairness).*

*When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV (New York: Lambda Legal, 2010). Available at [www.lambdalegal.org/health-care-report](http://www.lambdalegal.org/health-care-report)*

## EXECUTIVE SUMMARY

Many of us are vulnerable when we are ill or seeking health care services. For lesbian, gay, bisexual and transgender (LGBT) people and those living with HIV, that vulnerability is often exacerbated by disrespectful attitudes, discriminatory treatment, inflexible or prejudicial policies and even refusals of essential care. These barriers, in turn, can result in poorer health outcomes and often have serious and even catastrophic consequences.

**This survey is the first to examine refusal of care and barriers to health care among LGBT and HIV communities on a national scale.** We hope that these data will influence decisions being made about how health care is delivered in this country now and in the future.

In spring 2009, Lambda Legal and over 100 partner organizations distributed the survey to LGBT people and people living with HIV nationwide. The information in this report is gleaned from 4,916 respondents.

The respondents were not drawn from a random sample, but instead are people who chose to respond to the survey after it was promoted online and at events. The results are a rich and informative picture of the experiences of thousands of LGBT people and people living with HIV, but cannot be used to draw conclusions about the proportion of all LGBT people and people living with HIV who have had similar experiences. The data are powerful because they represent a diverse sampling of the LGBT and HIV communities with respect to sexual orientation, gender identity, HIV status, race and ethnicity, age and geography.

### Discrimination and Barriers to Care

The results of this survey highlight enormous challenges that remain for LGBT communities and those living with HIV in accessing quality, non-discriminatory health care services. More than half of all 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 status; or health care professionals being physically rough or abusive. **Almost 56 percent of lesbian, gay or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents**

**had one or more of these experiences; and nearly 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care.**

- **LGBT people and people living with HIV are too often denied the care they need because of their sexual orientation, gender identity and/or HIV status.** Almost 8 percent of LGB respondents reported that they had been denied needed health care outright. Over a quarter of all transgender and gender-nonconforming respondents (almost 27 percent) reported being denied care and 19 percent of respondents living with HIV also reported being denied care.
- **LGBT people and people living with HIV are frequently treated in a discriminatory manner while trying to obtain care, including providers using harsh language, refusing to touch patients and blaming them for their health status.**
  - Just over 10 percent of LGB respondents reported that health care professionals used harsh language toward them; 11 percent reported that health care professionals refused to touch them or used excessive precautions; and more than 12 percent of LGB respondents reported being blamed for their health status.
  - Almost 36 percent of respondents living with HIV reported that health care professionals refused to touch them or used excessive precautions and nearly 26 percent were blamed for their own health status.
  - Nearly 21 percent of transgender and gender-nonconforming respondents reported being subjected to harsh or abusive language from a health care professional, and almost 8 percent

reported experiencing physically rough or abusive treatment from a health care professional. Over 20 percent of transgender and gender-nonconforming respondents reported being blamed for their own health conditions.

- **In almost every category measured in this survey, transgender and gender-nonconforming respondents reported experiencing the highest rates of discrimination and barriers to care.** Transgender and gender-nonconforming respondents reported facing barriers and discrimination as much as two to three times more frequently than lesbian, gay or bisexual respondents.
- **In nearly every category, a higher proportion of respondents who are people of color and/or low-income reported experiencing discriminatory and substandard care.** For example, close to 33 percent of low-income transgender and gender-nonconforming respondents reported being refused care because of their gender identity and almost a quarter of low-income respondents living with HIV reported being denied care.
- **Respondents reported a high degree of anticipation and belief that they would face discriminatory care and such concerns were a barrier to seeking care.** Overall, 9 percent of LGB respondents are concerned about being refused medical services when they need them, and 20 percent of respondents living with HIV and over half of transgender and gender-nonconforming respondents share this same concern.

Survey respondents were somewhat more privileged than the LGBT population as a whole, with higher proportions having obtained advanced degrees, reporting higher household incomes and having better health insurance coverage. **Since these factors tend to improve access to care, this report likely understates the barriers to health care experienced by all LGBT people and those living with HIV.**

## Key Recommendations

### Health care institutions should:

- Establish nondiscrimination, fair visitation and other policies that prohibit bias and discrimination based on sexual orientation, gender identity and expression and HIV status, recognize families of LGBT people and their wishes and provide a process for reporting and redressing discrimination if it occurs.
- Develop and implement goals and plans to ensure that LGBT people and people living with HIV are treated fairly.
- Require health profession students and health professionals to undergo significant cultural competency training about sexual orientation, gender identity and expression and HIV status.
- Include training about the specific ways LGBT people and people living with HIV who are also people of color, low-income, seniors or members of other underserved populations may experience discrimination in health care settings and establish policies to prevent them.
- Advocate for laws and accreditation standards that require all providers to deliver to LGBT people and people living with HIV the same level of high-quality care afforded others.

### Our federal, state and local governments should:

- Include coverage of LGBT people and those living with HIV in all antidiscrimination and equal opportunity mandates.
- Require all health care facilities and education programs that receive government funding to develop and implement goals, policies and plans to ensure that LGBT people and people living with HIV are treated fairly and provide ongoing cultural competency training for all health care profession students and staff.

- Change laws to require recognition of the families of LGBT people, including those who live within less common family structures, and require health care providers to do the same.
- Eliminate overly broad religious exemptions that purport to exempt medical care from nondiscrimination laws.
- Prohibit discriminatory practices by insurance providers that deny or limit coverage for needed care by LGBT people and people living with HIV.
- Ensure that government-funded health research and surveys include sexual orientation and gender identity issues and demographic analysis so that more can be known about the health care discrimination experienced by our communities as well as about our communities' health care needs.

#### **Individuals and organizations should:**

- Educate themselves, each other and, when possible, health care providers about the rights and needs of LGBT patients and those living with HIV.
- Advocate for improved laws and policies.
- Use existing mechanisms that are appropriate — such as medical powers of attorney and other legal documents as well as formal legal relationships where that is a couple's choice — to create as much protection as possible for themselves and their loved ones.
- Fight back when discrimination occurs, including reporting discriminatory practices, sharing stories and contacting Lambda Legal and other advocacy organizations and/or attorneys.

#### **About Lambda Legal and the Study**

Lambda Legal is the oldest and largest national legal organization committed to achieving the full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those living with HIV. This survey was designed

as part of Lambda Legal's national Health Care Fairness Campaign launched in 2009. The goals of the campaign are to bring together advocates, partners and consumers to educate policy-makers, health care providers and the general public about the need for health care fairness and to advocate for reforms that address the issues of greatest concern to LGBT people and people living with HIV. Chronicling the types and prevalence of barriers to care faced by the range of groups in our communities is a vital part of helping to address and eliminate them.

For more information about Lambda Legal, visit [www.lambdalegal.org](http://www.lambdalegal.org)



## HEALTH CARE FAIRNESS: A PERSONAL ISSUE, A NATIONAL CAMPAIGN

Lambda Legal has been advocating for health care fairness through impact litigation, education and public policy work to make sure that LGBT people and those living with HIV have full and equal access to all medically appropriate health care without discrimination based on sexual orientation, gender identity or expression, HIV or family status. Some of the key components of health care fairness we have outlined include:

- privacy and confidentiality for all, including LGBT people and those living with HIV;
- recognition and respect for all families including same-sex couples and their children;
- equal access to affordable health care insurance for same-sex spouses, partners and their children, and elimination of discriminatory insurance policy exclusions for transgender care, reproductive health care or care based on HIV status;
- fair and comprehensive health care services for LGBT youth and adults in custody as well as those living with HIV;
- informed consent for HIV testing;
- protection of the rights of LGBT patients and those living with HIV to seek and obtain all medically appropriate care without restrictions based on the personal or religious views of providers;
- equal access to mental health and substance abuse treatment and services for LGBT people and people with living with HIV; and
- fair and compassionate services for LGBT seniors and older people living with HIV.

Because issues of health care access and fairness are so critical to the well-being of the LGBT and HIV communities, Lambda Legal made health care fairness one of our ten priority issue areas and in 2009 we chose to highlight these issues with a national **Health Care Fairness Campaign**. The goals of the campaign are to bring together advocates, partners and consumers to educate policy-

makers, health care providers and the general public about the need for health care fairness and to advocate for reforms that address the issues of greatest concern to LGBT people and people living with HIV.

### Why This Survey?

Anecdotal evidence suggests that LGBT individuals and people living with HIV in the United States — from all backgrounds — have less access to health care and face greater obstacles to navigating health care systems than do heterosexual people. For over three decades, Lambda Legal has been at the forefront of establishing recognition of the legal rights of LGBT people and people living with HIV. The organization's impact litigation cases present examples of the kinds of challenges many LGBT people and people living with HIV experience while trying to receive needed health care services every day. Our Legal Help Desk also consistently receives calls from LGBT people and people living with HIV with questions and concerns about how they have been treated by health care and health insurance providers.

Although there have been studies finding health disparities by sexual orientation in cancer screening, mental illness, substance abuse, smoking and some other commonly measured health status indicators, there are very few, if any, survey reports about the types of health care-related discrimination LGBT people and those living with HIV face, how common such experiences are and what impact this discrimination has on their care. Designed as part of Lambda Legal's national Health Care Fairness Campaign, this survey is the first to examine experiences with refusal of care and barriers to health care access among LGBT and HIV communities on a national scale.

With the nation in the midst of a vigorous debate about reforming the way health care is delivered, we at Lambda Legal and our partners want to ensure that the needs of LGBT people and those living with HIV are an integral part of the discussion. Chronicling the barriers to care faced by the range of groups in our communities and the scope of these problems is a vital part of helping to address these needs. We hope that these data will influence decisions being made now and in the future.

## WHAT WE FOUND: WHEN HEALTH CARE ISN'T CARING

Enormous challenges remain for lesbian, gay, bisexual and transgender (LGBT) communities and people living with HIV. Experiences of bias and outright hostility remain common in all areas of our lives. When those experiences occur in the context of obtaining health care, they are not only deeply distressing but potentially life-threatening.

The essential bond of trust between clinician and patient that many in the United States take for granted is not a given for LGBT people or people living with HIV. Whether because of prejudices, ignorance, outdated systems or short-sighted policies, many people across our communities are not receiving the health care they need.

The tables on the following pages, which present data from our health care fairness survey, illustrate this problem from two perspectives. Tables 1 to 5 show **patterns of discrimination and substandard care** experienced in specific interactions with medical providers. Table 6 deals with personal fears and alienation from the health care system. Such prevalent fears and alienation are **barriers to care**.

### Discrimination and Substandard Care

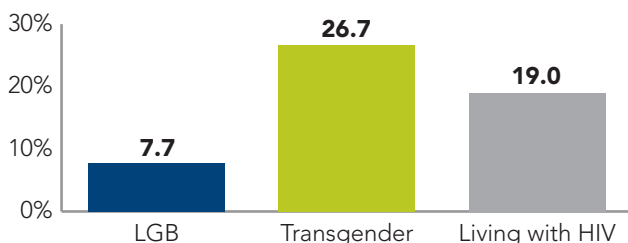
The responses we received are disturbing and require action. Respondents were asked to report whether they believed they received discriminatory care because of their sexual orientation, gender identity or HIV status. All the data reported below represent experiences that respondents felt were motivated by prejudice against lesbian, gay, bisexual, transgender people or people living with HIV. (Please note that the “transgender” category in the following charts includes both transgender and gender-nonconforming respondents because of the high visibility that puts both groups at a high risk for discrimination based on gender identity.)

More than half of all respondents reported that they have experienced at least one of the following types of

In 2008, Janice Langbehn (second from left) and Lisa Pond were about to depart from Miami on a family cruise with their three children. Pond suddenly collapsed and was rushed to Jackson Memorial Hospital. Janice was informed that she was in an antigay city and state, and she could expect to receive no information or acknowledgment as Lisa’s partner or family. Hospital personnel would not allow Janice or their children to see Lisa until nearly eight hours after their arrival as Lisa slipped into a coma, even though Lisa’s sister was allowed to visit as soon as she arrived. The next day, Lisa died. In 2008, Lambda Legal filed a lawsuit on behalf of the family. The court dismissed the case, agreeing with Jackson Memorial that the hospital has no obligation to allow their patients’ visitors in their trauma unit. Lambda Legal and our partners continue to fight for fair visitation policies.

*Langbehn v. Jackson Memorial Hospital*



**Table 1: I was refused needed health care**

Guadalupe “Lupita” Benitez (left) was denied infertility treatment by the North Coast Women’s Care Medical Group because she is a lesbian. Her former doctors are conservative Christians who claimed their religious beliefs gave them a right to withhold care from Benitez that they routinely provide to heterosexual patients. In 2001, Lambda Legal filed a lawsuit on behalf of Benitez fighting for the basic right of LGBT people to receive equal access to treatment from health care providers and tackling the issue of religiously motivated discrimination. In 2008, the California Supreme Court unanimously ruled in favor of Benitez, making clear that California’s state law prohibiting discrimination must be followed.

*Benitez v. North Coast Women’s Care Medical Group*

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 status; or health care professionals being physically rough or abusive. **Almost 56 percent of lesbian, gay or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and almost 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care.**

**Almost 8 percent of LGB respondents reported that they had been denied needed health care because of their sexual orientation. Over a quarter of all transgender respondents (nearly 27 percent) reported being denied care and 19 percent of respondents living with HIV also reported being denied care because of their transgender or HIV status, respectively.**

Many of our survey respondents also reported that they have been treated in a discriminatory manner while trying to receive care. Nearly 11 percent of LGB respondents have interacted with health care professionals who have used harsh language. That same percentage have encountered health care professionals who refused to touch them or used excessive precautions. More than 12 percent of LGB respondents were blamed for their health status.

Our survey showed that persons living with HIV are still facing ignorance, lack of respect and overt discrimination when accessing health care, with 19 percent of respondents reporting being refused needed health care. **Respondents living with HIV were most likely to report that health care professionals refused to touch them or used excessive precautions (nearly 36 percent) and blamed them for their own health status (nearly 26 percent).** And over 4 percent of respondents living with HIV reported being treated in a physically rough or abusive manner by health care providers.

**The picture is even more disturbing for transgender and gender-nonconforming respondents, who experienced**

Table 2: Health care professionals refused to touch me or used excessive precautions

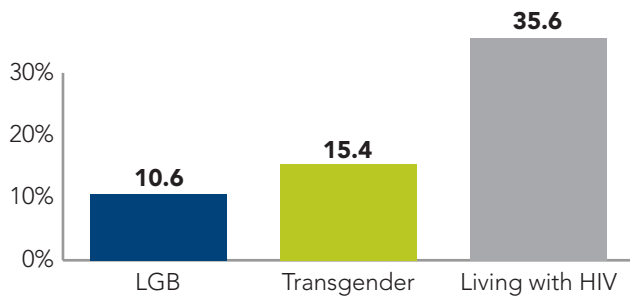


Table 4: Health care professionals blamed me for my health status

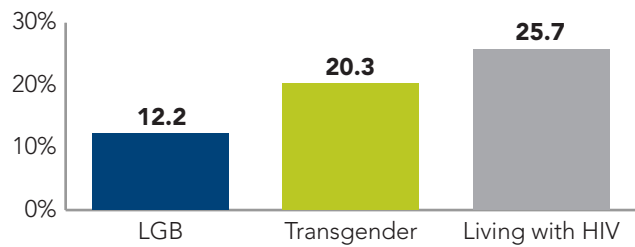


Table 3: Health care professionals used harsh or abusive language

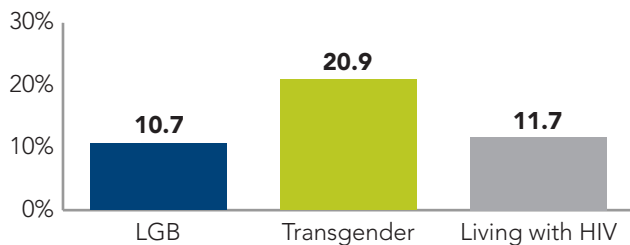
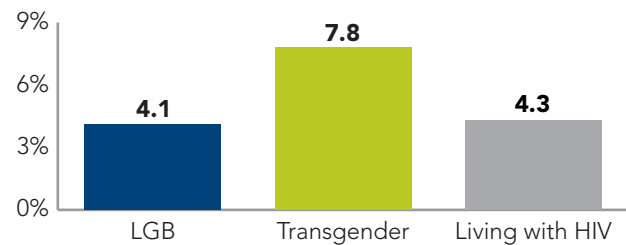


Table 5: Health care professionals were physically rough or abusive



**the highest rates of being refused care (nearly 27 percent), being subjected to harsh language (nearly 21 percent) and experiencing physically rough or abusive treatment (nearly 8 percent).** Over 20 percent of transgender and gender-nonconforming respondents reported being blamed for their own health problems and illnesses.

**In addition to the overall rates of substandard care, respondents of color and low-income respondents (defined in this survey as having a household income under \$20,000) in nearly every category experienced higher rates of discrimination and substandard care.** For example, while transgender respondents as a whole reported a care-refusal rate of almost 27 percent, low-income transgender respondents reported a rate of almost 33 percent. Over a quarter of low-income respondents living with HIV were refused care compared to 19 percent of respondents living with HIV overall. Almost 11 percent

of low-income LGB respondents and LGB respondents of color were refused care compared to almost 8 percent of LGB people overall.

Nearly half of low-income respondents living with HIV reported that medical personnel refused to touch them while the overall rate among those with living with HIV was nearly 36 percent. Over 35 percent of low-income respondents living with HIV were blamed for their health status, in contrast to about a quarter of those living with HIV overall.

Low-income respondents and respondents of color often reported harsh language by medical providers. Almost 17 percent of low-income LGB respondents and 14 percent of LGB respondents of color reported experiencing harsh language compared to almost 11 percent of LGB respondents overall. Over a quarter of transgender respondents of color and 28 percent of low-income



transgender respondents reported harsh language compared to 21 percent of transgender respondents overall. And nearly 13 percent of respondents of color living with HIV and 19 percent of low-income respondents living with HIV experienced harsh language compared to almost 12 percent of respondents living with HIV overall.

**People of color living with HIV and LBG people of color were at least twice as likely as whites to report experiencing physically rough or abusive treatment by medical professionals.** Of the LGB respondents, 3 percent of whites and almost 7 percent of people of color reported experiencing such treatment; among those living with HIV, the figures were just over 3 percent for whites and nearly 8 percent for people of color.

### Barriers to Care

In addition to asking about specific encounters with health care providers and systems, the Lambda Legal health care fairness survey also asked respondents about their fears and concerns about obtaining health care. Personal beliefs and perceptions about whether one can access quality health care have been shown to strongly affect whether and how individuals seek medical care and interact with medical

professionals. Past experiences of bias, humiliation, harsh treatment and isolation as well as perceived bias by health care providers can cause LGBT people and people living with HIV to become alienated from the health care system and even reluctant to seek care. Such reluctance can in turn result in poorer health outcomes because of delays in diagnosis, treatment or preventive measures.

Overall bias and stigma in our society — conveyed through negative family, community, institutional and cultural messages about our lives, combined with discriminatory policies and practices — can result in unwillingness for LGBT people and people living with HIV to disclose to clinicians personal information that can be essential to proper diagnosis and/or treatment. At times, disclosure can be a catch-22 — that is, lack of disclosure about one’s sexual orientation or gender identity can lead to inadequate care, while disclosure can make LGBT people more vulnerable to discrimination and denial of care. For transgender individuals, disclosing one’s gender identity may result in discriminatory practices by insurance companies who refuse to cover necessary cross-gender health care, such as pap smears for transgender men or prostate screenings for transgender women.

**Table 6: Fears and concerns about accessing health care**

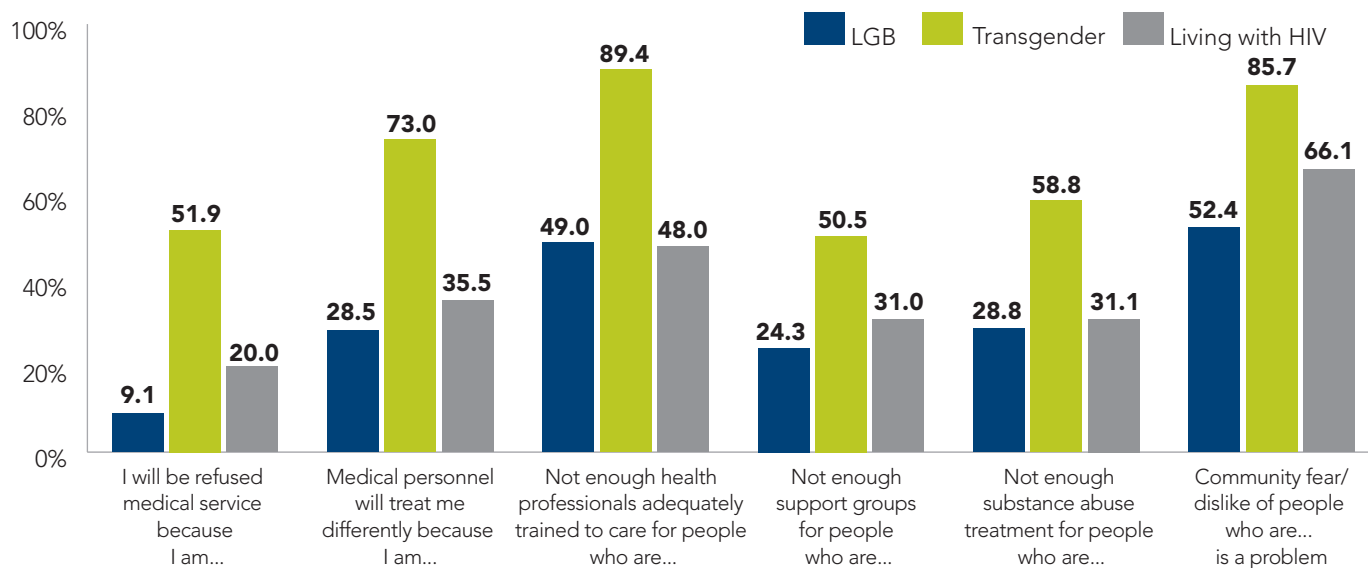


Table 6 shows the depth of the need for greater cultural competency throughout our health care systems to reduce serious barriers to care.

Survey respondents were asked to rate how much various factors make it hard for them to receive the care they need. Percentages reflect how many respondents designated each factor as “somewhat of a problem” or a “major problem” and indicate alarming amounts of perceived bias and barriers to care for LGB people and even greater alienation for people living with HIV and transgender people. (Please note: Only the responses from members of each group were counted in these statistics. For instance, the transgender group only includes responses from people who are transgender and gender non-conforming.)

**Overall, nine percent of LGB respondents are concerned about being refused medical services when they need them. Over half of transgender respondents and 20 percent of respondents living with HIV share this concern.** When asked about more specific concerns, the reports of perceived bias are even more disturbing. **For instance, nearly half of LGB respondents and respondents living with HIV and almost 90 percent of transgender respondents believe there are not enough**

**medical personnel who are properly trained to care for them.** Mental health issues were also of particular concern to LGB people, transgender people and those living with HIV, with almost 28 percent of the respondents concerned that not enough mental health professionals are available to help them. **Over half of LGB respondents, two-thirds of respondents living with HIV and almost 86 percent of transgender respondents indicated that overall community fear or dislike of people like them is a barrier to care.**

In this survey, we also examined barriers to care based on gender expression. Regardless of their sexual orientation or gender identity, people who are gender-nonconforming— men who appear more feminine, women who appear more masculine and people who have a more androgynous appearance — often face bias, harassment and discrimination in our society. In fact, one of the common ways many LGBT people experience discrimination in our society is based on their gender expression. This was a particular concern for the people who answered our survey. **Thirty percent of all respondents stated that they fear medical personnel will treat them differently based on their gender expression and presentation.**



I called a gynecologist’s office trying to schedule a hysterectomy. I told the receptionist that I was a transgender male. Two days later, I received a phone call telling me that the doctor did not take cases like mine and referring me to a hospital. I remember feeling like a freak. I called the second number. The receptionist told me they didn’t deal with transgender men either. After I got over the hurt, I called another doctor’s office. The receptionist told me that their office welcomed transgender clients. I told the doctor that I wanted a full hysterectomy. She performed an exam, Pap smear and ultrasound. She told me that the results showed that I was fine. I asked her again about the hysterectomy, this time telling her I would pay for it out of pocket. She continued to say that it would be unethical because there was nothing wrong with me. She was hiding her transphobia behind a bogus argument and dismissing a very real medical need. I told her that there was something wrong: “I am a man with a uterus. I need to have all female reproductive parts removed. I AM A MAN!” She refused. I left her office feeling like a freak again, vulnerable and depressed.

Tony Ferraiolo/ New Haven, CT



## THE PATH TO HEALTH CARE FAIRNESS: RECOMMENDATIONS FOR PROVIDERS, POLICY-MAKERS AND COMMUNITY MEMBERS

The findings in this survey raise serious concerns about the state of health care for the lesbian, gay, bisexual and transgender (LGBT) and HIV communities that must be addressed. Remediating the problems outlined in this report requires systemic change: an integrated combination of enforcement of legal protections that already exist, progressive legislation, thoughtful policy-making and ongoing education and training, all carried out with opportunities for community input.

### The Critical Role of Cultural Competency

**Increasing cultural competency should be one of the main methods for health care providers to address the discrimination experienced by LGBT people and people living with HIV and to close the gap in access to health care.** Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of health care, thereby producing better health outcomes.<sup>1</sup> According to the U.S. Department of Health and Human Services' Office of Minority Health, "It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it."<sup>2</sup>

Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of health care, thereby producing better health outcomes.<sup>1</sup> According to the U.S. Department of Health and Human Services' Office of Minority Health, "It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it."<sup>2</sup>

Policies about discrimination, visitation, patients' rights, employment and other matters should clearly communicate that bias and discrimination of LGBT people and people living with HIV will not be tolerated. Policies should also outline a grievance process and provide access to redress if the policies are violated. Health care providers should also recognize and honor the wishes of the families of LGBT people. Even though our survey did not ask about discriminatory behavior and attitudes towards the families of LGBT people (questions were about individual interactions with health care systems and providers), such attitudes contribute significantly to creating an unwelcoming environment for all LGBT people.

1 In Diane L. Adams, ed., *Health Issues for Women of Color: A Cultural Diversity Perspective* (Thousand Oaks, CA: Sage, 1995).

2 U.S. Department of Health and Human Services, Office of Minority Health, "What is Cultural Competency," <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11> (accessed January 10, 2010).

Institutions should also clearly inform patients of their policies and practices and regularly solicit input from the LGBT and HIV communities.

Education is another important component to cultural competency. Institutions should provide initial training as a part of orientation for new staff and require ongoing education for all staff. The optimal provision of health care and prevention services to sexual and gender minorities requires providers to be sensitive to historical stigmatization, to be informed about continued barriers to care and to become aware of the cultural aspects of their interactions with LGBT patients.<sup>3</sup>

Forms, questionnaires and other written materials should be sensitive to and inclusive of LGBT people and their families and communicate the institution's commitment to providing an environment that meets the needs of all patients including LGBT people and people living with HIV. Where appropriate, institutions should also provide and advertise LGBT and HIV-specific services and specialized care such as support groups or HIV prevention programs.

When fully implemented, cultural competency can reduce the systemic health care discrimination experienced by LGBT people and people living with HIV. The Mautner Project, a national lesbian health organization, has a training curriculum, "Removing the Barriers: Providing Culturally Competent Care to Lesbians and Women Who Partner with Women," that explains the benefits of culturally competent care as including: increased access to

3 K. H. Mayer, J.B. Bradford, H. J. Makadon, R. Stall, H. Goldhammer, and S. Landers, "Sexual and Gender Minority Health: What We Know and What Needs to be Done," *American Journal of Public Health*, 98, no. 6 (2008): 989-995.

services; improved prevention and early intervention; more accurate diagnoses; improved treatment adherence and compliance and increased patient retention.

By focusing on cultural competence for all LGBT people and people with HIV, providers, policy-makers and members of the community can begin taking steps to address substandard and discriminatory care as well as additional barriers that prevent LGBT people and people living with HIV from obtaining quality health care.

## Our Recommendations

### Health care institutions and providers should:

- **Establish nondiscrimination, fair visitation and other policies that:**
  - prohibit bias and discrimination based on sexual orientation, gender identity and expression and HIV status including refusal of care, disrespectful or abusive treatment, the use of excessive precautions and blaming patients for their health conditions;
  - convey a commitment to equally serve and provide culturally competent care to LGBT and HIV communities;
  - recognize families of LGBT people and their wishes; and
  - provide a process for reporting and redressing discrimination if it occurs.
- **Develop and implement goals and plans to ensure that LGBT people and people living with HIV are treated fairly, including strategies to maintain diverse staff, complete an initial assessment of services for LGBT patients, collaborate with LGBT and HIV community partners and implement culturally sensitive grievance procedures.**
- **Require health profession students and health professionals to undergo significant cultural competency training about sexual orientation, gender identity and expression and HIV status so they will**

### **be able to provide respectful and nondiscriminatory care to LGBT people and people living with HIV.**

Cultural competency needs to be implemented at both an institutional and individual level. Unfortunately, many professional schools and continuing education programs do not provide the training needed to teach culturally competent care for LGBT people and those living with HIV.<sup>4</sup> Ensuring that all medical, nursing, dental and other health profession students are trained in these issues as a mandatory part of the curriculum will increase the likelihood that they will have a basic understanding of the needs of the LGBT and HIV communities. Making cultural competency a key part of ongoing staff training and continuing education programs is equally important for ensuring that the inclusive policies of institutions are carried out consistently and uniformly.

- **Include training about gender identity and expression to ensure that the unique needs of transgender and gender-nonconforming people are addressed.**

In almost every category measured in this survey, proportionately more transgender respondents reported discrimination in care and barriers to care. Providers need to take particular care to address the issues of transgender and gender-nonconforming people.

- **Include training about the specific ways LGBT people and people living with HIV who are also people of color, low-income, seniors or members of other underserved populations may experience discrimination in health care settings and establish policies to prevent discrimination.**

Providers must address the discrimination experienced by low-income people and people of color and ensure that care is delivered in a culturally competent way to people who are part of more than one marginalized community. (For more discussion about the impact of health care discrimination on low-income people and people of color and the intersectionality of multiple

<sup>4</sup> Ibid., 989-995.

forms of oppression, see Lambda Legal's supplemental health care fairness survey fact sheets.)

- **Advocate for laws and accreditation standards that require all providers to deliver to LGBT people and people living with HIV the same level of high-quality care afforded others.** Laws and standards that mandate LGBT and HIV-inclusive practices are needed so that all providers will offer the same level of care.

**Federal, state and local governments should:**

- **Include coverage of LGBT people and those living with HIV in all antidiscrimination and equal opportunity mandates including laws related to employment discrimination, access to public accommodations, harassment and freedom of expression.**
- **Require all health care facilities and educational programs that receive government funding to develop and implement goals, policies and plans to ensure that LGBT people and people living with HIV are treated fairly and require that they provide ongoing cultural competence training for all health care profession students and staff.**
- **Change laws to require recognition of the families of LGBT people, including those who live within less common family structures, and require health care providers to do the same.**
- **Eliminate overly broad religious exemptions that purport to exempt medical care from nondiscrimination laws.**

Although questions about religion were not part of the survey, we know that, in an increasingly worrisome trend, some health care providers have claimed that their religious beliefs or affiliations allow them to deny providing the same care to LGBT individuals that they routinely offer to others. Providers should not be allowed to use their religious views or affiliations to circumvent antidiscrimination laws, medical ethics rules and professional standards of care.

- **Prohibit discriminatory practices by insurance providers that deny or limit coverage for needed care by LGBT people and people living with HIV, such as basic and/or gender transition care for transgender individuals or reproductive health care for LGBT people.**
- **Ensure that government-funded health research and surveys include sexual orientation and gender identity issues and demographic analysis so that more can be known about the health care discrimination experienced by our communities as well as about our communities' health care needs.**

**Individuals and organizations should:**

- **Educate themselves and each other about LGBT rights, and when possible, educate health care providers about the needs of LGBT patients and those living with HIV.**
- **Advocate for improved laws and policies.**
- **Report unfriendly and discriminatory practices and share referrals to friendly providers and institutions.**
- **Share stories of health care discrimination with organizations like Lambda Legal, as well as with policy-makers, friends, relatives and trusted co-workers.**
- **Create as much protection as possible for themselves and their loved ones using appropriate, existing mechanisms such as advance directives, medical powers of attorney and other legal documents as well as formal legal relationships such as domestic partnerships, civil unions and marriage, where that is a couple's choice.**
- **Fight back when discrimination occurs and contact Lambda Legal, other legal and advocacy organizations or a local attorney.**
- **Continue to fight attempts to roll back LGBT rights.**

## METHODOLOGY:

### HOW WE CONDUCTED THE SURVEY

In the spring and summer of 2009, Lambda Legal invited lesbian, gay, bisexual and transgender (LGBT), HIV and other partner organizations to join the national Health Care Fairness Campaign, asking them to promote the health care fairness survey and encouraging their participation in other aspects of this initiative. With the help of over 100 such organizations located in 35 states, the survey was distributed to LGBT people and people living with HIV nationwide. Participants included 25 national organizations and 75 local, state and regional organizations. Thirteen groups were specifically people of color organizations and 12 specifically focused on people living with HIV. Groups promoted the survey in various ways, including email requests to members and supporters; posting survey links on their websites and their social networking sites and distributing and collecting paper surveys where feasible.

Lambda Legal sent survey announcements and reminders to our email list, featured the survey on our web page and publicized the survey in Lambda Legal's *Impact* magazine and monthly eNews. Ads were placed on various LGBT

blogs, web sites and in a few LGBT newspapers, and the survey was promoted on Facebook and Twitter. Wallet cards announcing the survey were distributed at 15 Pride festivals and several other LGBT events around the country. In a few cities, Lambda Legal staff and/or interns collected surveys at locations in the LGBT community. All survey promotional and informational materials were available in both English and Spanish, as was the survey itself. The survey was not based on a random sample, but used "convenience sampling" and "snowball sampling," which means that responses came from those who chose to take the survey and many learned about it through e-mails and blog posts.

A total of 5,941 people took the survey from June 10 to July 14, 2009. The information in this report is gleaned from the 4,916 surveys that remained after invalid surveys (postal codes outside the U.S., missing key demographic info, not LGBT or living with HIV) were excluded from the sample.

## WHO RESPONDED

The tables below provide demographic information about the 4,916 individuals whose responses are reflected in this report. Because of the complexity of our communities, checking more than one category was an option for several of the demographic questions, so that some results add up to more than 100 percent.

### Sexual Orientation

Slightly over half the respondents, or 2,727 people, identified as gay, with just fewer than 30 percent, or 1,453 people identifying as lesbian. The categories of queer (nearly 16 percent or 774 people) and same-gender loving (just over 5 percent or 261 people) include both women and men, as does the bisexual category (just over 11 percent or 542 people). A very small number of responses came from heterosexuals (just over 1 percent or 66 people), who are either living with HIV or transgender.

### Gender Identity

Table 8 shows that almost 56 percent of all respondents identified as male and almost 38 percent of all respondents identified as female. These numbers include transgender and nontransgender respondents. Almost 53 percent (2,593 people) identified as non-transgender male and nearly 33 percent (1,614) as non-transgender female; 8 percent (397) as transgender (either transfeminine or transmasculine); just over 4 percent (220) as gender-nonconforming; and almost 2 percent (83) as two-spirit.

“Transgender” is an umbrella term that refers to people whose gender identity and/or gender expression differs from the sex they were assigned at birth. In general use, the term may include but is not limited to transsexuals, cross-dressers and other gender-variant people. In the related chart (Table 8), transgender respondents are listed as either “transmasculine” (individuals who were assigned the sex “female” at birth, but whose gender identity is along the masculine spectrum of gender) or “transfeminine” (individuals who were assigned the sex “male” at birth, but whose gender identity is along the feminine spectrum of gender). “Gender-nonconforming” (GNC) refers to individuals whose external manifestation of their gender identity does not conform to society’s expectations of gender roles. A gender-nonconforming person may or may not identify as transgender, gay, lesbian or bisexual but may

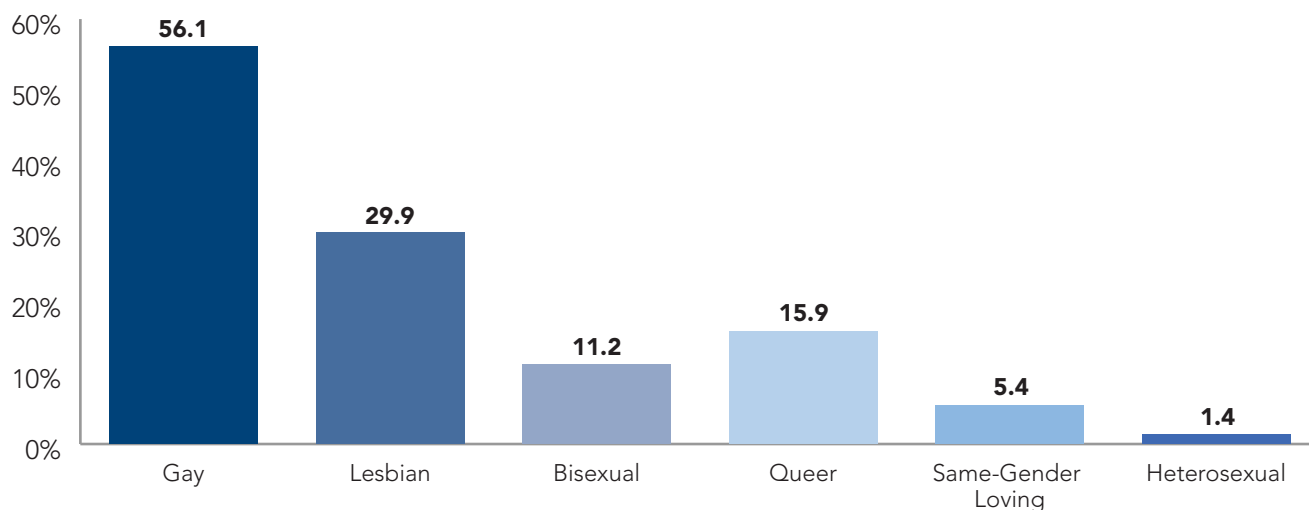
identify as gender-free, androgynous or moving back and forth between gender identities. The term “two-spirit” is a culturally specific category related to traditions among Native Americans/American Indians.

### Race and Ethnicity

Eighty-six percent of all respondents or 4,241 people identified as White and slightly over 18 percent or 892 people identified as people of color – meaning that they selected a racial/ethnic category other than or in addition to White. These numbers add up to more than 100 percent because some of the multiracial people selected white and another race or ethnicity.

Table 9 displays the racial and ethnic distribution of the people of color who completed the survey. Of the total survey respondents, almost 8 percent or 373 people were Latina/o; close to 5 percent or 231 people were Black; almost 4 percent or 176 people were American Indian; 3 percent or 153 people were Asian; and 1 percent or 48 people were Middle Eastern. Again, the numbers add up to more than 100 percent because respondents could choose more than one category. Almost 6 percent of all survey respondents, or 285 people, identified as multiracial. While Asians and American Indians who responded to the survey were proportionately represented compared to the overall population in the United States, Blacks, Latina/os and Middle Eastern respondents were underrepresented compared to their representation in the U.S. population as a whole. This underrepresentation indicates an ongoing need for more consistent and better-targeted outreach to communities of color.

**Table 7: Sexual orientation**



Totals more than 100% because respondents could select more than one category.

**Table 8: Current gender identity**

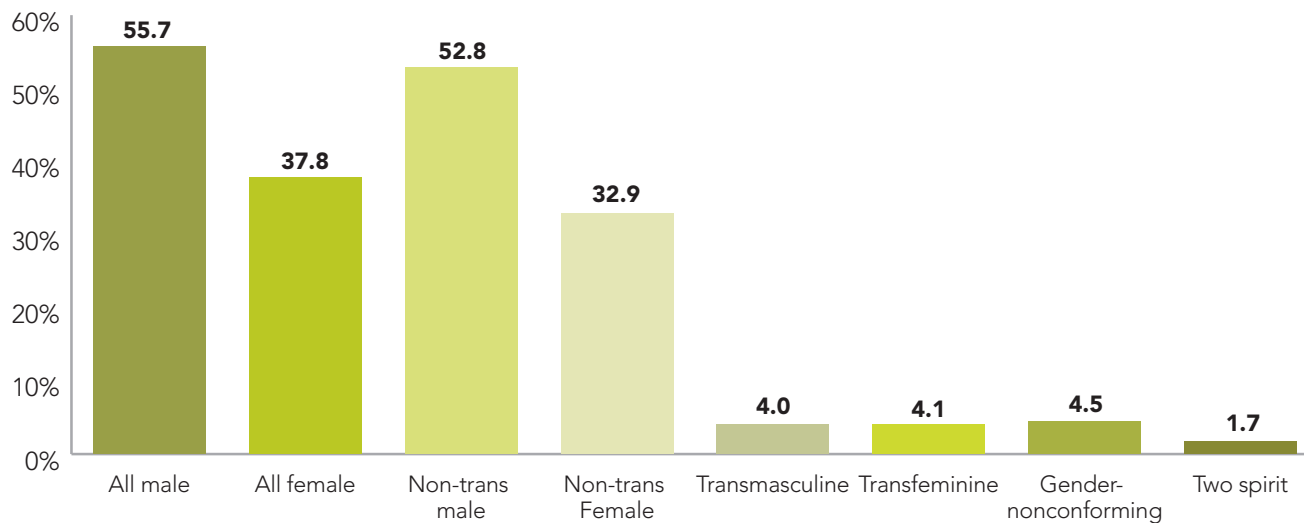
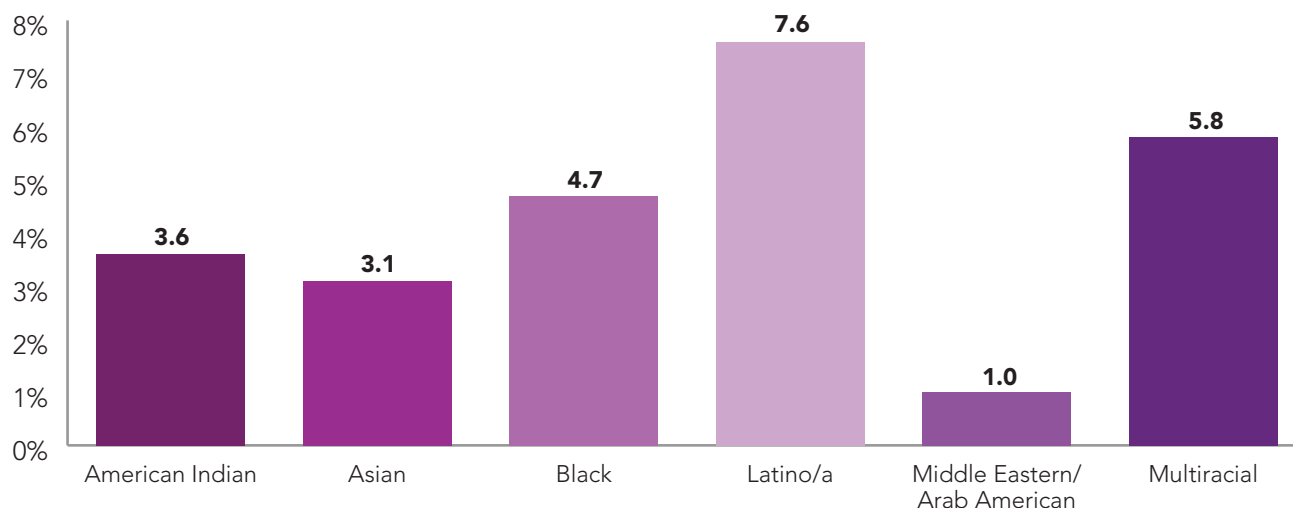




Table 9: Race and ethnicity of people of color respondents



## Other Demographics

All age groups are represented in the survey with responses somewhat skewed towards the 25-44 age group.

The survey generally achieved geographic distribution, with respondents from all fifty states and Washington, DC, although California provided a disproportionate number of respondents (nearly 21 percent or 985 people).

Individuals living with HIV were over 13 percent of the sample, or 662 people.

An important fact to note is that survey respondents were somewhat more privileged than the LGBT population as a whole, with higher proportions having obtained college, graduate and professional degrees; reporting higher household incomes and having better health insurance coverage. According to a groundbreaking study by the Williams Institute of the University of California School of Law, the stereotype of LGBT people as an affluent elite with high levels of education and income is debunked by more than a decade of research showing that LGBT people actually have lower incomes than comparable heterosexual individuals and households

and that existing research strongly hints at a sizable presence of LGBT people among the low end of the income distribution in the United States.<sup>5</sup> A recent study conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force also found that transgender respondents experience poverty at a much higher rate than the general population, with more than 15 percent reporting incomes of \$10,000 or lower, double the rate of the general population.<sup>6</sup>

**Since people who are affluent, educated and insured are more likely to be well-served by health care systems, this report likely *understates* the barriers to health care experienced by LGBT people and those with living with HIV.**

<sup>5</sup> R. Albeda, M. V. L. Badgett, A. Schneebaum, and G. J. Gates, "Poverty in the Lesbian, Gay, Bisexual and Transgender Community," <http://www.law.ucla.edu/WilliamsInstitute/pdf/LGBPovertyReport.pdf> (accessed November 23, 2009).

<sup>6</sup> National Center for Transgender Equality and National Gay and Lesbian Task Force, "National Transgender Discrimination Survey," [http://www.thetaskforce.org/downloads/release\\_materials/tf\\_enda\\_fact\\_sheet.pdf](http://www.thetaskforce.org/downloads/release_materials/tf_enda_fact_sheet.pdf) (accessed December 28, 2009).

Table 10: Age

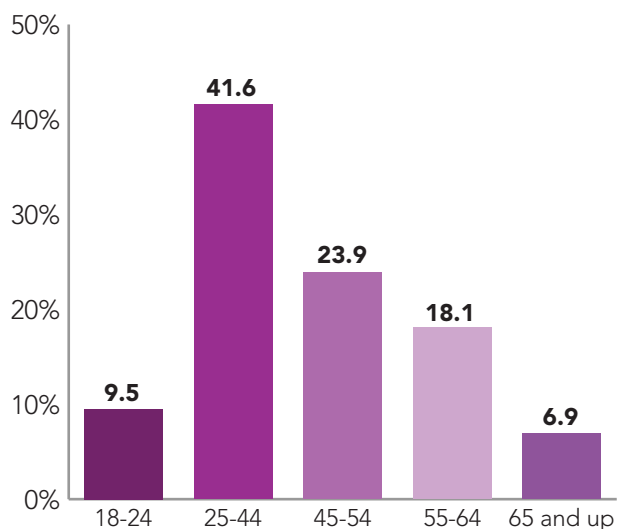


Table 11: HIV status

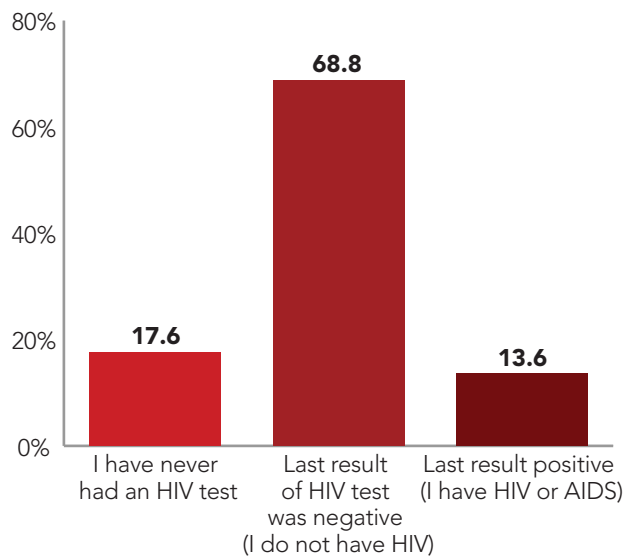


Table 12: Employment status

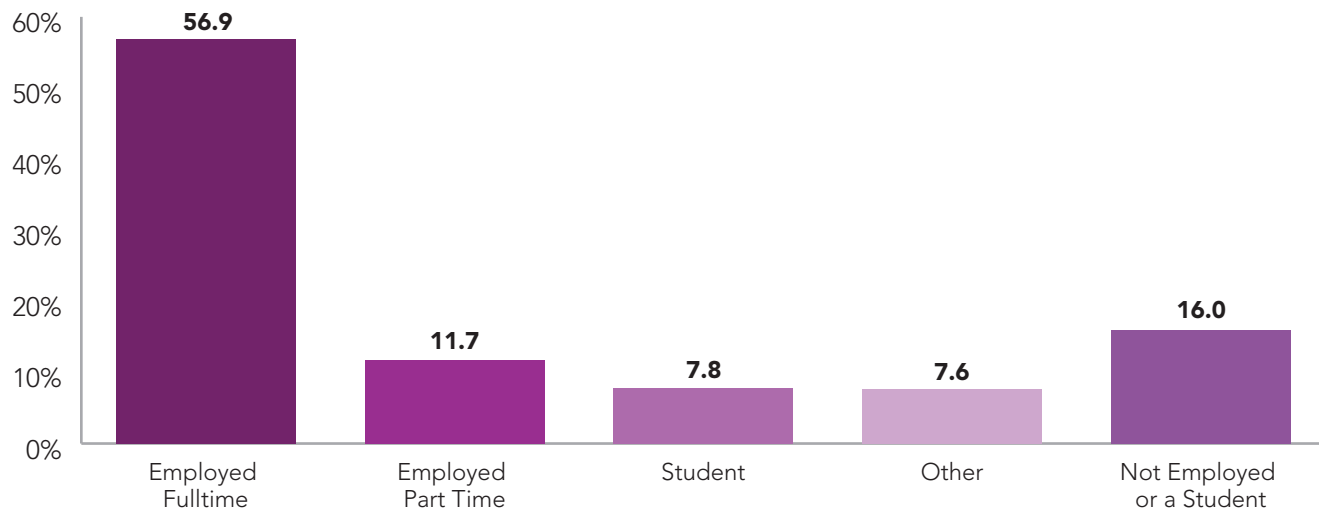


Table 13: Household income

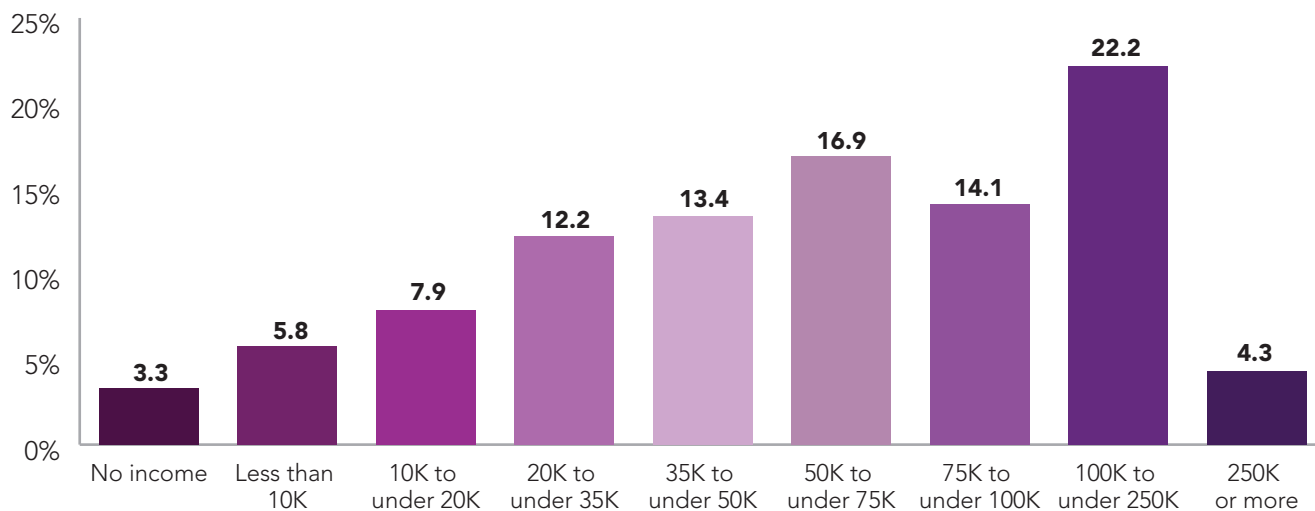
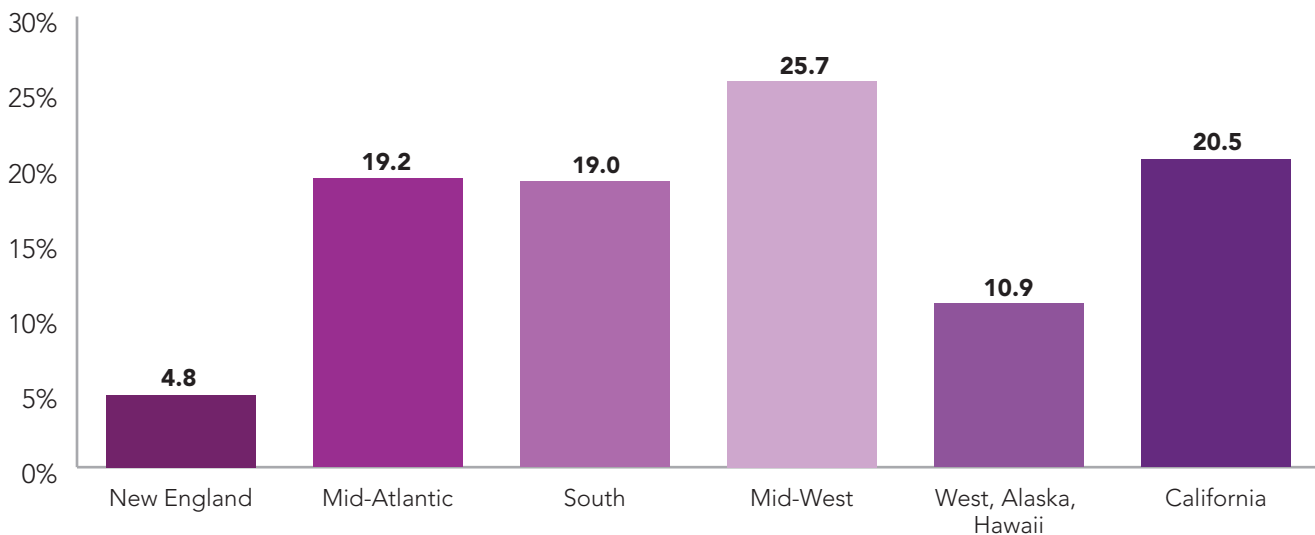


Table 14: Geographic distribution of responses



## GLOSSARY:

### EXPLANATION OF SURVEY TERMS

This section was created to enhance understanding of the terms in this report. However, it's important to remember that people defy labels. Identity is fluid and self-defined. Not everyone will fit into a definition, label or box, no matter how large we make it.

**Advance directive**, also known as a living will, is a legal document that gives instructions specifying what medical actions should be taken in the event that a person is no longer able to make decisions due to illness or incapacity.

**AIDS** or Acquired Immune Deficiency Syndrome is generally used to refer to the most advanced stages of HIV progression in which the human immune system becomes compromised, leaving the body susceptible to opportunistic infections it could otherwise defeat. There is some debate among medical professionals as to what actually constitutes a progression to AIDS and whether the term should continue to be used at all.

**Bisexual** people are attracted to and/or sexually active with people regardless of gender.

**Convenience sampling** is a technique for developing a research sample which involves drawing from that part of the population which is close to hand, readily available or convenient. This technique is different from random sampling.

**Cultural competence** is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings – in the context of this study, to increase the quality of health care, thereby producing better health outcomes.

**Gay** people are people who are romantically and/or sexually attracted to and/or sexually active with people of the same gender. "Gay" can refer either to women or men, but for the purposes of this report refers to men unless otherwise specified.

**Gender expression** refers to the way a person expresses gender through dress, grooming habits, choice of name and pronoun, mannerisms, activities, etc.

**Gender identity** is an individual's emotional and psychological sense of being male or female. Gender identity is not necessarily the same as an

individual's biological identity. In this survey, when the terms "male" and "female" are used alone, they refer to people who do not have transgender and gender-nonconforming identities, while transgender and gender-nonconforming people are identified by their current gender and the terms "transgender" and/or "gender non-conforming."

**Gender-nonconforming (GNC)** refers to individuals whose external manifestation of their gender identity does not conform to society's expectations of gender roles. A gender-nonconforming person may or may not identify as transgender, gay, lesbian or bisexual.

**HIV** or human immunodeficiency virus (HIV) is a retrovirus that targets the human immune system. Progression of HIV infection can lead to a serious compromise of immune system function, leaving the body open to opportunistic infections against which it could normally defend.

**HIV positive** people are living with HIV, although they might not have AIDS.

**Homophobia** refers to hatred, fear of or discrimination against lesbian, gay or bisexual people based on their sexual orientation.

**Lesbians** are people who are romantically and/or sexually attracted to and/or sexually active with people of the same gender. "Lesbian" refers exclusively to women while "gay" can refer either to women or men.

**LGBT** stands for lesbian, gay, bisexual or transgender.

**Low-income** is defined for the purposes of this report as having an annual household income of less than \$20,000.

**Medical power of attorney** is a legal document that gives someone the legal authority to act on an individual's behalf regarding health care decisions if they ever become incapacitated or unable to communicate.

**People living with HIV** includes all people who are infected with HIV, including people who have been diagnosed with AIDS and those who are HIV positive.

**Queer** is an identity used by people who reject conventional categories such as “LGBT” or embrace a political identity as ‘queer’ in addition to being LGB and/or T. It also may include heterosexuals who embrace a non-normative or counter-normative sexual identity.

**Same-gender loving** is a term most often used in communities of color to describe people with same-sex attractions since gay, homosexual, bisexual or lesbian can carry negative connotations to some people.

**Sexual orientation** generally refers to people’s sexual behavior or attraction.

**Snowball sampling** is a technique for developing a research sample where existing study subjects recruit future subjects from among their acquaintances. Thus the sample group appears to grow like a rolling snowball. As the sample builds up, enough data is gathered to be useful for research. This sampling technique is often used in hidden populations which are difficult for researchers to access.

**Transexual** is an older term which originated in the medical and psychological communities. Many transgender people prefer the term “transgender” to “transexual.” Some transexual people still prefer to use the term to describe themselves. However, unlike transgender, transexual is not an umbrella term, and many transgender people do not identify as transexual.

**Transfeminine** is a broad term used to describe individuals who were assigned the sex “male” at birth, but whose gender identity is along the feminine spectrum of gender. This can encompass those who have medically transitioned and those who have not, and may include (but is not limited to) those who identify as transwomen, MTF (male-

to-female), transgender female, transexual female, genderqueer, etc.

**Transgender** is a word commonly used to describe people who live in a gender different from the one assigned to them at birth. People often use this word to describe not only people who have changed their gender through surgery or cross-gender hormone treatment, but also people who have non-medical gender transitions or identify as transgender but do not seek to change their gender legally or medically. For the purposes of this report, “transgender” categories include people who self-identified as transgender and those who indicated a current gender identity that is different from what they stated was the sex on their birth certificate.

**Transmasculine** is a broad term used to describe individuals who were assigned the sex “female” at birth, but whose gender identity is along the masculine spectrum of gender. This can encompass those who have medically transitioned and those who have not, and may include (but is not limited to) those who identify as transmen, FTM (female-to-male), transgender male, transexual male, genderqueer, etc.

**Transphobia** refers to hatred, fear of or discrimination against transgender people based on their gender identity or expression.

**Two-spirit** is a culturally-specific gender-nonconforming identity within the culture and heritage of American Indian/Native American.

## OUR PARTNERS

We'd like to thank the following groups that have joined as partners in Lambda Legal's national Health Care Fairness Campaign for helping to promote the health care fairness survey and disseminate and utilize these findings. We would not have been able to collect responses from such a large and diverse group of people without their help and support. It should be noted that our partners did not participate in the writing of this report nor the development of the policy recommendations.

9 to 5 California	Circle of Voices
9 to 5 National Association of Working Women	COLAGE
Adolescent AIDS Program	Community HIV/AIDS Mobilization Project (CHAMP)
Aeromestiza	Crossdressers International
Affirmations	Dr. Maxwell Anderson & Associates
AIDS Legal Referral Panel	Emotional Healing and Empowerment Center
AIDS Project El Paso	Entre Hermanos
Al Gamea	Equality North Carolina
Allgo	Equality Texas
Alliance for Full Acceptance	Family Equality Council
American Friends Service Committee	Feminist Health Center
Asian Pacific Islander Coalition on HIV/AIDS (APICHA)	Gay & Lesbian Center of South Nevada
Atlanta Lesbian Health Initiative	Gay and Lesbian Medical Association
Basic Rights Oregon	Gay, Lesbian and Straight Education Network
BCC (Beth Chayir Chadoshim)	Gender Just
Best Koeppl APLC	Gender Rights Advocacy Association of New Jersey
BGLAD @ SCU Law	Georgia Equality
Bienestar	Giovanni's Room
Boston Alliance of LGBT Youth, Inc. (BAGLY)	Glory To God Christian Church
Bronx Pride	Human Rights Campaign
Brothas & Sistas, Inc.	Identity, Inc
CAEAR Foundation	Indiana Equality
Cascade AIDS Project	International Federation for Gender Education
Center for Medicare Advocacy, Inc.	International Gay & Lesbian Human Rights Commission
Centerlink	Kentucky Fairness Alliance



Knoxville/Knox County, Department of Air Quality Management

Latino Commission on AIDS

Legal Voice

LGBT Center New Orleans

LGBT Community Center of Greater Cleveland

LGBT Center, UCSF

Life Healing Center

Lighthouse Community Center

Love Makes a Family

Lotus Monk

Mautner Project

Metropolitan Community Church of Louisville

Missoula AIDS Council

Mocha Center

More Light Presbyterians

National Coalition for LGBT Health

National Gay & Lesbian Task Force

National Senior Citizens Law Center

National Youth Advocacy Coalition

Nevada Association of Latin Americans (NALA)

NIA Collective

New York Association for Gender Rights Advocacy

Northern Colorado AIDS Project

One Iowa

Our House

OUTLaw

Palm Beach County Human Rights Council

PFLAG National

PFLAG Bozeman

PFLAG Omaha

PFLAG Tulsa

Planned Parenthood of Southern Finger Lakes

Pride Collective & Community Center

Pro Latino

PROMO

Public Health - Seattle & King County

Rainbow Access Initiative

Rainbow Center

Rainbow Community Center

Raising Women's Voices for the Health Care We Need

Tennessee Transgender Political Coalition

The Butch/Femme Society

The MergerWatch Project

The Sperm Bank of California

The Wall - Las Memorias

Tomboy Magazine

Topeka AIDS Project

Transgender Individuals Living Their Truth (TILTT)

Transgender Legal Defense Fund

Triangle Foundation

Tri-City Health Center

Two Spirit Society of Denver

UCC Coalition for LGBT Concerns

Utah Pride Center

Ventura County Rainbow Alliance (VCRA)

Whitman-Walker Clinic

Wilson Resource Center

Workmen's Circle, So California Arberter Ring Education Center

Zuna Institute



## Contact Lambda Legal

### NATIONAL HEADQUARTERS

120 Wall Street  
Suite 1500  
New York, NY 10005-3904  
tel 212-809-8585  
fax 212-809-0055

### WESTERN REGIONAL OFFICE

3325 Wilshire Boulevard  
Suite 1300  
Los Angeles, CA 90010-1729  
tel 213-382-7600  
fax 213-351-6050

### MIDWEST REGIONAL OFFICE

11 East Adams  
Suite 1008  
Chicago, IL 60603-6303  
tel 312-663-4413  
fax 312-663-4307

### SOUTHERN REGIONAL OFFICE

730 Peachtree Street, NE  
Suite 1070  
Atlanta, GA 30308-1210  
tel 404-897-1880  
fax 404-897-1884

### SOUTH CENTRAL REGIONAL OFFICE

3500 Oak Lawn Avenue  
Suite 500  
Dallas, TX 75219-6722  
tel 214-219-8585  
fax 214-219-4455

[www.lambdalegal.org](http://www.lambdalegal.org)

Lambda Legal is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those with HIV through impact litigation, education and public policy work.

If you feel you have been discriminated against, please call Lambda Legal's Help Desk at (866) 542-8336 or visit [www.lambdalegal.org/help/online-form](http://www.lambdalegal.org/help/online-form)

Copyright © 2010 Lambda Legal  
All rights reserved.

# **EXHIBIT 3**



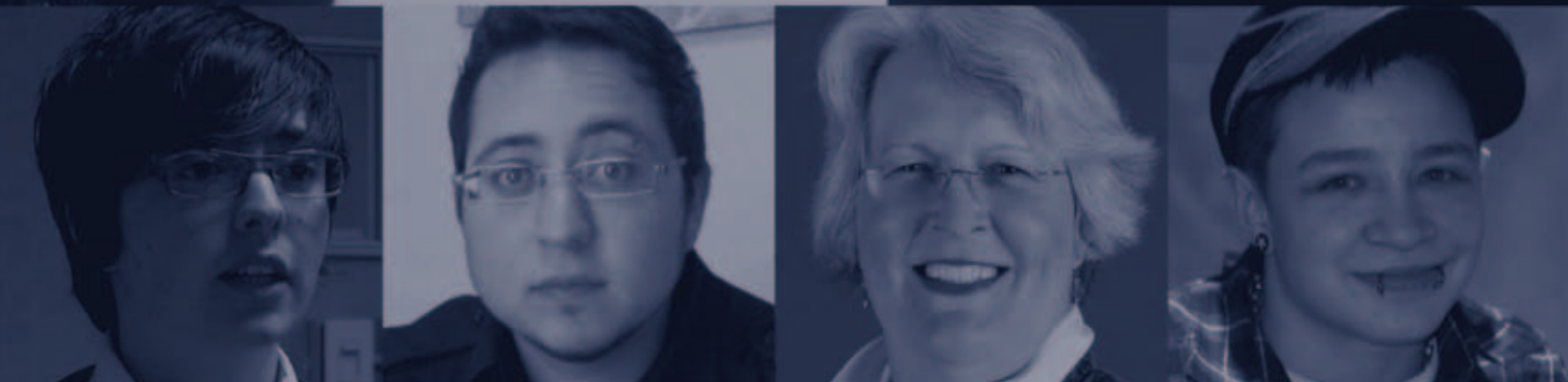
# Injustice at Every Turn

A Report of the National Transgender Discrimination Survey

*Lead authors in alphabetical order:*

Jaime M. Grant, Ph.D.  
Lisa A. Mottet, J.D.  
Justin Tanis, D.Min.

with Jack Harrison  
Jody L. Herman, Ph.D.  
and Mara Keisling







# INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY

*Lead authors in alphabetical order:*

Jaime M. Grant, Ph.D.

Lisa A. Mottet, J.D.

Justin Tanis, D.Min.

with Jack Harrison, Jody L. Herman, Ph.D., and Mara Keisling

## About the National Center for Transgender Equality

The National Center for Transgender Equality is a national social justice organization devoted to ending discrimination and violence against transgender people through education and advocacy on national issues of importance to transgender people. By empowering transgender people and our allies to educate and influence policymakers and others, NCTE facilitates a strong and clear voice for transgender equality in our nation's capital and around the country.

## About the National Gay and Lesbian Task Force

The mission of the National Gay and Lesbian Task Force is to build the grassroots power of the lesbian, gay, bisexual and transgender (LGBT) community. We do this by training activists, equipping state and local organizations with the skills needed to organize broad-based campaigns to defeat anti-LGBT referenda and advance pro-LGBT legislation, and building the organizational capacity of our movement. Our Policy Institute, the movement's premier think tank, provides research and policy analysis to support the struggle for complete equality and to counter right-wing lies. As part of a broader social justice movement, we work to create a nation that respects the diversity of human expression and identity and creates opportunity for all.

© 2011 The National Gay and Lesbian Task Force and the National Center for Transgender Equality. We encourage, and grant permission to, reproduction and distribution this publication in whole or in part, provided that it is done so with attribution. Further written permission is not required.

### RECOMMENDED CITATION

Grant, Jaime M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.

# TABLE OF CONTENTS

Acknowledgements.....	1
Executive Summary .....	2
Introduction.....	10
Methodology.....	12
Demographic Composition of Sample .....	16
The Findings	
A Portrait of Transgender and Gender Non-Conforming People.....	20
Education .....	32
Employment.....	50
Health.....	72
Family Life .....	88
Housing.....	106
Public Accommodations .....	124
Identification Documents .....	138
Police and Incarceration .....	158
Cross-Dressers .....	174
Policy Priorities.....	178
Conclusion .....	179
Appendices	
Appendix A —Glossary.....	180
Appendix B — Survey Instrument—Issues and Analysis.....	182
Appendix C — Survey Instrument (paper version).....	204
About the Authors .....	221

# HEALTH

Access to health care is a fundamental human right that is regularly denied to transgender and gender non-conforming people.

Transgender and gender non-conforming people frequently experience discrimination when accessing health care, from disrespect and harassment to violence and outright denial of service. Participants in our study reported barriers to care whether seeking preventive medicine, routine and emergency care, or transgender-related services. These realities, combined with widespread provider ignorance about the health needs of transgender and gender non-conforming people, deter them from seeking and receiving quality health care.

Our data consistently show that racial bias presents a sizable additional risk of discrimination for transgender and gender non-conforming people of color in virtually every major area of the study, making their health care access and outcomes dramatically worse.

## KEY FINDINGS IN HEALTH

- Survey participants reported that when they were sick or injured, they **postponed medical care** due to discrimination (28%) or inability to afford it (48%).
- Respondents faced **serious hurdles to accessing health care**, including:
  - **Refusal of care:** 19% of our sample reported being refused care due to their transgender or gender non-conforming status, with even higher numbers among people of color in the survey.
  - **Harassment and violence in medical settings:** 28% of respondents were subjected to harassment in medical settings and 2% were victims of violence in doctor's office.
  - **Lack of provider knowledge:** 50% of the sample reported having to teach their medical providers about transgender care.
- The **majority of survey participants have accessed some form of transition-related medical care** despite the barriers; the majority reported wanting to have some type of surgery but have not had any surgeries yet.
- **If medical providers were aware of the patient's transgender status, the likelihood of that person experiencing discrimination increased.**
- Respondents reported **over four times the national average of HIV infection**, 2.64% in our sample compared to .6% in the general population, with rates for transgender women at 4.28%, and with those who are unemployed (4.67%) or who have done sex work (15.32%) even higher.<sup>1</sup>
- Over a quarter of the respondents **misused drugs or alcohol specifically to cope with the mistreatment** they faced due to their gender identity or expression.
- A staggering **41% of respondents reported attempting suicide** compared to 1.6% of the general population, with unemployment, bullying in school, low household income and sexual and physical associated with even higher rates.

## Access to Healthcare

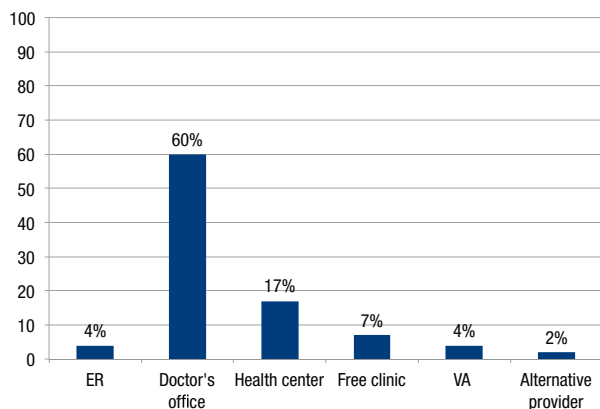
### HEALTH CARE SETTINGS

A majority of study participants sought care (“when you are sick or need advice about your health”) through a doctor’s office (60%); however a sizable minority used health centers and clinics (28%). Four percent (4%) of respondents primarily used emergency rooms for care. Several studies have shown that individuals who use emergency rooms for primary care experience more adverse health outcomes than those who regularly see a primary physician.<sup>2</sup> Factors that correlated with increased use of emergency rooms (ERs) among our respondents were:

- Race—17% of African-Americans used ERs for primary care, as did 8% of Latino/a respondents;
- Household income—8% of respondents earning under \$10,000 per year used ERs for primary care;
- Employment status—10% of unemployed respondents and 7% of those who said they had lost their jobs due to bias used ERs for primary care;
- Education—13% of those with less than a high school diploma used ERs for primary care.

Visual conformers and those who had identity documents that matched their presentation had high rates of using doctor’s offices for their care.

Primary Source of Medical Care for Respondents



*“After an accident on ice, I was left untreated in the ER for two hours when they found my breasts under my bra while I was dressed outwardly as male.”*

*“I have been refused emergency room treatment even when delivered to the hospital by ambulance with numerous broken bones and wounds.”*

## Health Care Experiences

### DISCRIMINATION BY MEDICAL PROVIDERS

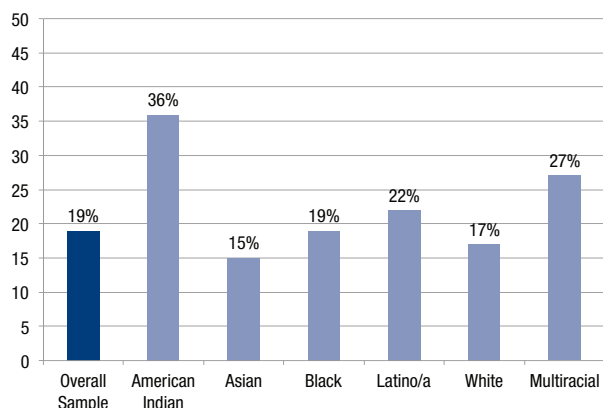
Denial of health care and multiple barriers to care are commonplace in the lives of transgender and gender non-conforming people. Respondents in our study seeking health care were denied equal treatment in doctor’s offices and hospitals (24%), emergency rooms (13%), mental health clinics (11%), by EMTs (5%) and in drug treatment programs (3%).<sup>3</sup> Female-to-male respondents reported higher rates of unequal treatment than male-to-female respondents. Latino/a respondents reported the highest rate of unequal treatment of any racial category (32% by a doctor or hospital and 19% in both emergency rooms and mental health clinics).

19% of our sample reported being refused care altogether, due to their gender identity or expression, with even higher numbers among people of color in the survey.

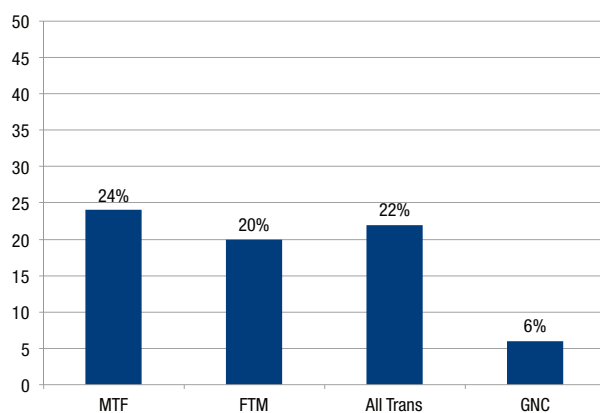
We also asked whether respondents had been **denied service altogether** by doctors and other providers.<sup>4</sup> Nineteen percent (19%) had been refused treatment by a doctor or other provider because of their transgender or gender non-conforming status.

Twenty-four percent (24%) of transgender women reported having been refused treatment altogether and 20% of transgender men did. Respondents who reported they had lost jobs due to bias (36%); American Indians (36%); those who worked in the underground economy (30%); those on public insurance (28%); and those who transitioned (25%) experienced high occurrence of refusal to treat.

Refusal to Provide Medical Care by Race



Refusal to Provide Care by Gender Identity/Expression



*“I have had general practitioners refuse to accept me as a patient on the basis of having a history of gender identity disorder.”*

## VIOLENCE AND HARASSMENT WHEN SEEKING MEDICAL TREATMENT

Doctors’ offices, hospitals, and other sources of care were often unsafe spaces for study participants. Over one-quarter of respondents (28%) reported verbal harassment in a doctor’s office, emergency room or other medical setting and 2% of the respondents reported being physically attacked in a doctor’s office.

*2% of respondents reported being physically attacked in a doctor’s office.*

*28% reported being verbally harassed in a medical setting.*

Those particularly vulnerable to physical attack in doctors’ offices and hospitals include those who have lost their jobs (6%); African-Americans (6%); those who done sex work, drug sales or other work in the underground economy (6%); those who transitioned before they were 18 (5%); and those who are undocumented non-citizens (4%).

In emergency rooms, 1% reported attack. Those more vulnerable to attack include those who are undocumented (6%); those who have worked in the underground economy (5%); those who lost their jobs (4%); and Asian respondents (4%). Obviously, harassment and physical attacks have a deterrent effect on patients seeking additional care and impact the wider community as information about such abuses circulates.

*“My experiences in dealing with hospital personnel after my rape was not pleasant and lacked a lot of sensitivity to trans issues.”*

*“When I tried to kill myself and was taken to a suicide center, I was made fun of by staff and treated roughly.”*

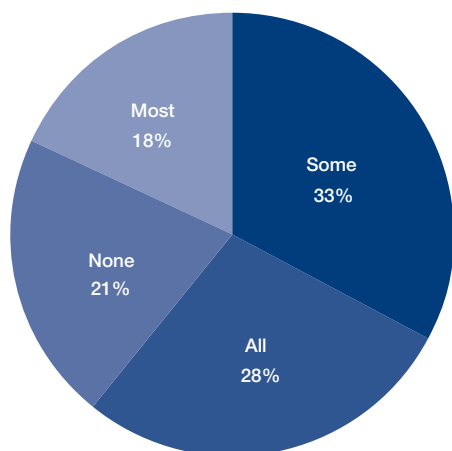
*“I was forced to have a pelvic exam by a doctor when I went in for a sore throat. The doctor invited others to look at me while he examined me and talked to them about my genitals.”*



## OUTNESS AND DISCRIMINATION

Twenty-eight percent (28%) of respondents said they were out to all their medical providers. Eighteen percent (18%) said they were out to most, 33% said some or a few, and 21% were out to none.

When Seeking Medical Care, How Many People Know or Believe You Are Transgender or Gender Non-Conforming?



Doctors can provide more effective care when they have all medically relevant information about their patients. Unfortunately, our data shows that doctors' knowledge of a patient's transgender status increases the likelihood of discrimination and abuse. Medical professionals' awareness of their patient's transgender status **increased experiences of discrimination** among study participants up to eight percentage points depending on the setting:

- **Denied service altogether:** 23% of those who were out or mostly out to medical providers compared to 15% of those who were not out or partly out
- **Harassment in ambulance or by EMT:** 8% of those who were out or mostly out to medical providers compared with 5% of those who were not out or partly out
- **Physically attacked or assaulted in a hospital:** 2% of those who were out or mostly out to medical providers compared with 1% of those who were not out or partly out

*"I have been harassed and physically assaulted on the street. One time, I didn't go the hospital until I went home, changed [out of feminine] clothes, and then went to the emergency room in male mode. I had a broken collar bone as a result of that attack."*

*"I rarely tell doctors of my gender identity. It just seems so hard to explain what "genderqueer" means in a short doctor's appointment. I also am reluctant to take the risk of discrimination; I need to be healthy more than I need to be out to my doctors. I hate making this compromise. But I'm not quite that brave yet."*

*"Denial of health care by doctors is the most pressing problem for me. Finding doctors that will treat, will prescribe, and will even look at you like a human being rather than a thing has been problematic. Have been denied care by doctors and major hospitals so much that I now use only urgent care physician assistants, and I never reveal my gender history."*

## MEDICAL PROVIDERS' LACK OF KNOWLEDGE

When respondents saw medical providers, including doctors, they often encountered ignorance about basic aspects of transgender health and found themselves required to “teach my provider” to obtain appropriate care. Fully 50% of study respondents reported having to teach providers about some aspect of their health needs; those who reported “teaching” most often include transgender men (62%), those who have transitioned (61%) and those on public insurance (56%).

50% of the sample reported having to teach their medical providers about transgender care.

*“I have several health issues and have been refused care by one doctor who ‘suggested’ that I go someplace else because she could not treat me since she ‘did not know anything about transgender people.’ “*

## POSTPONEMENT OF NECESSARY AND PREVENTIVE MEDICAL CARE

We asked respondents whether they postponed or did not try to get two types of health care: preventive care “like checkups” and necessary care “when sick or injured.” We found that many postponed care because they *could not afford it* and many postponed care because of *discrimination and disrespect from providers*.

One fourth of study participants reported delaying needed care because of disrespect and discrimination from medical providers.

A large number of study participants postponed necessary medical care due to inability to afford it, whether seeking care when sick or injured (48%), or pursuing preventive care (50%). Transgender men reported postponing any care due to inability to afford it at higher rates (55%) than transgender women (49%).

Insurance was a real factor in delayed care: those who have private insurance were much less likely to postpone care because of inability to afford it when sick or injured (37%) than those with public (46%) or no insurance who postponed care (86%).

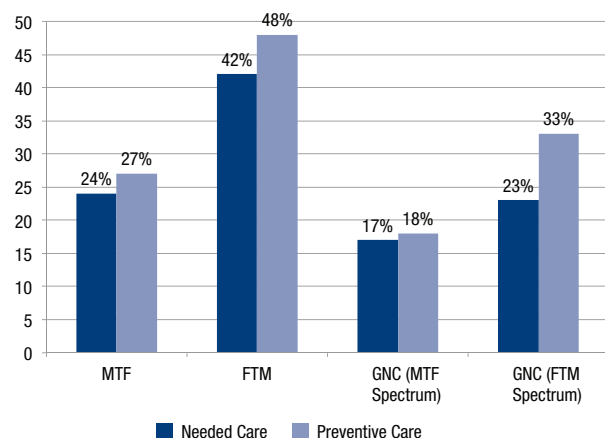
In terms of preventive care, those without insurance reported delaying care due to inability to afford it much more frequently (88%) than those with private insurance (39%) or public insurance (44%). Failing to obtain preventive care is known to lead to poor long-term health outcomes.

Due to discrimination and disrespect, 28% postponed or avoided medical treatment when they were sick or injured and 33% delayed or did not try to get preventive health care. Female-to-

male transgender respondents reported postponing care due to discrimination and disrespect at a much higher frequency (42%, sick/injured; 48% preventive) than male-to-female transgender respondents (24%, sick/injured; 27% preventive). Those with the highest rates of postponing care when sick/injured included those who have lost a job due to bias (45%) and those who have done sex work, sold drugs, or done other work in the underground economy for income (45%). Twenty-nine percent (29%) of respondents who were “out” or “mostly out” to medical providers reported they had delayed care when ill and 33% postponed or avoided preventive care because of discrimination by providers.

*“The transition and health care has been expensive, all at a time where my main source of income (my law practice) deteriorated. I have exhausted my savings and the equity from selling my home just to pay medical and living expenses.”*

Postponement Due to Discrimination by Providers



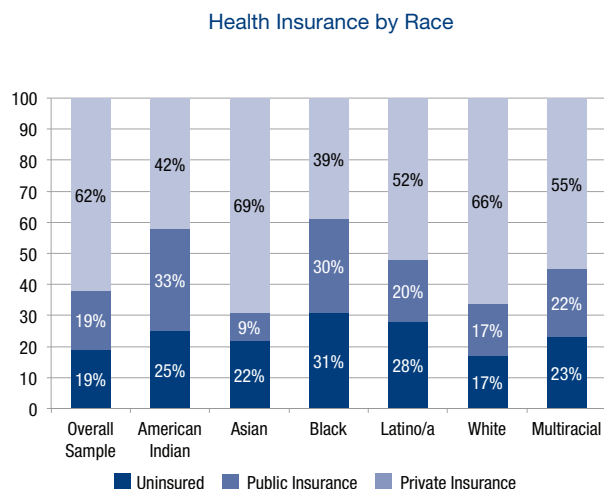
## ACCESS TO INSURANCE

Study participants were less likely than the general population to have health insurance, more likely to be covered by public programs such as Medicare or Medicaid, and less likely to be insured by an employer.

Nineteen percent (19%) of the sample lacked any health insurance compared to 17% of the general population.<sup>5</sup> Fifty-one percent (51%) had employer-based coverage compared to 58% of the general population.<sup>6</sup>

African-American respondents had the worst health insurance coverage of any racial category: 39% reported private coverage and 30% public. Thirty-one percent (31%) of Black respondents reported being uninsured; by contrast 66% of white respondents reported private insurance, 17% public insurance and 17%

uninsured. In the general population, 68% have private insurance and 28% have public insurance.<sup>7</sup>

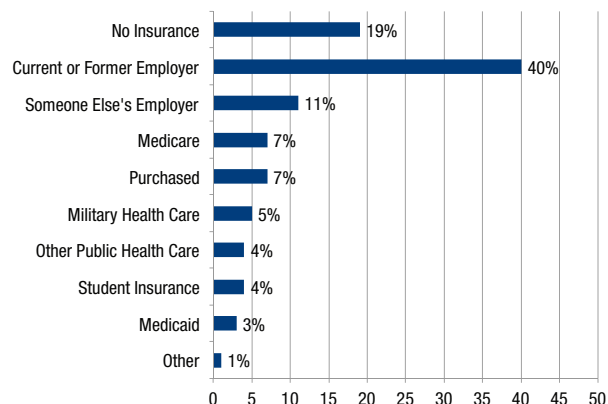


Undocumented non-citizens had very low rates of coverage: 26% reported private insurance, 37% public insurance, and 36% no insurance. The South was the worst region for coverage where 59% of respondents reported private insurance, 17% public insurance and 25% no insurance.

Transgender women reported private insurance at 54%, public insurance at 24% and 22% were uninsured. Transgender men reported private insurance at 68%, public insurance at 13% and 19% with no insurance. Transgender respondents, overall, reported private insurance at 60%, public insurance at 20% and 20% had no insurance. Gender non-conforming respondents were insured at higher rates than their transgender counterparts, with 73% reporting private insurance, 11% public insurance, and 17% uninsured.

*“I have been living with excruciating pain in my ovaries because I can’t find a doctor who will examine my reproductive organs.” (from a transgender man)*

**Source of Insurance**



## Transition-related Care

Most survey respondents had sought or accessed some form of transition-related care. Counseling and hormone treatment were notably more utilized than any surgical procedures, although the majority reported wanting to “someday” be able to have surgery. The high costs of gender-related surgeries and their exclusion from most health insurance plans render these life-changing (in some cases, life-saving) and medically necessary procedures inaccessible to most transgender people.

Throughout this section, we focus primarily on transgender people rather than on gender non-conforming people, though they too may also desire and sometimes use various forms of gender-related medical care.

The World Professional Association for Transgender Health (WPATH) publishes Standards of Care<sup>8</sup> which are guidelines for mental health, medical and surgical professionals on the current consensus for providing assistance to patients who seek transition-related care. They are intended to be flexible to assist professionals and their patients in determining what is appropriate for each individual. The Standards of Care are a useful resource in understanding the commonly experienced pathways through transition-related care.

*The majority of survey participants have accessed some form of transition-related medical care despite the barriers.*

*“My choices for health coverage at my employer all exclude any treatment for transgender issues, even though they cover things like hormones for other people.”*

## COUNSELING

Counseling often plays an important role in transition. Because of the WPATH Standards of Care, medical providers often require a letter from a qualified counselor stating that the patient is ready for transition-related medical care; transgender people may seek out counseling for that purpose. Counseling may also play a role in assisting with the social aspects of transition, especially in dealing with discrimination and family rejection.

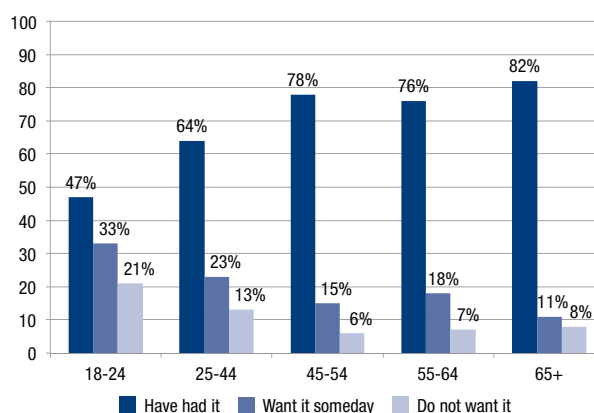
Seventy-five percent (75%) of respondents received counseling related to their gender identity and an additional 14% hoped to receive it someday. Only 11% of the overall sample did not want it. Those who identified as transgender were much more likely to have had counseling (84%) than those who are gender non-conforming (48%). Eighty-nine percent (89%) of those who medically transitioned have received counseling, as have 91% of those who had some type of surgery.

Part of counseling can involve receiving a gender-related mental health diagnosis such as “Gender Identity Disorder.” Many doctors require this diagnosis before providing hormones or surgical treatment, but the diagnosis itself is widely criticized for categorizing naturally occurring gender variance as pathological.<sup>9</sup> Fifty-percent (50%) of study participants have received a gender-related mental health diagnosis. Transgender women reported a higher rate of diagnosis (68%) than transgender men (56%); and transgender-identified participants had a substantially higher rate of diagnosis (63%) than gender non-conforming respondents (11%).

## HORMONE THERAPY

Sixty-two percent (62%) of respondents have had hormone therapy, with the likelihood increasing with age; an additional 23% hope to have it in the future. Transgender-identified respondents accessed hormonal therapy (76%) at much higher rates than their gender non-conforming peers, with transgender women more likely to have accessed hormone therapy (80%) than transgender men (69%). Almost all respondents who reported undertaking transition-related surgeries also reported receiving hormone therapy (93%).

Hormone Therapy by Age of Respondent

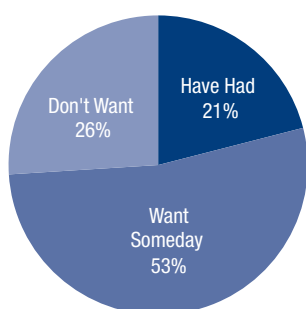


*“I can no longer afford health care of any kind. I am fully transitioned and thus reliant upon estradiol as my body produces neither estrogens nor androgens in sufficient quantity. I am unable to go to the doctor for my prescriptions, and thus have been unable to buy my hormones for over one year. Thus I watch my hair falling out, my nails dissolve and am weak and tired like a far older lady than I am.”*

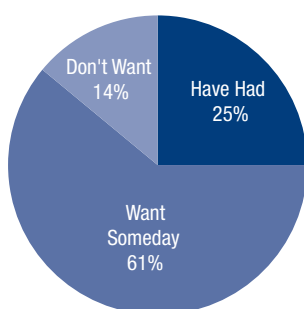
**SURGERY—MALE-TO-FEMALE**

Transgender women may elect to undertake a variety of surgeries, including breast augmentation, orchiectomy (removal of testes), vaginoplasty (creation of a vagina and/or removal of the penis), and facial feminization surgeries. We asked respondents to report on whether they had, or wanted, breast augmentation surgery, orchiectomies and vaginoplasties. As the charts below show, most transgender women reported wanting or having these surgeries. In addition, 17% reported having had facial surgery.<sup>10</sup> However, it is impossible to know how many others would desire or utilize surgery if it was more financially accessible.

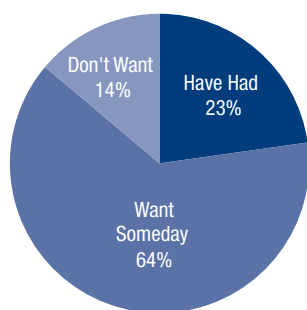
MTF Breast Augmentation Surgery



MTF Orchiectomy



MTF Vaginoplasty

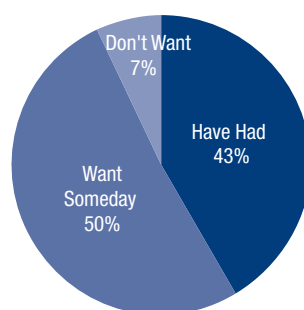


*“I cannot afford gender reassignment surgery which is crucial to my mental well being and thoughts of suicide are always present.”*

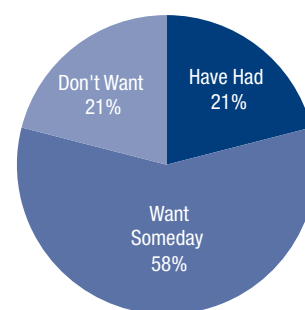
**SURGERY—FEMALE-TO-MALE**

Transgender men may elect to undertake a variety of surgeries, including chest reconstruction, hysterectomy, metoidioplasty and other genital surgeries. We asked respondents to report on chest surgery; hysterectomy; metoidioplasty, which releases the clitoris; surgeries that create testes; and phalloplasty, which surgically creates a penis and testes. The majority of FTM transgender-identified respondents wanted to have, or have already had, chest surgery and a hysterectomy. However, when it came to genital surgeries, very few reported having such surgeries; a slim majority (53%) reported desiring other genital surgery such as metoidioplasty in addition to the 3% that have had it; and one-quarter (27%) wanted to have a phalloplasty in addition to the 1% who have had it. It is impossible to know how these rates would change if these surgeries were more financially accessible.

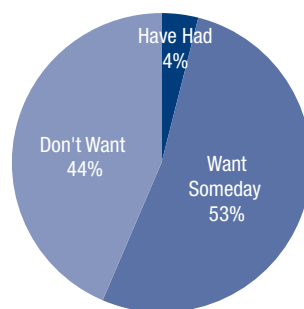
FTM Chest Surgery



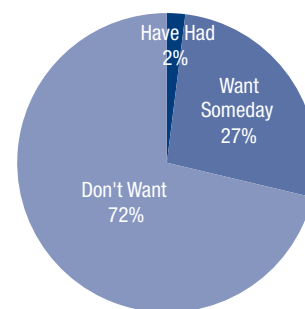
FTM Hysterectomy



FTM Metoidioplasty/  
Creation of Testes



FTM Phalloplasty



*“I have also have had several bouts with depression and anxiety disorders and once ended up in the emergency room for depression. I still bounce in and out of depression due to not being able to get the appropriate surgical procedures.”*

## Health Vulnerabilities

Survey participants reported poorer health outcomes than the general population in a variety of critical health areas.

### PHYSICAL VIOLENCE AND SEXUAL ASSAULT

In questions related to experiences in educational settings, at work, in interactions with police and with family members, at homeless shelters, accessing public accommodations, and in jails and prisons, respondents were asked about physical violence or sexual violence, or both, committed against them because of their gender identity/expression. There was no *general question* asked about whether respondents had ever experienced any bias-motivated violence, and further, there was no question that asked to report on violence that was not *specifically motivated* by anti-transgender bias.

Twenty-six percent (26%) of respondents had been physically assaulted in at least one of these contexts because they were transgender or gender non-conforming. Ten percent (10%) of respondents were sexually assaulted due to this bias.

Having been physically or sexually assaulted aligned with a range of other negative outcomes, as described below in each relevant section.

### HIV

Respondents reported an HIV infection rate of 2.64%,<sup>11</sup> over four times the rate of HIV infection in the general United States adult population (0.6%) as reported by the United Nations Programme on HIV/AIDS and the World Health Organization.<sup>12</sup> People of color reported HIV infection at substantially higher rates: 24.90% of African-Americans, 10.92% of Latino/as, 7.04% of American Indians, and 3.70% of Asian-Americans in the study reported being HIV positive. This compares with national rates of 2.4% for African Americans, .08% Latino/as, and .01% Asian Americans.<sup>13</sup> Non-U.S. citizens in our sample reported more than twice the rate of HIV infection of U.S. citizens (2.41%), with documented non-citizens at 7.84% and undocumented at 6.96%.

*“As a child because I acted “girly,” I was a victim of severe child abuse, and was sexually assaulted. I avoided transitioning until I came to the point of suicide.”*

**Respondents reported over four times the national average of HIV infection.**

Doing sex work for income clearly was a major risk factor, with 61% of respondents who were HIV positive reporting they had done sex work for income. To consider this from a different angle, of all the people in our sample who had done sex work, 15.32% reported being HIV positive.

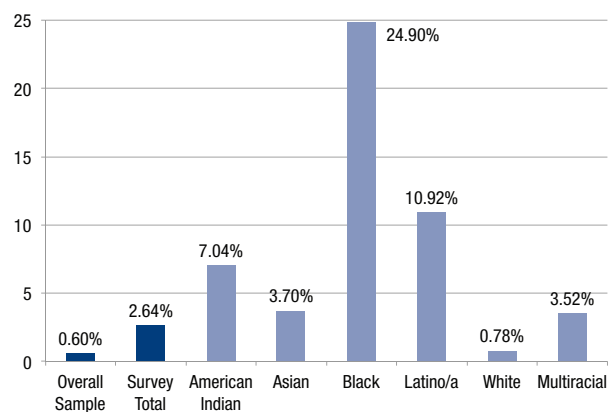
Among survey participants, 88% of those who reported being HIV positive identified as either MTF or gender non-conforming on the male-to-female spectrum. The reported rate of HIV infection for the MTF transgender respondents was 4.28%. The reported rate of HIV infection for FTM respondents was .51%, lower than the national average.

Other categories that reported substantially higher HIV rates than the sample as a whole were:

- Those without a high-school diploma (13.49%)
- Those who had been sexually assaulted due to bias (10.13%)
- Those with household income below \$10,000 a year (6.40%)
- Those who had lost a job due to bias (4.59%) or reported being unemployed (4.67%)

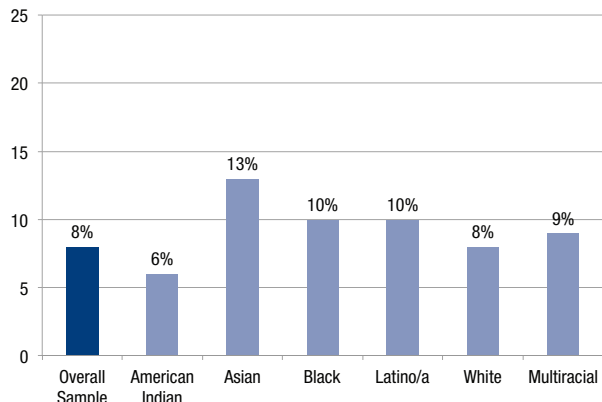
Eight percent (8%) of our sample reported that they did not know their HIV status. Transgender women and transgender men had equal rates of not knowing, both 8%, with transgender respondents also at 8% and gender non-conforming respondents at 9%. Those most likely not to know their HIV status include undocumented non-citizens (17%), those with household incomes under \$10,000/year (14%), and those with lower educational attainment (those with no high school diploma and high school diploma only, both at 13%). With regard to race, Asian respondents were least likely to know their status (13%).

HIV Infection By Race, Compared to U.S. General Population





HIV Status Unknown By Race



**DRUG AND ALCOHOL USE**

The National Institutes of Health (NIH) estimate that 7.3% of the general public abuses or is dependent on alcohol, while 1.7% abuses or is dependent on non-prescription drugs.<sup>14</sup> Eight percent (8%) of study participants reported currently using alcohol or drugs specifically to cope with the mistreatment that they received as a result of being transgender or gender non-conforming, while 18% said they had done so in the past but do not currently. We did not ask about general use of alcohol and drugs, only usage which the respondents described as a coping strategy for dealing with the mistreatment they face as transgender or gender non-conforming persons.

*26% use or have used alcohol and drugs to cope with the impacts of discrimination.*

Doing sex work, drug sales, and other work in the underground economy for income more than doubles the risk of alcohol or drug use because of mistreatment, with 19% of these respondents currently using alcohol and/or drugs while 36% reported that they had done so in the past. Those who have been the physically attacked due to bias also had a higher rate of current alcohol and drug misuse (15%) as did those who have been sexually assaulted due to bias (16%). Also at elevated

*“I do not use drugs but my drinking has increased over the past 3 years due to stress and loneliness.”*

*“When I started coming out, I stopped the drinking and stopped the depression medicines. When I started living full time in my real gender, I blossomed into an outgoing, loving, giving person.”*

risk were those who had lost a job due to discrimination; 12% reported currently using drugs and alcohol, while 28% have done so in the past.

Alcohol and drug use decreased by age among our participants, as they did in studies of the general population,<sup>15</sup> with those 65 years and above reporting less than half the rate of use (4%) of those who are the 18-44 age range (9%). This contrasts with studies of LGBT populations that show a less dramatic decrease in use over the life cycle;<sup>16</sup> however, because our study only asked about use connected to mistreatment, the comparisons with both the general population and LGBT studies are not precise.

**SMOKING**

Thirty percent (30%) of our sample reported smoking daily or occasionally, compared to 20.6% of U.S. adults.<sup>17</sup> Studies of LGBT adults show similar rates to those in our study, with elevated rates of 1.1-2.4 times that of the general population,<sup>18</sup> and a 2004 California study found a 30.7% smoking rate for transgender people.<sup>19</sup> In the general population, men smoke at higher rates than women, but in LGBT studies, women smoke at higher rates than men. Our sample resembled the LGBT data regarding elevated smoking levels but differed in that more men than women in our sample smoke, a pattern that is closer to that of the general population. When asked if they would “like to quit,” 70% of smokers in the study selected yes.

Comparative Smoking Rates from Other Studies,<sup>20</sup> Compared to Our Study

	General Population	Lesbian and Gay	Bisexual	Our Sample
Men	23.1%	26.5-30.9%	29.5-38.1%	33%
Women	18.3%	22.3-26%	30.9-39.1%	29%

Visual conformers were less likely to be current smokers (27%) than visual non-conformers (37%), suggesting that the stress caused by the additional mistreatment that visual non-conformers face may be involved in the development of an addiction to nicotine. Similarly, those who have been physically assaulted due to bias (40%) and sexually assaulted due to bias (45%) have higher smoking rates than their peers who were not assaulted.

**SUICIDE ATTEMPTS**

When asked “have you ever attempted suicide?” 41% of respondents answered yes. According to government health estimates, five million, or 1.6% of currently living

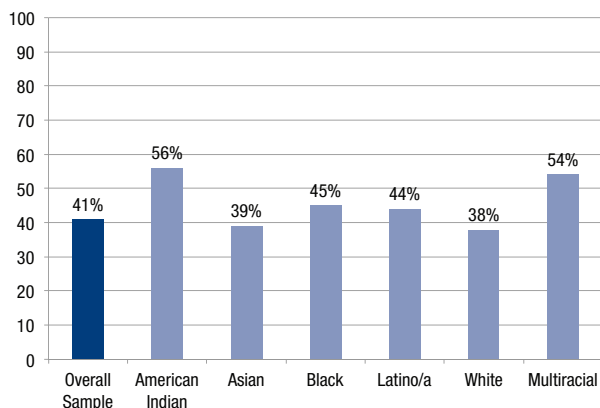
41% of respondents reported attempting suicide.

Americans have attempted suicide in the course of their lives.<sup>21</sup> Our study asked if respondents had ever attempted suicide while most federal studies refer to suicide attempts within the last year; accordingly it is difficult to compare our numbers with other studies. Regardless, our findings show a shockingly high rate of suicidality.

The National Institute for Mental Health (NIMH) reports that most suicide attempts are signs of extreme distress, with risk factors including precipitating events such as job loss, economic crises, and loss of functioning.<sup>22</sup> Given that respondents in this study reported loss in nearly every major life area, from employment to housing to family life, the suicide statistics reported here cry out for further research on the connection between the consequences of bias in the lives of transgender and gender non-conforming people and suicide attempts.<sup>23</sup>

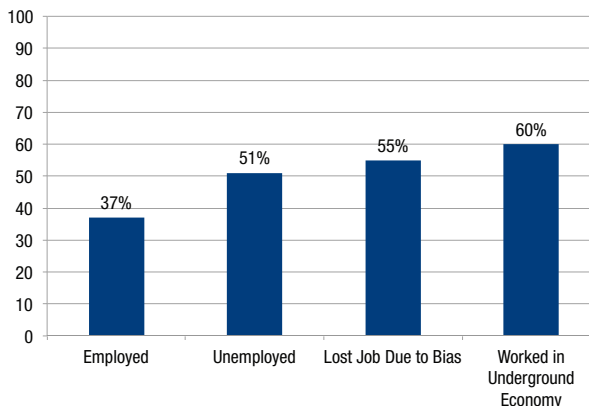
NIMH also reports that generally African-Americans, Latino/as and Asians have much lower suicide rates than whites and American Indians; our sample showed a different pattern of risk for suicide by race, with Black and Latino/a respondents showing dramatically elevated rates in comparison to their rates in the general population.

Suicide Attempt by Race



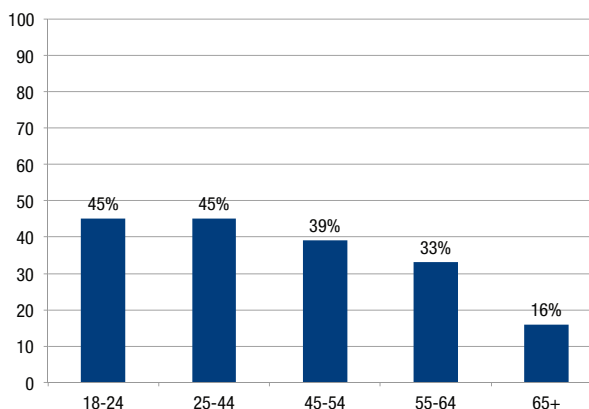
Respondents’ work status and experiences of discrimination in employment also had a sizable impact on their likelihood of having attempted suicide.

Suicide Attempt by Employment



In terms of age group risk, the highest rates of suicide attempts in this study were reported among those in the 18-24 age group (45%) and 25-44 age group (45%), with only 16% of those over 65 reporting a suicide attempt. These rates are inverse to the general population, which shows a higher incidence of attempts among older Americans than youth.<sup>24</sup>

Suicide Attempts by Age



Our questionnaire did not ask at what age the respondents made suicide attempts and therefore it is difficult to draw conclusions about the risk of suicide over their life spans.

However, there are a number of attributes that align with an increased rate of attempted suicide. High risk groups include visual non-conformers (44%) and those who are generally out about their transgender status (44%). Those who have medically transitioned (45%) and surgically transitioned (43%) have higher rates of attempted suicide than those who have not (34% and 39% respectively).

Over half of those bullied, harassed, assaulted, or expelled due to bias in school attempt suicide.

Those who were bullied, harassed, assaulted, or expelled because they were transgender or gender non-conforming in school (at any school level) reported elevated levels of suicide attempts (51% compared with 41% of our sample as a whole). Most notably, suicide attempt rates rise dramatically when teachers were the reported perpetrators: 59% for those harassed or bullied by teachers, 76% among those who were physically assaulted by teachers and 69% among those who were sexually assaulted by teachers. These numbers speak to the urgency of ending violence and harassment of transgender students by both their peers and their teachers.

Education and household income both align with suicide rates, with those earning \$10,000 annually or less at extremely high risk (54%), while those making more than \$100,000 are at comparatively lower risk (26%), while still tremendously higher than the general population. Those who have not completed college attempted suicide at higher rates (48% among those with no high school diploma, 49% for those with a high school diploma only, and 48% for those with some college education) while those who have completed college (33%) or graduate school (31%) have lower rates.

Those who had survived violence perpetrated against them because they were transgender or gender non-conforming were at very high risk; 61% of physical assault survivors reported a suicide attempt, while sexual assault survivors reported an attempt rate of 64%.

*“My suicide attempt had a lot to do with the fact that I felt hopeless and alone in regards to my gender identity.”*

## CONCLUSIONS FOR HEALTH

Respondents reported serious barriers to health care and outrageous frequencies of anti-transgender bias in care, from disrespect to refusal of care, from verbal harassment to physical and sexual abuse. Transgender people of color and low-income respondents faced substantially elevated risk of abuse, refusal of care, and poor health outcomes than the sample as a whole.

The data gathered here speak to a compelling need to examine the connection between multiple incidences of discrimination, harassment and abuse faced by our respondents in the health care system and the high risk for poor health outcomes. Additionally, our data suggest that discriminatory events are commonplace in the daily lives of transgender people and that this has a cumulative impact—from losing a job because of bias to losing health insurance; from experiencing health provider abuse to avoiding health care; from long-term unemployment to turning to work on the streets. The collective impact of these events exposed our respondents to increased risk for HIV infection, smoking, drug/alcohol use, and suicide attempts.

It is important to note that the traumatic impact of discrimination also has health care implications. Transgender people face violence in daily life; when this risk is compounded by the high rates of physical and sexual assault they face while accessing medical care, health care costs increase, both to treat the immediate trauma as well as ongoing physical and psychological issues that may be created.

As we have seen across a number of categories in the survey, the ability to work substantially impacts transgender health. In particular, those who have been fired due to anti-transgender bias and those who have done sex work, drug sales, or other work in the underground economy are much more likely to experience health risks that are shown to lead to poorer health outcomes.

Discrimination in the health care system presents major barriers to care for transgender people and yet a majority of our survey participants were able to access some transition-related care, with 75% receiving counseling and 62% obtaining hormones. Genital surgery, on the other hand, remains out of reach for a large majority, despite being desired by most respondents. This is one important reason why legal rights for transgender people must never be determined by surgical status.

*“I saw a doctor in New York and told her how I wanted [chest surgery]. She looked at me sternly and said, ‘I can’t believe you are wasting my time. Do you know what your problem is? You just want to be a boy. You want to be a boy and that’s never gonna happen so just do yourself a favor and get over it.’ Then she left the room abruptly. I grabbed my things and bolted down the street, feeling like the biggest freak in the world.”*

## RECOMMENDATIONS FOR HEALTH

- Anti-transgender bias in the medical profession and U.S. health care system has catastrophic consequences for transgender and gender non-conforming people. This study is a call to action for the medical profession:
  - The medical establishment should fully integrate transgender-sensitive care into its professional standards, and this must be part of a broader commitment to cultural competency around race, class, and age;
  - Doctors and other health care providers who harass, assault, or discriminate against transgender and gender non-conforming patients should be disciplined and held accountable according to the standards of their professions.
- Public and private insurance systems should cover transgender-related care; it is urgently needed and is essential to basic health care for transgender people.
- Ending violence against transgender people should be a public health priority, because of the direct and indirect negative effect it has on both victims and on the health care system that must treat them.
- Medical providers and policy makers should never base equal and respectful treatment and the attainment of appropriate government-issued identity documents on:
  - Whether an individual has obtained surgery, given that surgeries are financially inaccessible for large majorities of transgender people because they are rarely covered by either public or private insurance;
  - Whether an individual is able to afford or attain proof of citizenship or legal residency.
- Rates of HIV infection, attempted suicide, drug and alcohol abuse, and smoking among transgender and gender non-conforming people speak to the overwhelming need for:
  - Transgender-sensitive health education, health care, and recovery programs;
  - Transgender-specific prevention programs.
- Additional data about the health outcomes of transgender and gender non-conforming people is urgently needed:
  - Health studies and other surveys need to include gender identity as a demographic category;
  - Information about health risks, outcomes and needs must be sought specifically about transgender populations;
  - Transgender people should not be put in categories such as “men who have sex with men” (MSM) as transgender women consistently are and transgender men sometimes are. Separate categories should be created for transgender women and transgender men so HIV rates and other sexual health issues can be accurately tracked and researched.

**EXHIBIT 4**



Center for American Progress



# The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial

By Sharita Gruberg and Frank J. Bewkes March 7, 2018

After six years and nearly 25,000 public comments, the U.S. Department of Health and Human Services (HHS) issued a rule in May 2016 to implement Section 1557 of the Affordable Care Act (ACA), clarifying that discrimination based on sex stereotyping and gender identity is impermissible sex discrimination under the law.<sup>1</sup> This position was in line with growing case law to support prohibitions against sex discrimination covering LGBTQ people.<sup>2</sup>

In December 2016, however, the U.S. District Court for the Northern District of Texas issued a nationwide injunction prohibiting HHS from enforcing the regulation's prohibition on discrimination on the basis of gender identity, and, to date, the current administration has failed to defend the regulation.

Franciscan Health, formerly Franciscan Alliance Inc., is a religiously affiliated health care alliance. Along with eight states and two other private health care providers, it sued HHS over the regulation.<sup>3</sup> They alleged that doctors would be forced against their will to perform medical procedures that are contrary to their religious beliefs and that they believe are harmful to the patient. Most specifically, they objected to providing medical treatments related to gender transition, especially for children. The rule implementing Section 1557 requires providers to offer medically necessary health care services to transgender people if those services are within their scope of practice. Franciscan Alliance claimed that following their beliefs and performing procedures for some people, such as mastectomies for cancer patients, but not others, such as "top surgery" for transgender patients, would open them to liability. Due to this concern, they even went so far as to claim that doctors would be forced to cease providing certain medical care treatments for all patients in order to exempt themselves from providing transition-related care to which they have a religious objection.

To learn more about the nature of anti-LGBTQ discrimination in health care and HHS's enforcement of Section 1557's protections for LGBTQ people, the Center for American Progress conducted an analysis of closed complaints of discrimination based on sexual orientation, sex stereotyping related to sexual orientation, and gender identity. HHS received

these complaints prior to the injunction. The analysis revealed that the majority of patients who filed such complaints of discrimination with HHS had not been denied care related to gender transition. Rather, transgender patients who filed complaints were often denied in general, unrelated to transition-related treatments, solely because of their gender identity.

This finding is significant, because Franciscan Alliance’s stated concern in *Franciscan Alliance v. Burwell* is that the implementation of Section 1557 would force its doctors to help patients with gender transition care. But the data show that health care providers most often discriminate against transgender people simply for being who they are—not based on the care they need. With the majority of discrimination complaints grounded in gender identity rather than gender transition, the desire of opponents—including Franciscan Alliance—to undo Section 1557’s protections for transgender people would have sweeping consequences and possibly indicates an underlying animus toward transgender people generally. CAP’s analysis of these claims indicates that, if successful for Franciscan Alliance, *Franciscan Alliance v. Burwell*’s attack on gender identity discrimination protections would allow many forms of discrimination against patients—such as refusing to use proper pronouns and to provide reproductive health care simply because a person’s gender presentation does not match their ID or records—and undermine the quality of care for many people while increasing litigation costs for providers.

Thankfully, a different federal court ruled in September 2017 that discrimination on the basis of gender identity is sex discrimination prohibited under Section 1557 itself.<sup>4</sup> This ruling affirmed that transgender individuals can go directly to court, rather than file gender identity discrimination complaints through the administrative procedures of the Office of Civil Rights (OCR) at HHS.<sup>5</sup> Since gender identity discrimination is prohibited sex discrimination under the ACA itself, the administration should not amend the rule interpreting Section 1557 in response to *Franciscan Alliance*; to the contrary, it should continue to defend the rule and fight to overturn the injunction.

---

## Section 1557’s nondiscrimination protections

Section 1557 prohibits discrimination by any health program or activity receiving federal assistance; health programs and activities administered by HHS; and marketplaces under the ACA, on the basis of race, color, national origin, sex, age, or disability.<sup>6</sup> The definition of what constitutes sex discrimination in Section 1557 is informed by the prohibitions against sex discrimination in Title IX of the Education Amendments of 1972, as well as Title VII of the Civil Rights Act of 1964.<sup>7</sup> The courts have clarified that discrimination on the basis of gender identity is sex discrimination, despite the stance of the Trump administration.<sup>8</sup> In other words, as a federal court recently found, “Because Title VII, and by extension Title IX, recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex, the Court interprets the ACA to afford the same protections.”<sup>9</sup> (see text box) The ACA offers protections regardless of the status of its implementing regulations.

## Prescott v. Rady Children's Hospital-San Diego

In September 2017, the U.S. District Court for the Southern District of California ruled on *Prescott v. Rady Children's Hospital-San Diego*, a case brought by a mother on behalf of her deceased transgender son.<sup>10</sup> Kyler, her son, had battled with gender dysphoria, depression, and suicidal ideation. His mother sought help at Rady Children's Hospital-San Diego (RCHSD), where hospital staff proceeded to repeatedly misgender Kyler. Unfortunately, RCHSD did not correct the behavior after it was brought to light by Kyler's mother; instead, it discharged Kyler from psychiatric hold early. Kyler died by suicide a month later. The court's ruling in this case was in response to an order on a motion to dismiss, so the merits of Kyler's mother's claim that her son was discriminated against were not addressed. The court did, however, hold that the discrimination claim based on Kyler's transgender identity arose from the language of the ACA itself, rather than the implementing regulation, and that the claim was plausible.

To provide further clarity on the nature of the protections afforded by the ACA, HHS issued a rule that interpreted the sex discrimination prohibition in Section 1557 to prohibit discrimination based on sex stereotyping and gender identity.<sup>11</sup> There is growing case law to support prohibitions against sex stereotyping, including sexual orientation discrimination.<sup>12</sup> The rule specifies that insurers are prohibited from denying or limiting health insurance or coverage because of someone's gender identity; that there cannot be a categorical exclusion from insurance coverage for transition-related care; and that if health services are ordinarily available to individuals of a certain sex, they cannot be denied to a transgender person for whom they are medically relevant. For example, a gynecologist cannot refuse to perform a Pap test or mammogram on a transgender man. The rule is in line with what the vast majority of insurers have already done. A 2017 study of 71 insurers in 18 states found that 90 percent of insurers did not include transgender-specific exclusions and nearly one-third affirmatively stated that medically necessary treatment for gender dysphoria is covered.<sup>13</sup> The rule also clarifies that persistently and intentionally refusing to use a transgender person's correct name and gender pronoun constitutes impermissible harassment on the basis of sex and that transgender people must have access to facilities and programs consistent with their gender identity.

The OCR is charged with accepting and investigating complaints under Section 1557. The statute also provides a private right of action, allowing individuals who experience discrimination to file a lawsuit under Section 1557.

Even without a formal finding of discrimination, the OCR can work with health care providers to take proactive steps to ensure LGBTQ patients are protected from discrimination like it did with The Brooklyn Hospital Center. In July 2015, the OCR reached a voluntary settlement agreement with The Brooklyn Hospital Center after a transgender

woman filed a complaint with the office that the hospital violated Section 1557 when it assigned her to a double occupancy patient room with a man despite her gender identity.<sup>14</sup> The hospital agreed to adopt new nondiscrimination policies and train employees on compliance with those policies.<sup>15</sup>

---

### Analysis of sexual orientation and gender identity discrimination complaints under Section 1557

On January 24, 2017, CAP submitted a Freedom of Information Act (FOIA) request to HHS for complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the ACA from March 23, 2010, to January 20, 2017. In response, CAP received information about a subset of complaints that were received by the agency and were closed—a total of 34 complaints from 2012 through 2016. Review of the documents, however, indicated that the Brooklyn Hospital Center case was not among the complaints provided. These FOIA data do not reflect complaints that remain open or that have been held without action based on the *Franciscan Alliance* litigation. In the final rule interpreting Section 1557, HHS estimated that, each year, it receives a total of 15 to 20 Section 1557 complaints that cannot be filed under other statutes. HHS, however, predicted this number would increase following publication of the proposed rule.<sup>16</sup> Among the complaints, which sometimes had more than one issue claim, there were 31 claims involving gender identity discrimination and six involving sexual orientation discrimination.<sup>17</sup> In two instances, HHS completed its investigation and found the complaints were substantiated; in other words, HHS issued actual findings of discrimination. Most of the closed complaints resulted in the subject of the complaint taking voluntary corrective action. In 22 cases, the covered entity worked with HHS to institute trainings or change policies or HHS provided technical assistance to address the complaint.

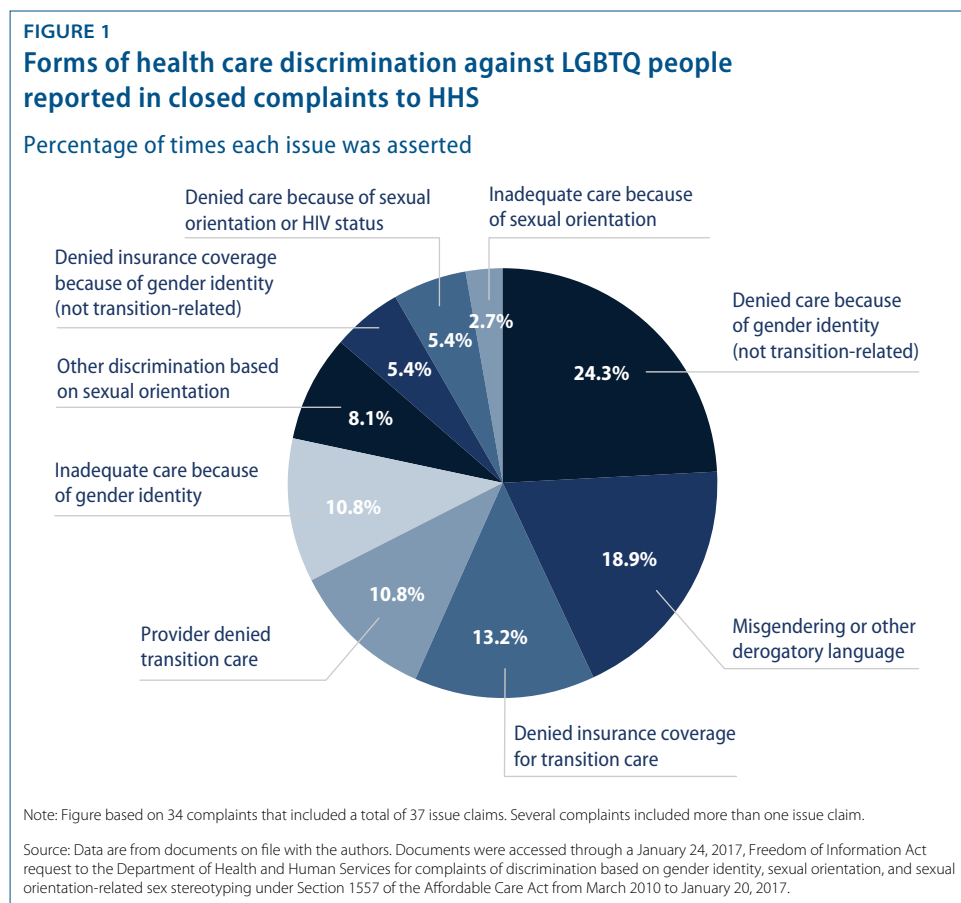
### Most complaints involved denials of care or insurance coverage because of a person's gender identity

The most common complaints involved individuals being denied care because of their gender identity or transgender status. There were 13 such closed complaints among the 31 complaints involving gender identity discrimination that CAP reviewed. Complaints included a transgender woman being denied a mammogram because of her gender identity; transgender people being denied sexual assault medical forensic examinations; and a transgender man being refused a screening for a urinary tract infection because the clinic claimed it only provided those screenings to women.

One of the next most common complaints involved people being denied insurance coverage because of their gender identity. Five of these complaints were denials of coverage for transition-related care; however, there was one incident of an individual who was

refused insurance coverage for reproductive health care because of his gender identity and another because the insurer would only cover genetic testing for breast cancer for women and not for a transgender man—despite the fact that the testing was recommended by the complainant’s doctor.

- Additional examples of discrimination in the complaints include:<sup>18</sup>
- A transgender woman went to the hospital with cold symptoms, but her care was delayed because of repeated questions about her gender identity and inappropriate questions about her anatomy at intake.
- A transgender woman with a disability was repeatedly harassed by the driver of a medical transport service that took her to and from her doctor’s appointments.
- A woman was separated from her wife during an emergency room visit and her wife was not permitted to enter her room for more than two hours.
- While recovering from an appendectomy, the doctor treating a transgender woman refused to call her by the correct pronouns and said the doctor does not deal with “these kinds” of patients.<sup>19</sup>



Many complaints were resolved through voluntary corrective action rather than costly litigation

The plaintiffs in *Franciscan Alliance* claimed that they feared facing costly litigation as a result of the rule. However, what the available complaints show is that HHS overwhelmingly worked with the subject of the complaint to amend policies and implement trainings to teach staff how to treat transgender patients without discrimination, rather than taking them to court. This was true for all cases involving the misgendering of patients—seven of the 37 closed issue claims CAP reviewed—and for nearly all cases involving coverage or provision of transition-related care—11. HHS investigations had uncovered evidence to substantiate two of the complaints CAP obtained. In one of two complaints, a receptionist told a transgender person the clinic would not perform surgery because the “Lord does not approve.”<sup>20</sup> After the complaint was filed and HHS investigated, the clinic offered to proceed with the surgery, updated its nondiscrimination policy, formulated new policies on transgender health care, and trained its staff on the policy. While the *Franciscan Alliance* litigation relied heavily on hypothetical scenarios—and misstatements of accepted medical standards of care—regarding transgender children, none of the complaints CAP reviewed involved transition-related care for a minor.<sup>21</sup>

Finally, beyond the outright denial of care, there were five complaints involving patients who alleged receiving substandard care because of their sexual orientation or gender identity. These involved situations where someone’s care was delayed or they were released from a hospital prematurely. In these instances, the subjects of the complaints took voluntary corrective action and trained their staff on nondiscrimination obligations under the law and LGBTQ cultural competency. There were also two complaints of people being treated differently because their spouse was the same sex. In these cases, the subjects of the complaints also voluntarily trained staff or changed their record-keeping policies to ensure all married couples were treated the same.

In the two instances CAP reviewed where the complaints were substantiated by HHS, the subjects of the complaints also took corrective actions. In addition to the case mentioned above, an individual was denied a flu shot because they were HIV-positive. In this case it was determined they were discriminated against on the basis of having a disability.

Finally, contrary to assertions made by the plaintiffs in *Franciscan Alliance*, in no case did HHS threaten to sue or withhold federal funding, nor did it order a health care professional to perform a service against their medical judgment.

---

## Conclusion

Reviewing this subset of Section 1557 complaints resolved by HHS shows that the enforcement of the statute was working well to resolve very real issues of discrimination, and that the fears raised by the *Franciscan Alliance* lawsuit are not well-founded.



Research shows that discrimination affects whether transgender people are able to receive timely, quality care, as well as the willingness of transgender people to seek care in the future. A survey by CAP found 23.5 percent of transgender respondents avoided doctor's offices in the past year out of fear of facing discrimination.<sup>22</sup> Robust enforcement of the ACA's nondiscrimination protections reassures these Americans that they will not be refused for discriminatory reasons.

Contrary to the findings of the Texas court in *Franciscan Alliance*,<sup>23</sup> Section 1557's implementing rule simply creates a regulatory structure and administrative process for enforcing what the ACA already requires. A claim for anti-transgender discrimination already existed under the ACA. The implementing rule is important, because its administrative procedures enable victims to seek redress without the costs and time associated with litigation. The present analysis suggests that this process has often worked well for those who have availed themselves of it.

As *Franciscan Alliance v. Burwell* proceeds, the ACA's protections remain in effect and continue to be critical for addressing the well-documented health disparities facing LGBTQ people.<sup>24</sup> However, due to costs of litigation and the apparent success of the closed administrative claims, it is vital that the administrative process remain an avenue for addressing discrimination grievances. Unfortunately, HHS indicated in recent court filings that rather than preserving this critical mechanism for protecting LGBTQ people from discrimination, it is rewriting the rule and likely removing explicit protections for LGBTQ people.<sup>25</sup> HHS also recently announced that it will open a separate civil rights office that is solely focused on defending religious refusals to provide health care. HHS' recent actions do not signal a commitment to protecting all Americans' access to care. Rather, they further underline the Trump administration's commitment to undermining the basic rights, health, and well-being of LGBTQ people.<sup>26</sup>

*Sharita Gruberg is the associate director of the LGBT Research and Communications Project at the Center for American Progress. Frank J. Bewkes is a policy analyst for the LGBT Research and Communications Project at the Center.*

*The authors would like to thank Jocelyn Samuels, Sunu Chandu, Kelli Garcia, Harper Jean Tobin, Kellan Baker, and Katie Keith for reviewing and providing feedback on this issue brief.*

## Endnotes

- 1 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities," *Federal Register* 81 (96) (2016), available at <https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities>; Kellan Baker, "LGBT Protections In Affordable Care Act Section 1557," *Health Affairs*, June 6, 2016, available at <http://www.healthaffairs.org/doi/10.1377/hblog20160606.055155/full/>.
- 2 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities." See, for example, *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004), available at [https://scholar.google.com/scholar\\_case?case=988234023344471066&q=Smith+v.+City+of+Salem,+378+F.3d+566&hl=en&as\\_sdt=20006&as\\_vis=1](https://scholar.google.com/scholar_case?case=988234023344471066&q=Smith+v.+City+of+Salem,+378+F.3d+566&hl=en&as_sdt=20006&as_vis=1).
- 3 See *Franciscan Alliance Inc. v. Burwell*, 227 F.Supp.3d 660 (N.D. Tex., 2016).
- 4 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756 (S.D. Cal., 2017), available at <https://www.court-news.com/wp-content/uploads/2017/09/Trans-Rady-MTD-ORDER.pdf>.
- 5 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756 (S.D. Cal., 2017).
- 6 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities."
- 7 Legal Information Institute, "42 U.S. Code § 18116 – Nondiscrimination," available at <https://www.law.cornell.edu/uscode/text/42/18116> (last accessed February 2018).
- 8 See, for example, *Whitaker v. Kenosha Unified School District*, 858 F.3d 1034 (7th Cir. 2017), available at <http://media.ca7.uscourts.gov/cgi-bin/rssExec.pl?Submit=Display&Path=Y2017/D05-30/C:16-3522:J:William:aut:T:fnOp:N:1971382:S:0> (Title IX and Equal Protection Clause); *Dodds v. U.S. Department of Education*, 845 F.3d 217 (6th Cir. 2016), available at <http://www.opn.ca6.uscourts.gov/opinions.pdf/16a0291p-06.pdf> (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), available at <http://caselaw.findlaw.com/us-6th-circuit/1413440.html>; *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. Department of Health and Human Services*, 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 and Parents for Privacy v. U.S. Department of Education*, No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); *Mickens v. General Electric Co.* No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); *Fabian v. Hospital of Central Connecticut*, 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); *United States v. Southeast Oklahoma State University*, No. CIV–15–324–C, 2015 WL 4606079 (Title VII); *Finkle v. Howard County*, 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 and Diagnostic Group, 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); *Tronetti v. Healthnet Lakeshore Hospital*, No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII). But see *Etsitty v. Utah Transit Authority*, 502 F.3d 1215 (10th Cir. 2007) (relying on now-overturned U.S. Court of Appeals for the 7th Circuit precedent to hold that anti-transgender discrimination is not covered per se under Title VII but may be covered as sex stereotyping discrimination).
- 9 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756, at \*4 (S.D. Cal., 2017).
- 10 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756 (S.D. Cal., 2017).
- 11 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities."
- 12 See, for example, *Hively v. Ivy Tech Community College of Indiana* 853 F.3d 339 (7th Cir. 2017), available at <http://media.ca7.uscourts.gov/cgi-bin/rssExec.pl?Submit=Display&Path=Y2017/D04-04/C:15-1720:J:W:ood:aut:T:fnOp:N:1942256:S:0>; *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004), available at [https://scholar.google.com/scholar\\_case?case=988234023344471066&hl=en&as\\_sdt=6&as\\_vis=1&oi=scholar](https://scholar.google.com/scholar_case?case=988234023344471066&hl=en&as_sdt=6&as_vis=1&oi=scholar); *Koren v. Ohio Bell Telephone Co.*, 894 F. Supp. 2d 1032, 1038 (N.D. Ohio 2012), available at [http://courtweb.pamd.uscourts.gov/courtwebsearch/ndoh/Ydlx\\_0N8uG.pdf](http://courtweb.pamd.uscourts.gov/courtwebsearch/ndoh/Ydlx_0N8uG.pdf); *Heller v. Columbia Edgewater Country Club*, 195 F. Supp. 2d 1212, 1223 (D. Or. 2002), available at [https://scholar.google.com/scholar\\_case?case=12565249645123009449&hl=en&as\\_sdt=6&as\\_vis=1&oi=scholar](https://scholar.google.com/scholar_case?case=12565249645123009449&hl=en&as_sdt=6&as_vis=1&oi=scholar).
- 13 Out2Enroll, "Summary of Findings: 2018 Marketplace Plan Compliance with Section 1557," available at <https://out2enroll.org/out2enroll/wp-content/uploads/2017/11/Overview-of-Trans-Exclusions-in-2018-Marketplace-Plans-1.pdf> (last accessed February 2018).
- 14 Sam P.K. Collins, "How Obamacare Is Helping Protect Trans People's Right To Health Care," ThinkProgress, July 15, 2015, available at <https://thinkprogress.org/how-obamacare-is-helping-protect-trans-peoples-right-to-health-care-d79fa20034bf/>.
- 15 U.S. Department of Health and Human Services, *Voluntary Resolution Agreement Between the U.S. Department of Health and Human Services Office for Civil Rights and the Brooklyn Hospital Center* (2015), available at <https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBHC/vra.pdf>.
- 16 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities."
- 17 One case in CAP's FOIA response was an employment discrimination case that was submitted to the wrong agency and was not included in the authors' totals. Data are from documents on file with authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the U.S. Department of Health and Human Services for copies of de-identified complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 23, 2010 to January 20, 2017.
- 18 Data are from documents on file with authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the U.S. Department of Health and Human Services for copies of de-identified complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 23, 2010 to January 20, 2017.
- 19 Data from documents are on file with authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the U.S. Department of Health and Human Services for copies of de-identified complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 23, 2010 to January 20, 2017.
- 20 *Ibid.*

- 21 But see *Cruz et al v. Zucker*, 218 F.Supp.3d 246, 247 (S.D.N.Y., 2016), available at <https://cases.justia.com/federal/district-courts/new-york/nysdce/1:2014cv04456/428588/134/0.pdf?ts=1467894220>, which finds that New York State's age exclusion for Medicaid coverage of transition-related care violated Section 1557 and Title XIX of the Social Security Act, based in part on published clinical standards and expert testimony supporting coverage.
- 22 Sejal Singh and Laura Durso, "Widespread Discrimination Continues to Shape LGBT People's Lives in Both Subtle and Significant Ways," Center for American Progress, May 2, 2017, available at <https://www.americanprogress.org/issues/lgbt/news/2017/05/02/429529/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways/>.
- 23 *Franciscan Alliance, Inc. et al v. Burwell*, 227 F.Supp.3d 660 (N.D. Tex., 2016), available at <https://www.clearinghouse.net/chDocs/public/PB-TX-0012-0003.pdf>.
- 24 Sandy E. James and others, "The Report of the 2015 U.S. Transgender Survey" (Washington: National Center for Transgender Equality, 2016), available at <http://www.ustranssurvey.org>; Kellan Baker and others, "The Senate Health Care Bill Would Be Devastating for LGBTQ People," Center for American Progress, July 6, 2017, available at <https://www.americanprogress.org/issues/lgbt/news/2017/07/06/435452/senate-health-care-bill-devastating-lgbtq-people/>; Lambda Legal, "When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV" (2010), available at <https://www.lambdalegal.org/publications/when-health-care-isnt-caring>; Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Washington: National Academies Press, 2011), available at <https://www.ncbi.nlm.nih.gov/books/NBK64806/>.
- 25 Equality Case Files, "7:16-cv-00108 #11," available at <http://files.eqcf.org/cases/716-cv-00108-11/> (last accessed February 2018).
- 26 U.S. Government Publishing Office, "83 FR 2802 – Statement of Organization, Function, and Delegations of Authority," January 19, 2018, available at <https://www.gpo.gov/fdsys/granule/FR-2018-01-19/2018-00820>.

# **EXHIBIT 5**

Morning Mix

# Pediatrician refuses to treat baby with lesbian parents and there's nothing illegal about it

By **Abby Phillip** February 19, 2015

A Michigan pediatrician declined to treat the infant daughter of a lesbian couple in yet another example of the growing tensions between advocates for LGBT rights and those who want greater religious expression protections.

Krista and Jami Contreras were eager to bring their 6-day-old infant for her first doctor visit after her birth in October. The doctor that they had carefully chosen knew they were lesbians and after the first prenatal visit, they were under the impression that everything was fine. But the morning they arrived for the appointment after baby Bay's birth, another doctor in the practice greeted them instead.

"The first thing Dr. Karam said was, 'I'll be your doctor, I'll be seeing you today because Dr. Roi decided this morning that she prayed on it and she won't be able to care for Bay,'" [Jami told WJBK](#). "Dr. Karam told us she didn't even come to the office that morning because she didn't want to see us."

[\['Relationship with Jesus' doesn't justify florist's refusal to serve gay couple, judge rules\]](#)

In [a handwritten letter](#) to the couple months later, their would-be doctor Vesna Roi explained what happened.

"After much prayer following your prenatal, I felt that i would not be able to develop the personal patient-doctor relationships that I normally do with my patients," Roi wrote in her letter on Feb. 9. "I felt that it was an exciting time for the two of you and I felt that if I came in and shared my decision it would take away much of the excitement. That was my mistake. I should not have made that assumption and I apologize for that."

The incident has raised valid questions about whether Roi's actions were justified, ethical or even legal.

"As far as we know, Bay doesn't have a sexual orientation yet so I'm not really sure what that matters," Jami added to WJBK. "We're not your patient — she's your patient. And the fact is that your job is to keep babies healthy and you can't keep a baby

[[This Colorado baker refused to put an anti-gay message on cakes. Now she is facing a civil rights complaint.](#)]

The answer is: It depends.

Ethically speaking, the American Medical Association takes a strong stance against denying care to people because of their sexual orientation — and it is reasonable to assume, the sexual orientation of their parents.

But their ethical guidance is just that: Guidance. Doctors aren't bound by it.

“Respecting the diversity of patients is a fundamental value of the medical profession and reflected in long-standing AMA ethical policy opposing any refusal to care for patients based on race, gender, sexual orientation, gender identity or any other criteria that would constitute invidious discrimination,” said Gregory Blaschke, chair of the AMA's LGBT Advisory Committee, [in a statement to the Detroit Free Press](#).

But what about the legality of it all? Well, that depends, too.

There's no federal law prohibiting doctors or any other service providers or merchants from refusing service to gay people. And in Michigan, there's no state law prohibiting it either.

“There's no law that prohibits it,” Wayne State University constitutional law Prof. Robert Sedler [explained to the Free Press](#). “It's the same as a florist refusing to sell flowers for a same-sex wedding.”

And while [individual states](#) have taken steps to ban the practice, Michigan is considering going in exactly the opposite direction.

[[Some conservatives urging right not to serve gays on religious grounds](#)]

A House bill that would allow adoption agencies to refuse placements based on moral or religious grounds is [under consideration in the legislature](#). And last year, the Michigan House [passed a controversial “religious freedom” bill](#), but it stalled in the Senate. The bill was introduced in the state Senate in this year's [legislative session in January](#).

Backers of Michigan's “religious freedom” legislation, Michigan House Speaker James “Jase” Bolger, explained it to the [The Post's Sandhya Somashekhar this way](#):

He said he was compelled by the stories of business owners who have been punished for declining to participate in same-sex weddings, such as the couple in Upstate New York who provided their barn to gay couples for receptions but balked when asked to host a same-sex wedding ceremony. The couple was fined.



“I have been stunned at the number of Americans arguing that the only place people can practice their religion is while they’re hiding in their homes and hiding in their churches, and once they leave their home and their church they are not allowed to practice their religion,” Bolger said.

The wave of same-sex marriage legalization across the country has only emboldened conservatives to turn to legislative alternatives that would codify “religious freedoms” or their right to refuse service to gay people based on moral or religious beliefs.

Roi didn’t specify that Bay’s lesbian parents were the reason felt she couldn’t serve as her doctor. But the subtext was clear. And with no law prohibiting the practice, the couple has little choice but to accept it.

“When we started calling other pediatricians, my first thing on the phone was, we’re lesbian moms — is this okay with you?” Krista [told the Free Press](#).

 **82 Comments**

Abby Phillip is a national political reporter covering the White House for The Washington Post.

**EXHIBIT 6**

# STATUS OF LGBTQ HEALTH: SANTA CLARA COUNTY 2013

# LGBTQ Health Assessment

2

- Historically, very limited data available on LGBTQ health in Santa Clara County
- Board President Ken Yeager, State of the County 2013
- *First* health assessment of Lesbian, Gay, Bisexual, Transgender and Queer SCC residents
- Goal: understand health needs of LGBTQ residents to identify priorities, strategies, and resources to address disparities

# Timeline

3

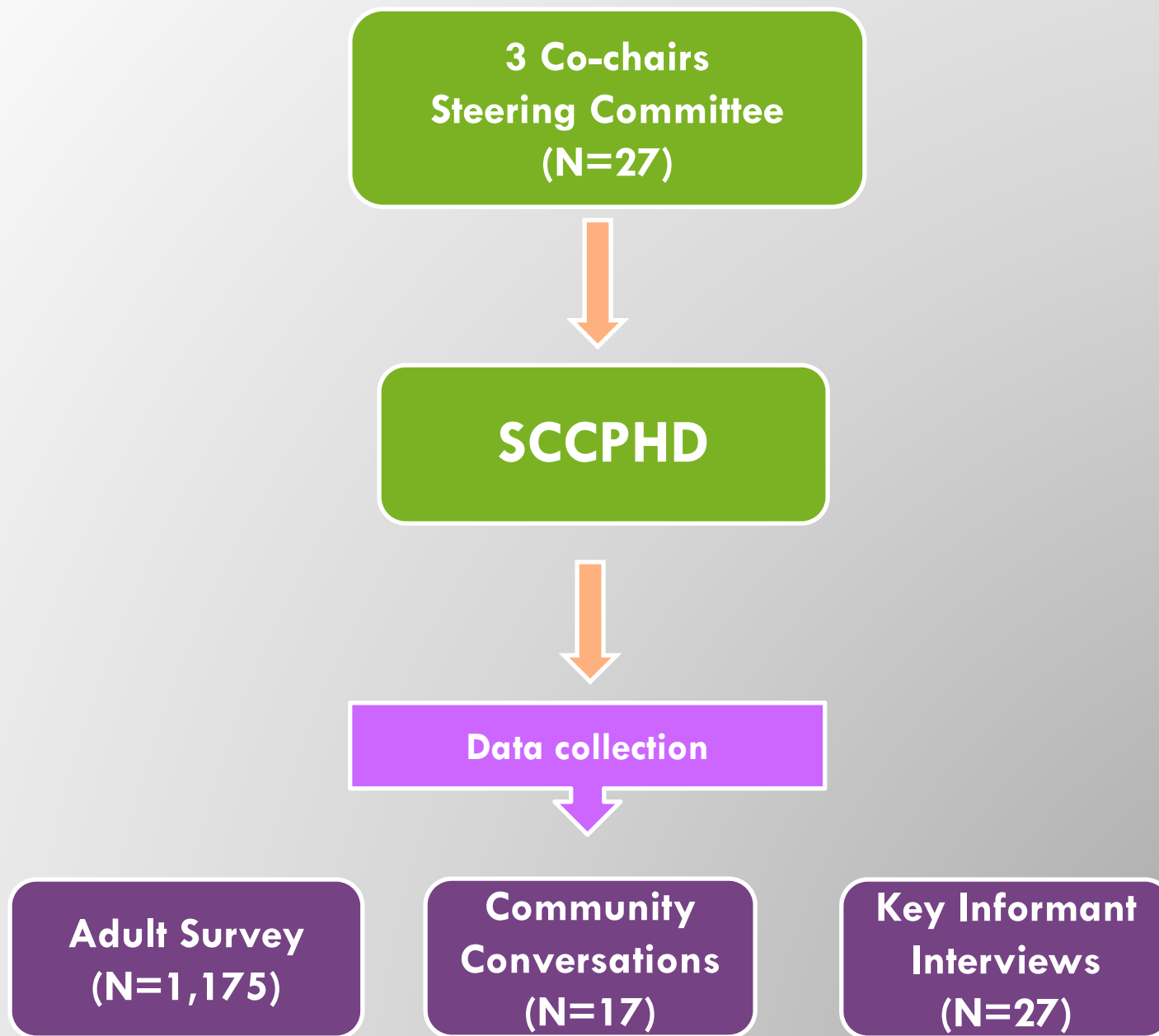
- ❑ **August 5:** First Steering Committee Meeting
- ❑ **August 17-18:** Adult paper survey administered at San Jose PRIDE
- ❑ **August 28:** Community stakeholder meeting and community conversations
- ❑ **September-October:** Online LGBTQ adult survey in English, Mandarin, Spanish & Vietnamese
- ❑ **September-November:** Key Informant Interviews and additional community conversations
- ❑ **November 14:** Community Forum (i.e. recommendations and strategy development)
- ❑ **December 20:** Final Report

# Community engagement & participation

4







# Community conversations

6

## Health and social issues

- ❑ Community connectedness and social cohesion
- ❑ Discrimination and acceptance
- ❑ Health care access and discrimination
- ❑ Families
- ❑ Outness
- ❑ Substance use and abuse
- ❑ Resiliency
- ❑ Safety
- ❑ Youth
- ❑ Mental health



### **Additional population specific conversations identified:**

Latino/a LGBTQ (in Spanish); Asian; Seniors; Lesbian; Transgender men/women; African Americans; Youth (<18)



# Key informant interviews

8

- 27 community leaders, experts, and service providers knowledge about particular issues or populations
- Similar topics as in community conversations





# Community forum

9



# SOCIODEMOGRAPHICS



# Population size and SES

11

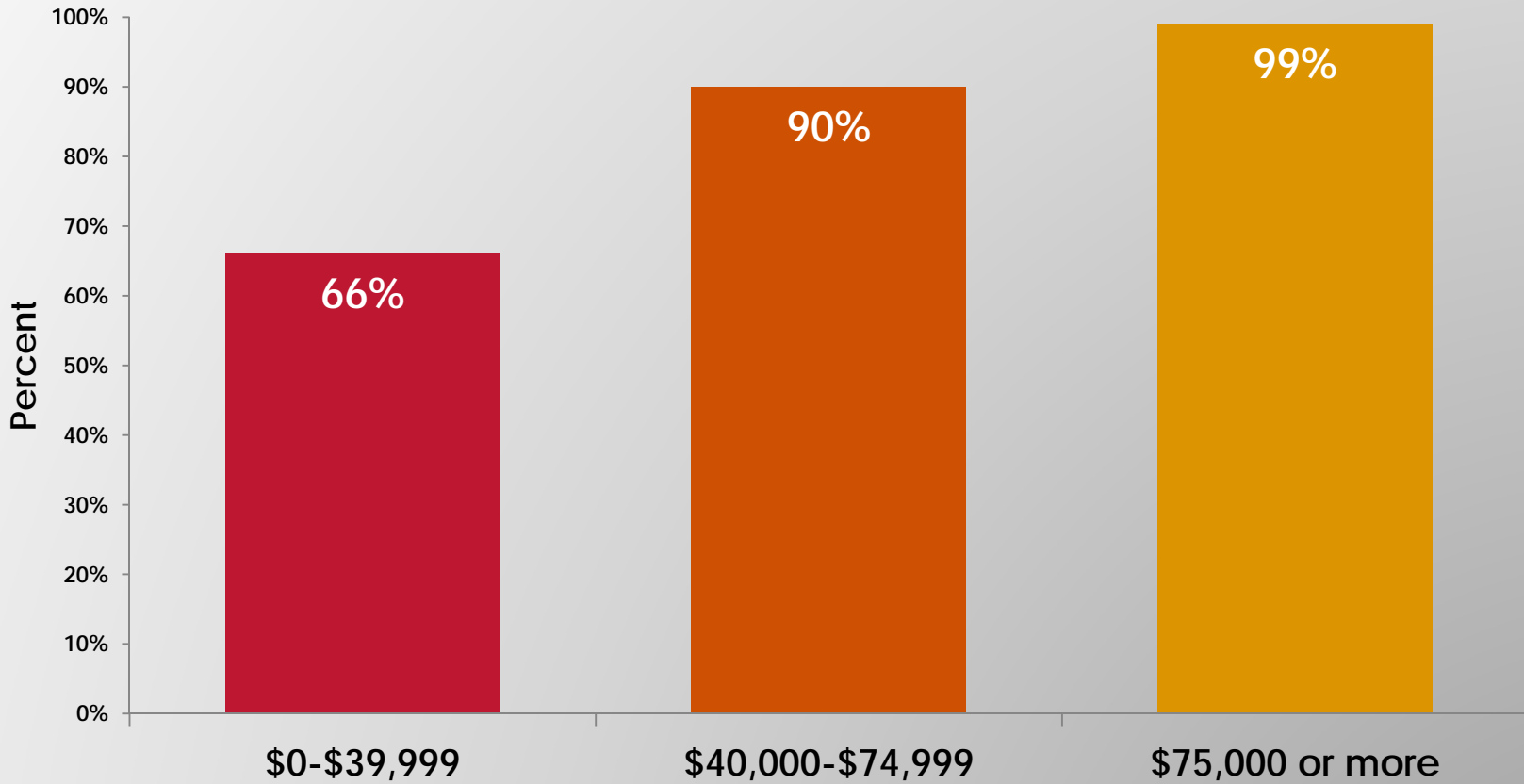
- Lesbian or gay: 31,000 adults (3% of SCC adults)
- Bisexual: 16,000 adults (1% of SCC adults)
- Transgender: 3,500 adults (based on national estimates)
- Higher education than heterosexual adults but more likely to live below 200% FPL

Source: California Health Interview Survey, 2011-12

HEALTHCARE

# Percentage of LGBTQ survey respondents with health insurance by household income

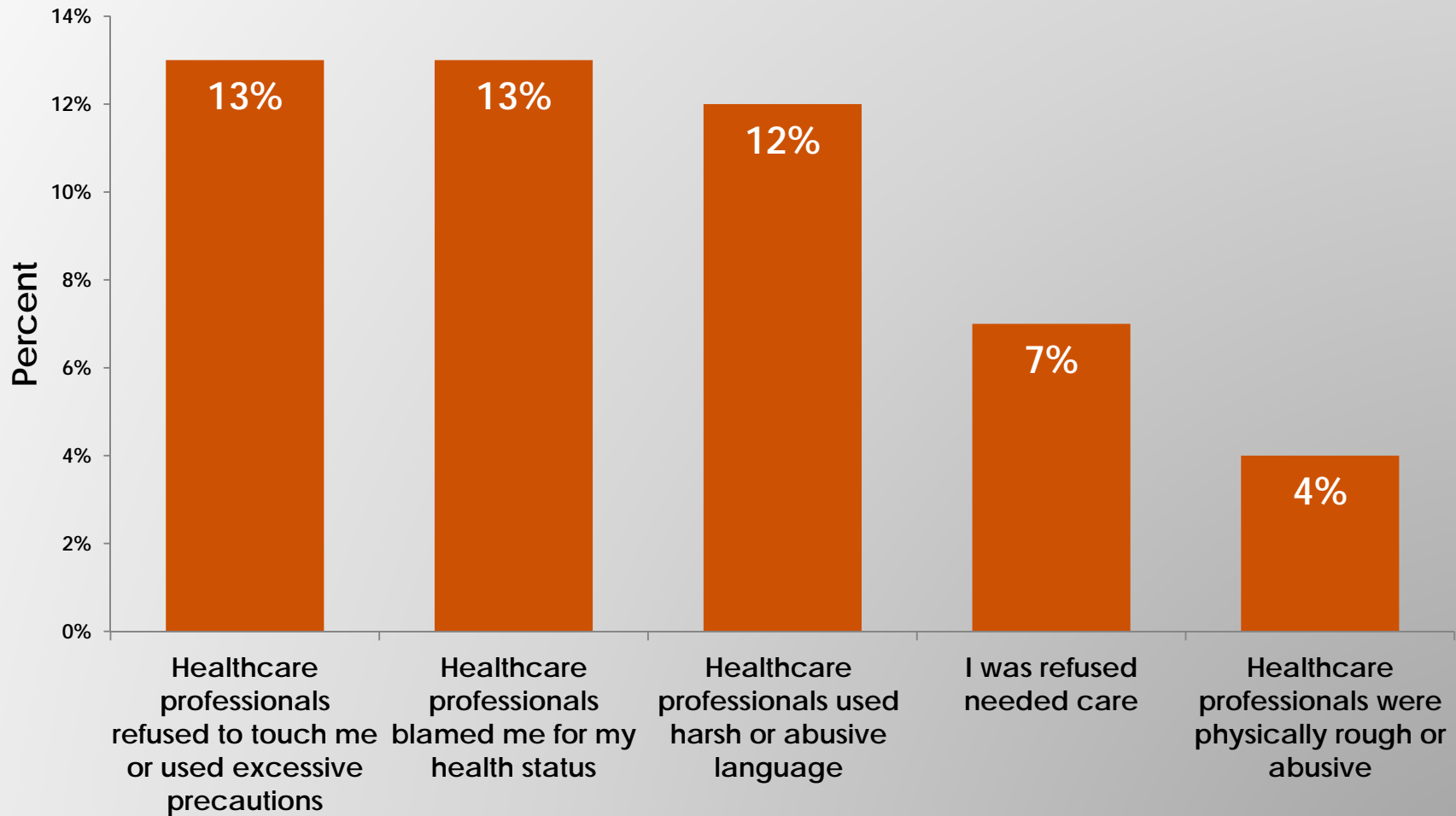
13



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

# Percentage of LGBTQ survey respondents who have experienced healthcare discrimination in the past 5 years

14



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

# Out to healthcare provider

15

## ■ By race/ethnicity:

- African American: 29%
- Asian/PI: 67%
- Latino: 66%
- White: 78%

## ■ By age:

- Ages 18-24: 56%
- Ages 25-54: 69%
- Ages 55+: 96%

Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

## In their own words: Medical provider competence

16

- ▣ *Being “LGBTQ friendly” is not enough; providers need to be “LGBTQ knowledgeable”.*
- ▣ *“It’s nice to educate our doctors [about trans issues], but I want to know that they know what they’re doing, and not just fudging a little bit and figuring it out on us.”*



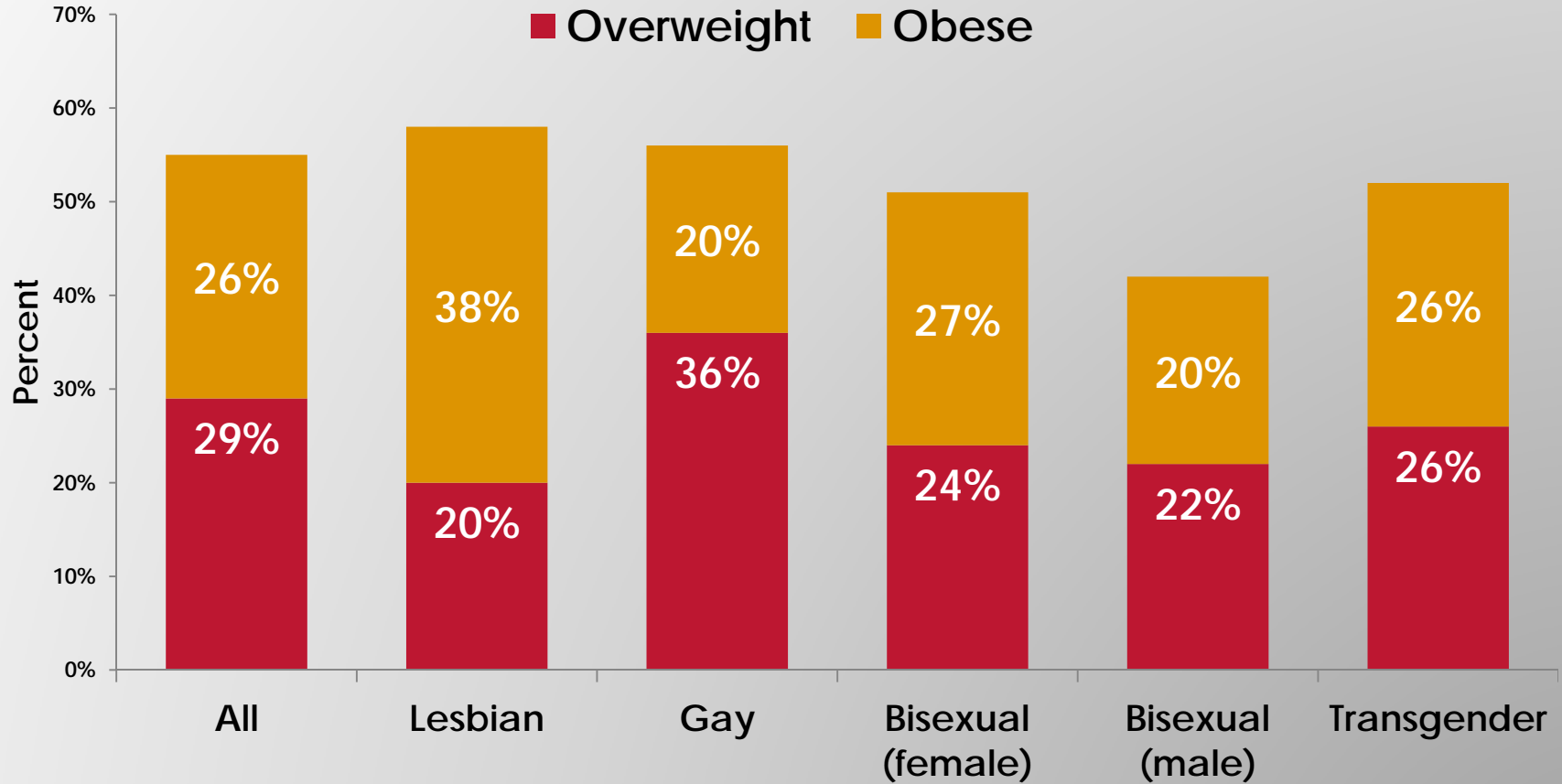
# Recommendations: Healthcare

- ❑ **Develop LGBTQ competency trainings** for all providers and staff in healthcare settings.
- ❑ **Educate LGBTQ healthcare consumers and providers about LGBTQ rights** and enforce existing nondiscrimination statutes.
- ❑ **Standardize medical forms** to include optional gender identity and sexual orientation questions to prevent unintentional discrimination.
- ❑ **Create an inventory** of LGBTQ-competent healthcare providers and conduct outreach around available services.

# GENERAL HEALTH

# Percentage of LGBTQ survey respondents who are overweight or obese

19

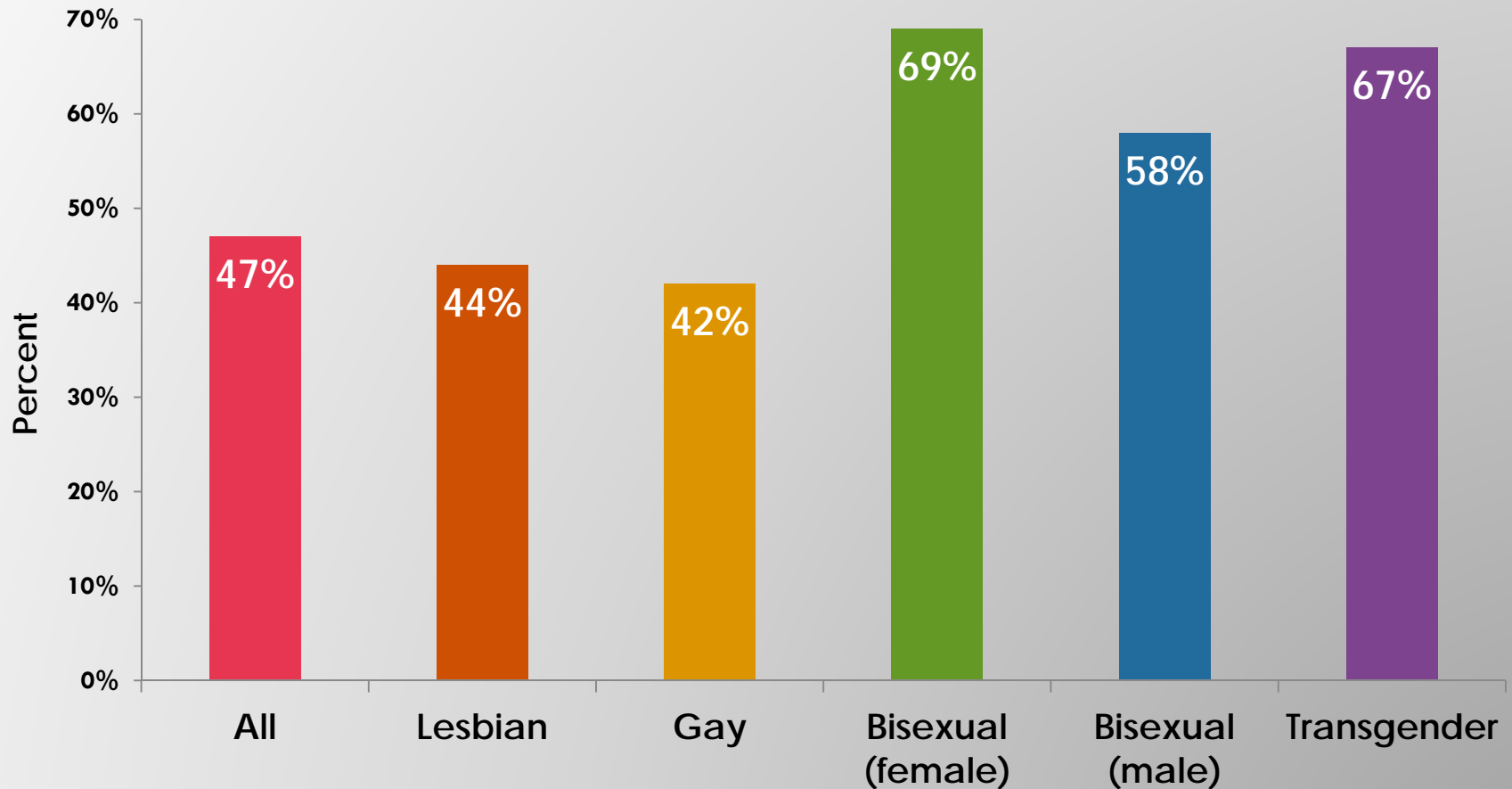


Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

# MENTAL HEALTH AND SUBSTANCE USE

## Percentage of LGBTQ survey respondents who felt that they might need to see a professional in the past 12 months because of concerns with their mental health, emotions, nerves, or use of alcohol or drugs

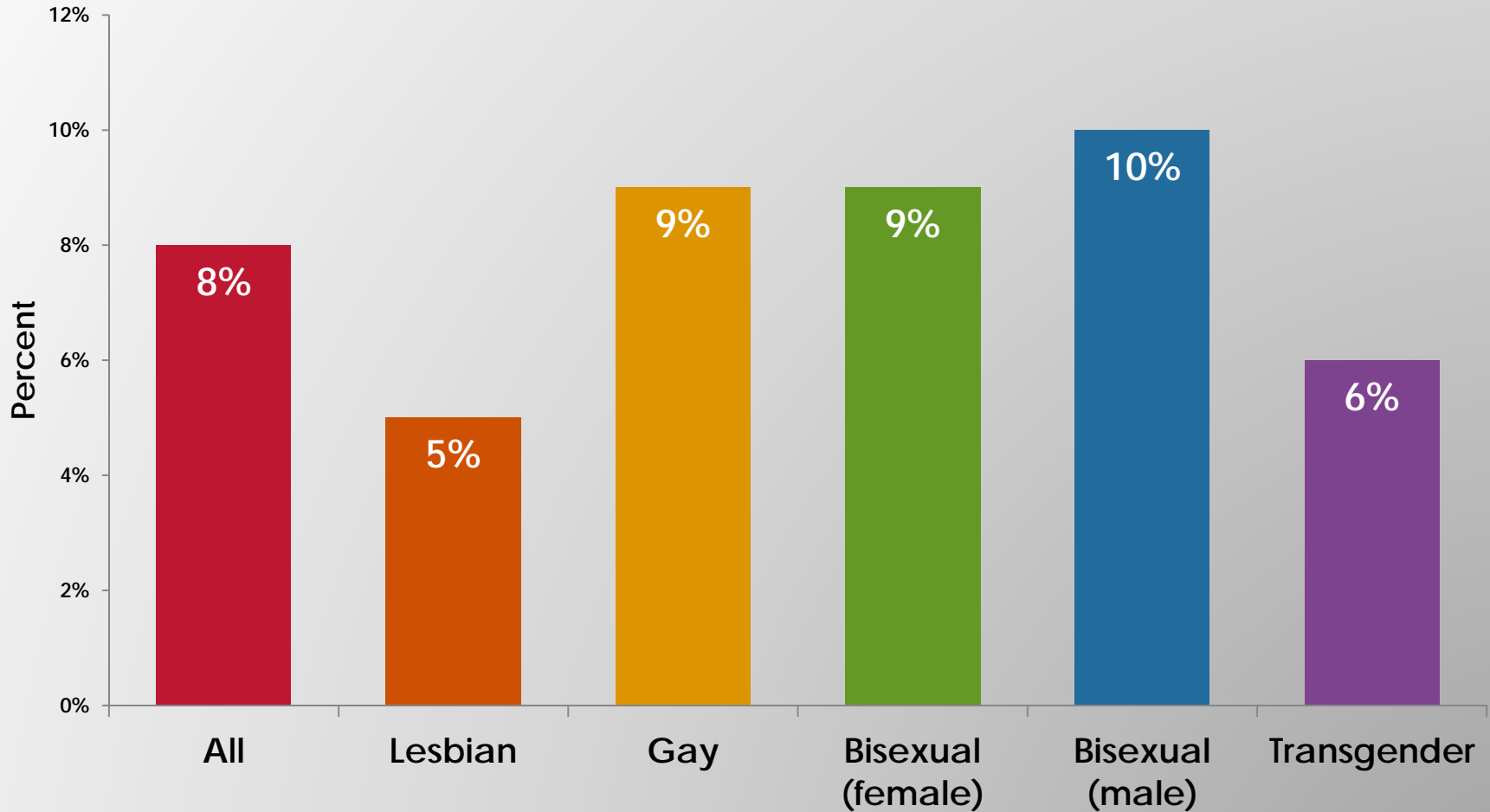
21



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

## Percentage of LGBTQ survey respondents who had ever shot up or injected any drugs other than those prescribed

22



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey



## In their voices: Mental health and substance use

23

- ❑ *Mental health and substance use among LGBTQ people are often connected to rejection, isolation from families, discrimination, and harassment.*
- ❑ *“Mental health issues are dramatically different from the straight community. Not only do you have internal struggles; there is a lot of internalized oppression and stigma.”*
- ❑ *“I had two episodes where I was near suicidal - one before transition because of the stress of that, and one after because it broke up my family.”*

# Homelessness and LGBTQ in SCC

24

- ▣ LGBTQ: 29% of the homeless < age 25
- ▣ LGBTQ: 10% of the homeless ages 25+
- ▣ Transgender: 4% of homeless < age 25
- ▣ Transgender or “other”: 2% of homeless ages 25+

Source: Santa Clara County Homeless Census and Survey, 2013

# Affordable housing and homelessness

25

- ▣ *“Everybody I know who has come out [as trans] has had some family relationship that’s been disrupted. For young people it impacts their ability to survive.”*
- ▣ *“[As a senior] there are two choices: Maintaining my identity and being isolated or going back to the closet after being out for so many years.”*

## Recommendations: Mental health and substance use

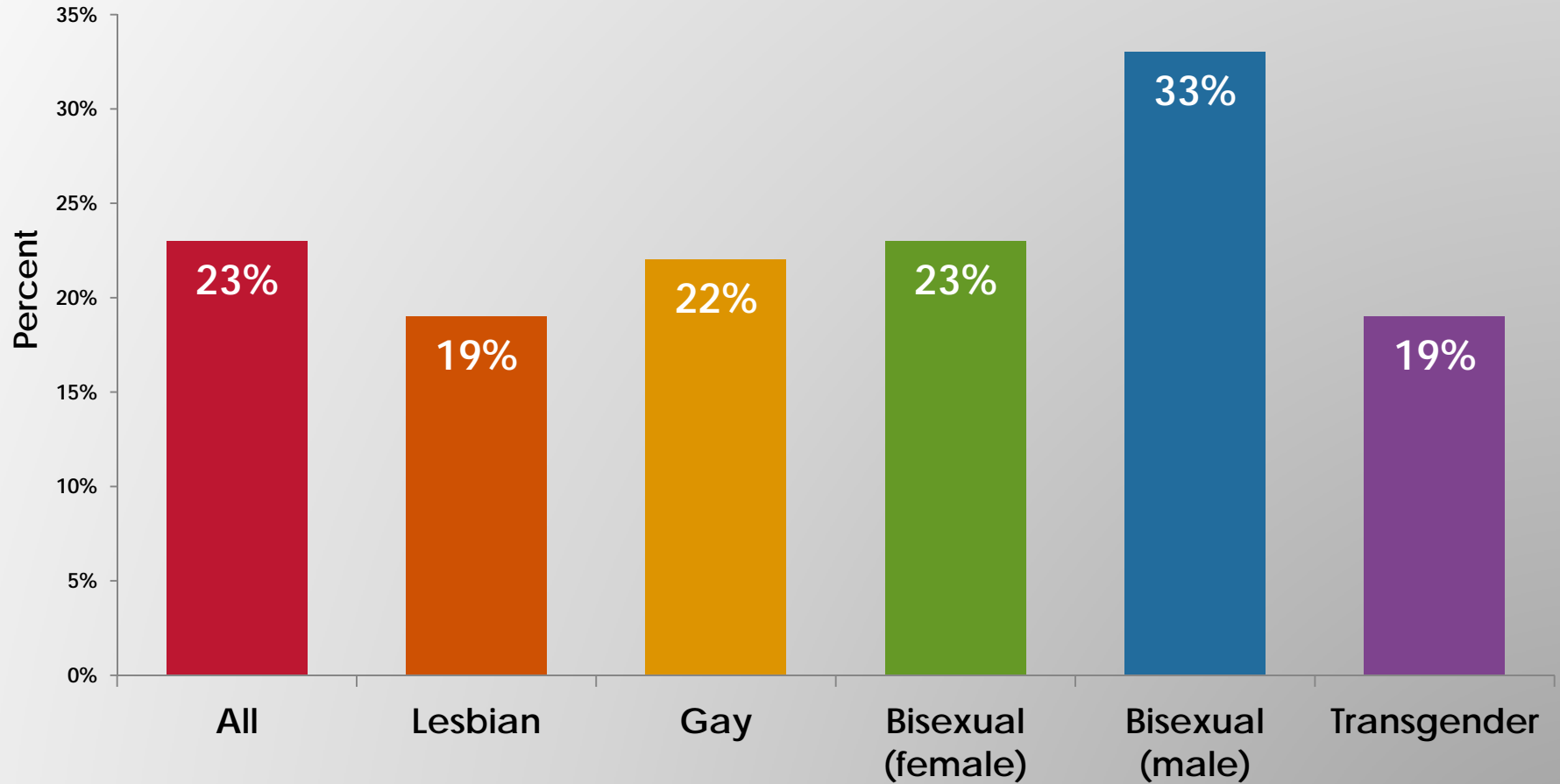
26

- ❑ **Designate the LGBTQ population as high-risk for mental health issues** in order to prioritize services and funding.
- ❑ **Develop LGBTQ-specific mental health and substance use services** to reduce barriers and mitigate fears of discrimination.
- ❑ **Provide training to ensure an LGBTQ-competent workforce** in mental health and substance use.
- ❑ **Continue targeted outreach and education** related to mental health and substance use as well as information on available services.
- ❑ **Conduct regular tobacco cessation campaigns** that target LGBTQ populations.

# TOBACCO USE

# Percentage of LGBTQ survey respondents who smoked 1 or more cigarettes in the past 7 days

28



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey



## In their voices: Tobacco use

29

- *Some participants expressed that tobacco use in the LGBTQ community, specifically smoking, is an issues of concern that should not be overlooked.*
- *Community members cited sporadic LGBTQ public health-related tobacco education campaigns, acknowledging a need for more frequent outreach and education.*

# SEXUALLY TRANSMITTED INFECTIONS AND SAFER SEX

## Testing for sexually transmitted infections

31

### **Among MSM survey respondents:**

- ▣ 21% have never been tested for HIV
- ▣ 43% have never been tested for syphilis
- ▣ 38% have never been tested for gonorrhea

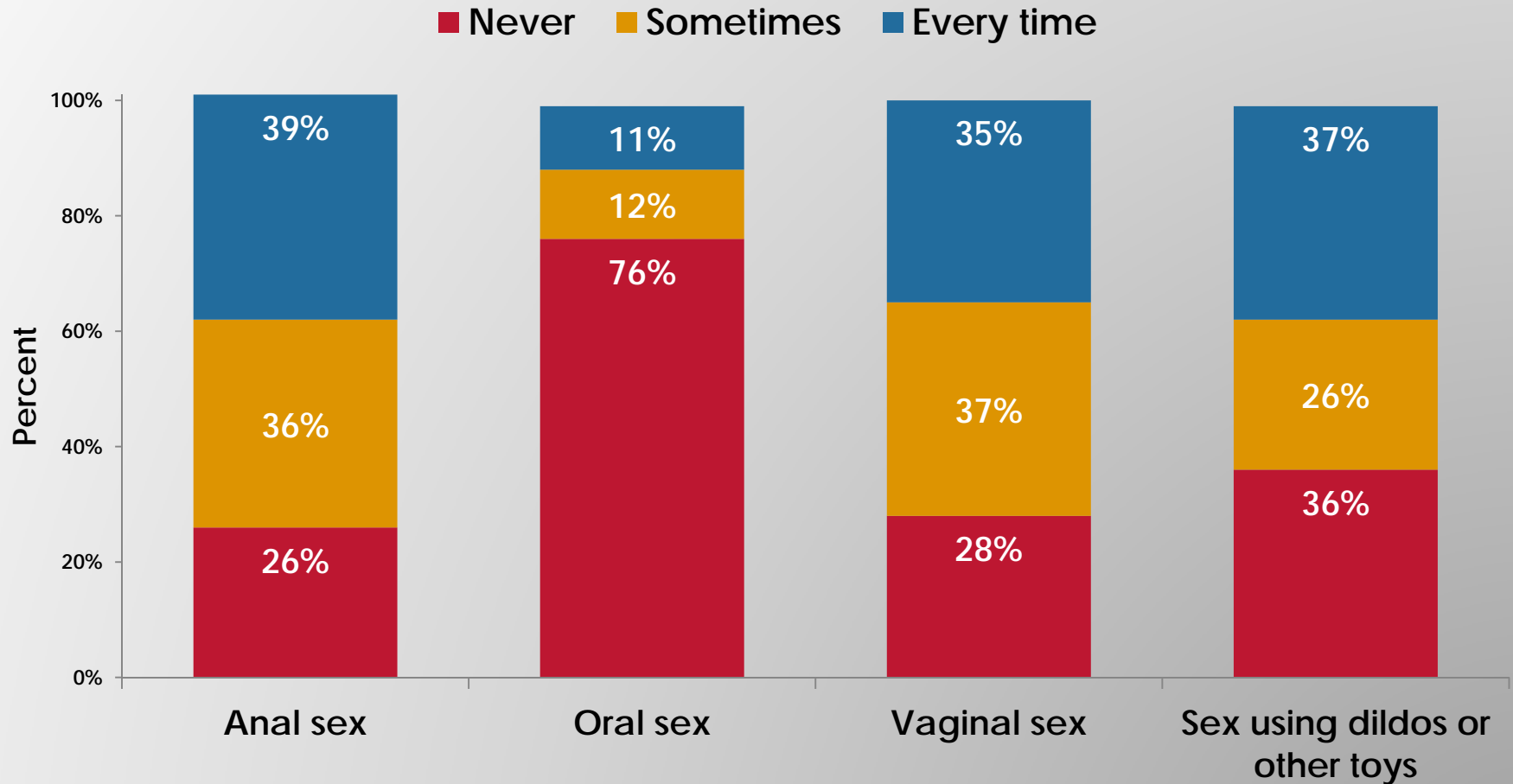
### **Among lesbian, bisexual women, and transgender survey respondents:**

- ▣ Between 34% and 40% have never been tested for HIV
- ▣ Between 45% and 65% have never been tested for chlamydia, gonorrhea, or syphilis (transgender)

Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

# Percentage of MSM survey respondents who used condoms when having sex in the past 6 months

32



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

## In their voices: STIs

33

- *Community members identified a shortage of HIV and other STI outreach and testing.*
- *Participants highlighted stereotypes about who is at risk for HIV and other STIs as a barrier to increasing access to HIV and other STI testing.*
- *“Normally, gay men go out of the county to San Francisco to get a one-stop shop service.”*

# Recommendations: STIs

34

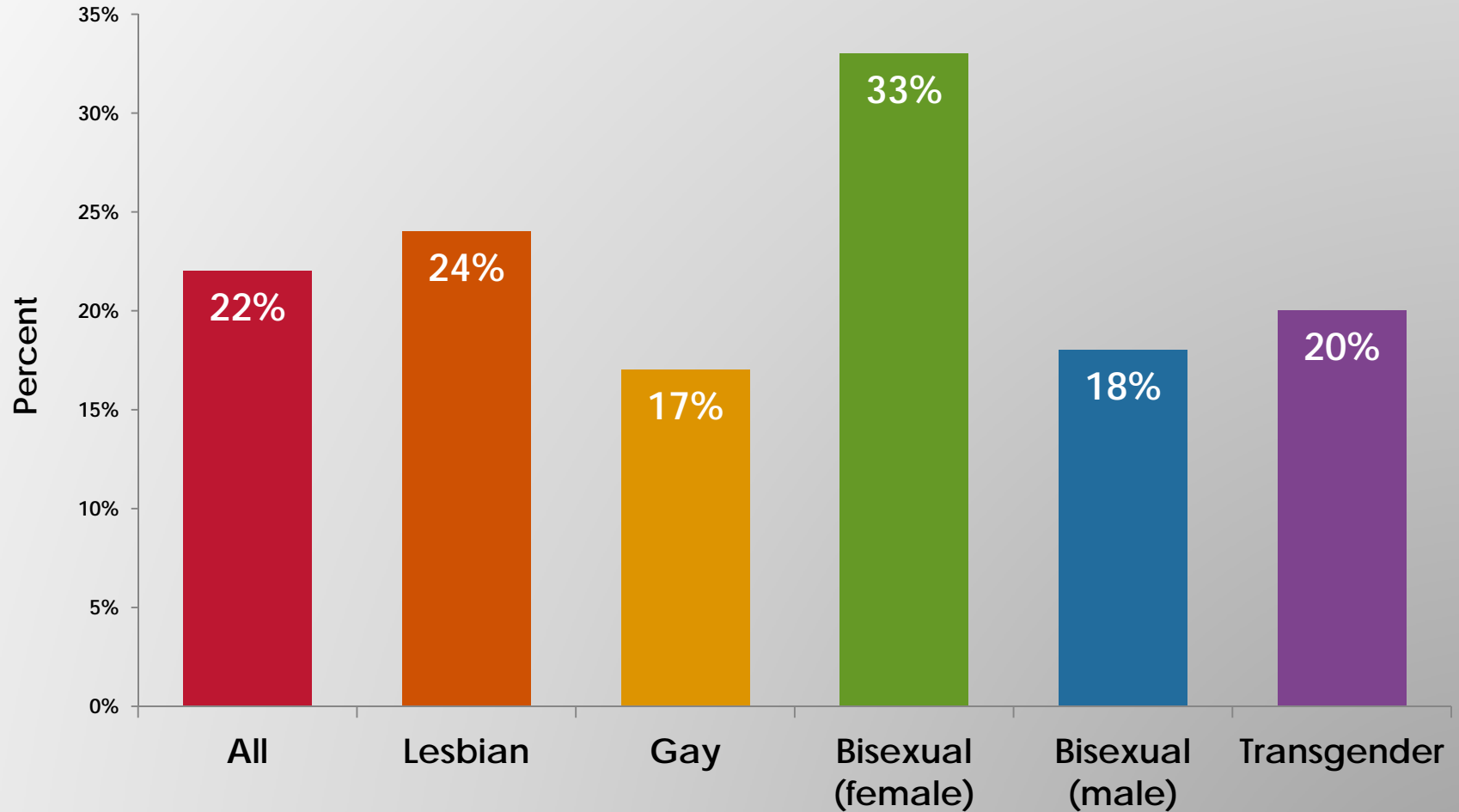
- ▣ **Offer free, comprehensive HIV and other STI testing.**
- ▣ **Integrate testing in community venues.**
- ▣ **Reduce barriers to testing** by offering low-cost and anonymous testing.
- ▣ **Promote and subsidize in-home HIV testing kits.**
- ▣ **Train medical providers** on how to talk to patients about STI risk, testing, and care.
- ▣ **Improve outreach for hard-to-reach groups.**
- ▣ **Raise public awareness to reduce stigma** about HIV and other STIs.
- ▣ **Mandate school-based sex education** inclusive of LGBTQ identities.



# DOMESTIC VIOLENCE

## Percentage of LGBTQ survey respondents ever hit, slapped, pushed, kicked, or physically hurt in any way by an intimate partner

36



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

## In their own words: Domestic violence

37

- Community members emphasized that intimate partner violence is a hidden issue in the LGBTQ community.
- Participants also cited instances of parents abusing their children for coming out.
- *“LGBT people in family violence situations often don't come forward. Domestic violence is a dirty little secret in our community.”*

## Recommendations: Domestic violence

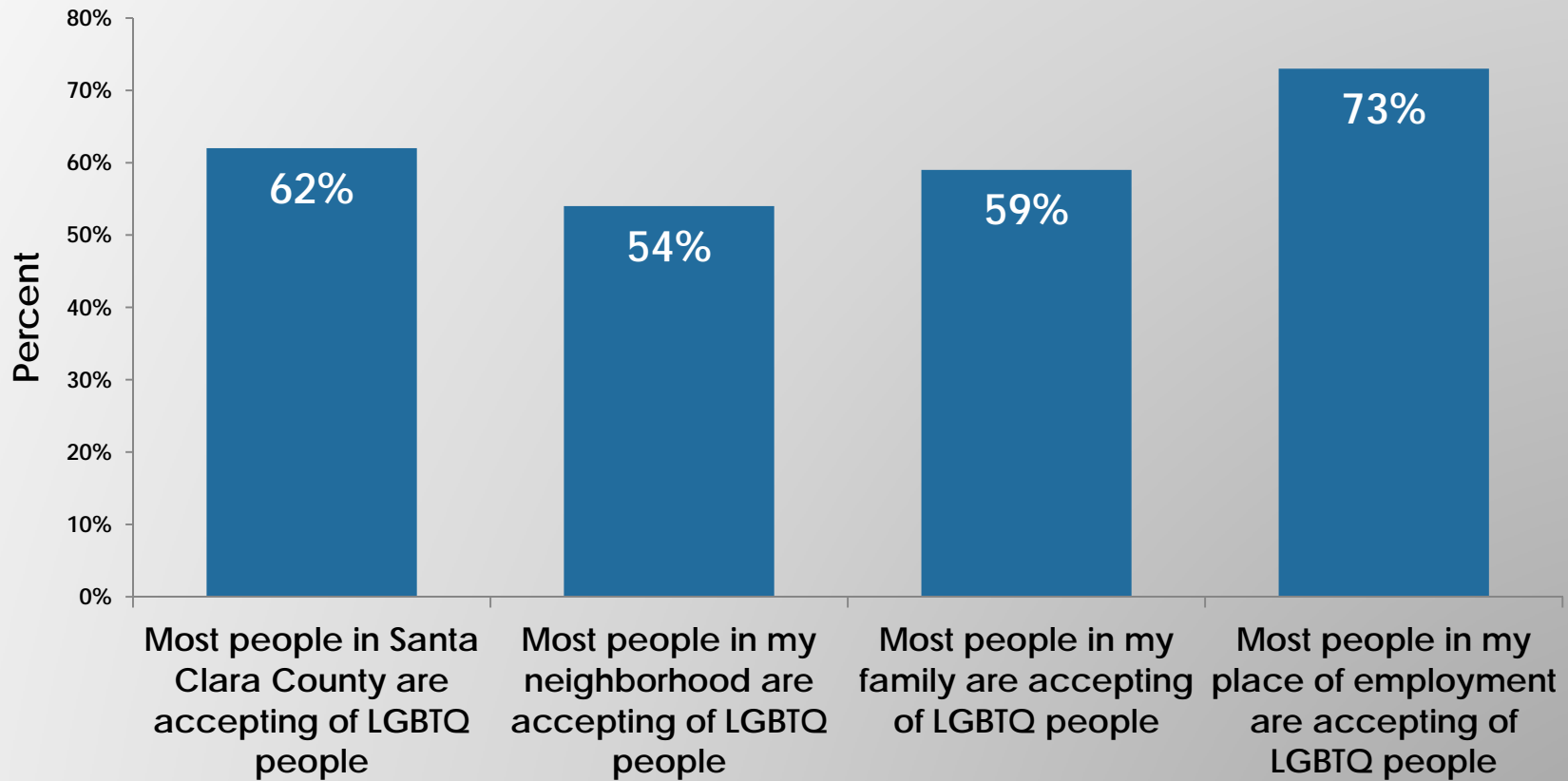
38

- ▣ **Increase education and outreach within the LGBTQ community** to lessen stigma around intimate partner violence.
- ▣ **Develop LGBTQ-specific** intimate partner violence services, shelters, and youth crisis services.
- ▣ **Facilitate reporting** by training law enforcement agencies and courts about responding to LGBTQ intimate partner violence. Instate victims advocates trained in LGBTQ issues at local police stations.

# SOCIAL ACCEPTANCE AND DISCRIMINATION

## Percentage of LGBTQ survey respondents who agreed or strongly agreed with statements regarding social acceptance of LGBTQ people in Santa Clara County

40

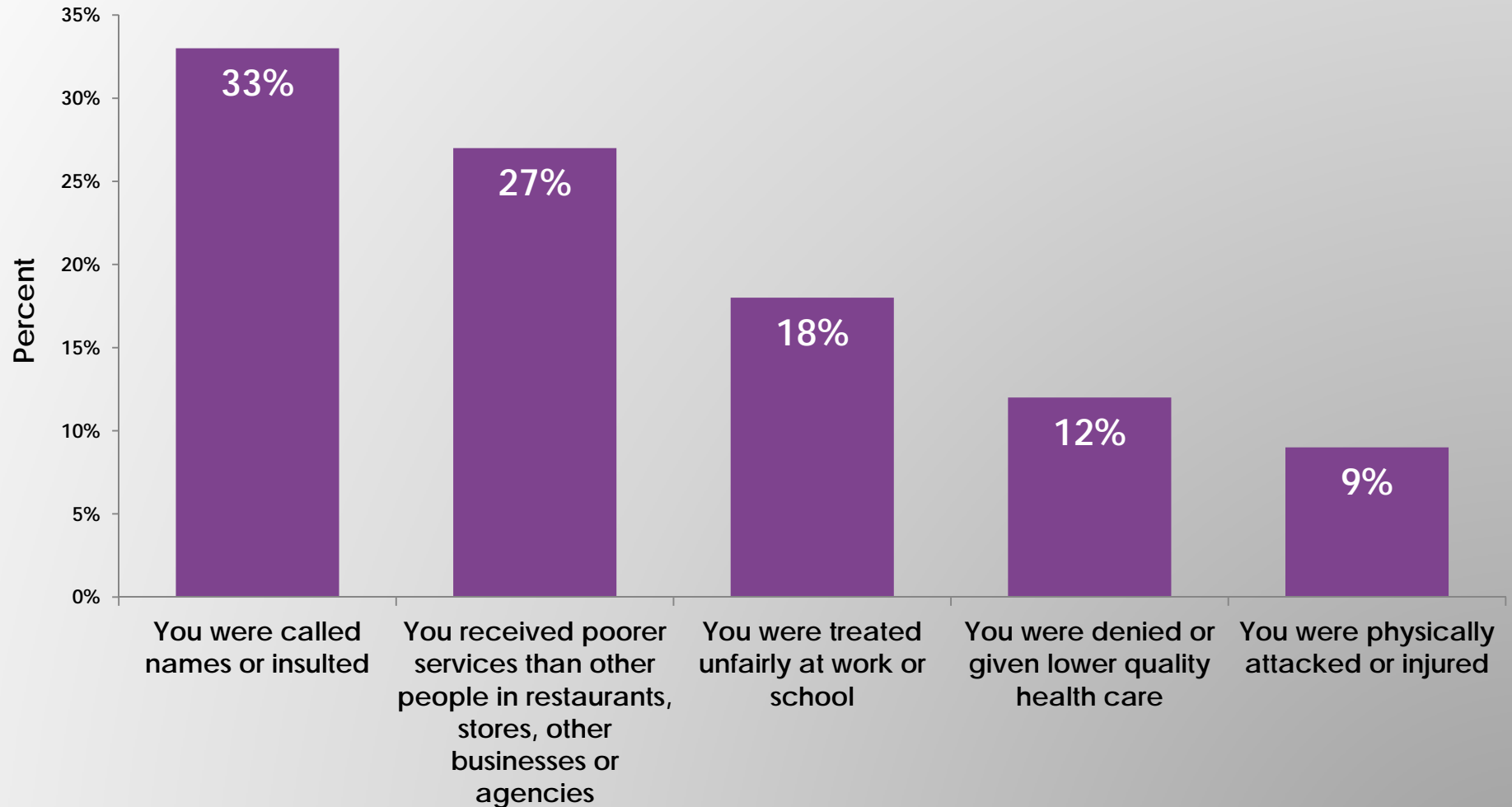


Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey



## Percentage of LGBTQ survey respondents who experienced discrimination due to sexual orientation and/or gender identity in the past 12 months

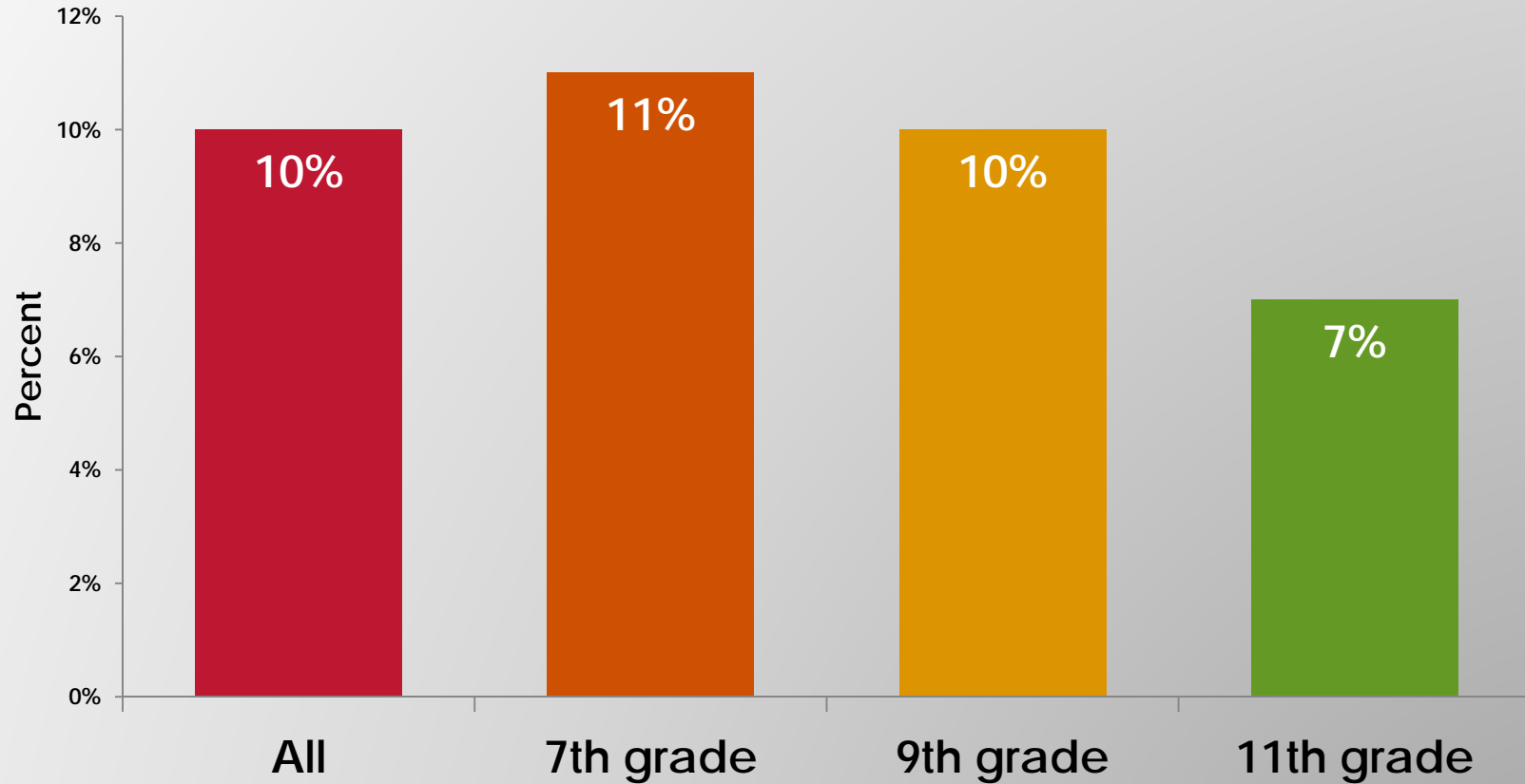
41



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

## Percentage of 7th, 9th, and 11th graders who were harassed or bullied on school property in the past 12 months because they were gay or lesbian or someone thought they were

42



Source: California Healthy Kids Survey, 2009-10

## In their voices: Social acceptance and discrimination

43

- ▣ “[The trans] community as a whole recognize that walking out the door, sitting at the bus stop, going to the store, realistically can cost us our lives.”

# Next steps

44

- ❑ Disseminate widely: report available online & print
- ❑ Data from report and recommendations from forum will help inform: community organizations, county agencies, and elected officials
- ❑ Goal: generate equitable action-oriented solutions to improve the lives of the LGBTQ community

# Acknowledgements

45

- Supervisor Ken Yeager, Dr. Marty Fenstersheib, and Mr. Fred Ferrer
- Public Health Department staff
  - CDIP: Kris Vantornhout and staff
  - HIV/AIDS: Maharlika Aguirre and Raj Gill
  - Communications: Danica Cho, Amy Cornell and Johanna Silverthorne
- Steering Committee and community organizations
- Special thanks to the LGBTQ community of Santa Clara County

Reports - Public Health Department - County of Santa Clara - Windows Internet Explorer

http://www.sccgov.org/sites/sccphd/en-us/Partners/Data/Pages/Reports-and-Fact-Sheets.aspx

File Edit View Favorites Tools Help

Search Public Health Department...

Contacts Agencies & Departments Services

Santa Clara County  
**PUBLIC HEALTH** Great Things Start with Good Health

En Español | Tiếng Việt

About SCCPHD For Residents For Partners For Providers For Media Disease Search

Home > For Partners > Data and Statistics PRINT

### Reports

This section contains health status reports and fact sheets created by the Public Health Department.

- Status of LGBTQ Health in Santa Clara County, 2013**
  - Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey
- HIV/AIDS Report, 2012
- Pertussis Report, through September 28, 2013
  - Previous Pertussis Reports in 2013
- Child Poverty in Santa Clara County Report, 2013
- Obesity, Physical Activity and Nutrition Report, 2013
- Secondhand Smoke and Multi-Unit Housing in Gilroy: A Desktop HIA, 2013
- Influenza Reports**
  - Influenza Report, January 12-18, 2014
  - Influenza Report, January 5-11, 2014
    - Previous Influenza Reports
- Status of Latino/Hispanic Health Santa Clara County 2012**
  - Executive Summary (English)
  - Executive Summary (Spanish)
  - Volume 1: Latino/Hispanic Health Matters
  - Volume 2: Neighborhood Conditions that Affect Latino/Hispanic Health
  - Appendix: Methods and Tools
  - Additional Tables and Graphs
  - Presentations
  - Neighborhood Profiles

#### Leading Causes of Death for Latinos/Hispanics versus Other Racial/Ethnic Groups

Group	Heart Disease	Cancer	Stroke	Accidents (Injury-related Deaths)	Other (Unintentional Deaths)
Latinos/Hispanics	~25%	~15%	~10%	~5%	~5%
White	~20%	~25%	~10%	~5%	~5%
African American	~25%	~20%	~10%	~5%	~5%
Asian/Pacific	~20%	~25%	~10%	~5%	~5%
Hispanic	~25%	~15%	~10%	~5%	~5%

#### External Links

- Centers for Disease Control and Prevention
- California Department of Public Health
- American FactFinder

Local intranet 100% 3:45 PM



# Status of LGBTQ Health

Santa Clara County  
2018

Santa Clara County  
**PUBLIC  
HEALTH**



**One Community, Many Voices**

# Questions?

# **EXHIBIT 7**

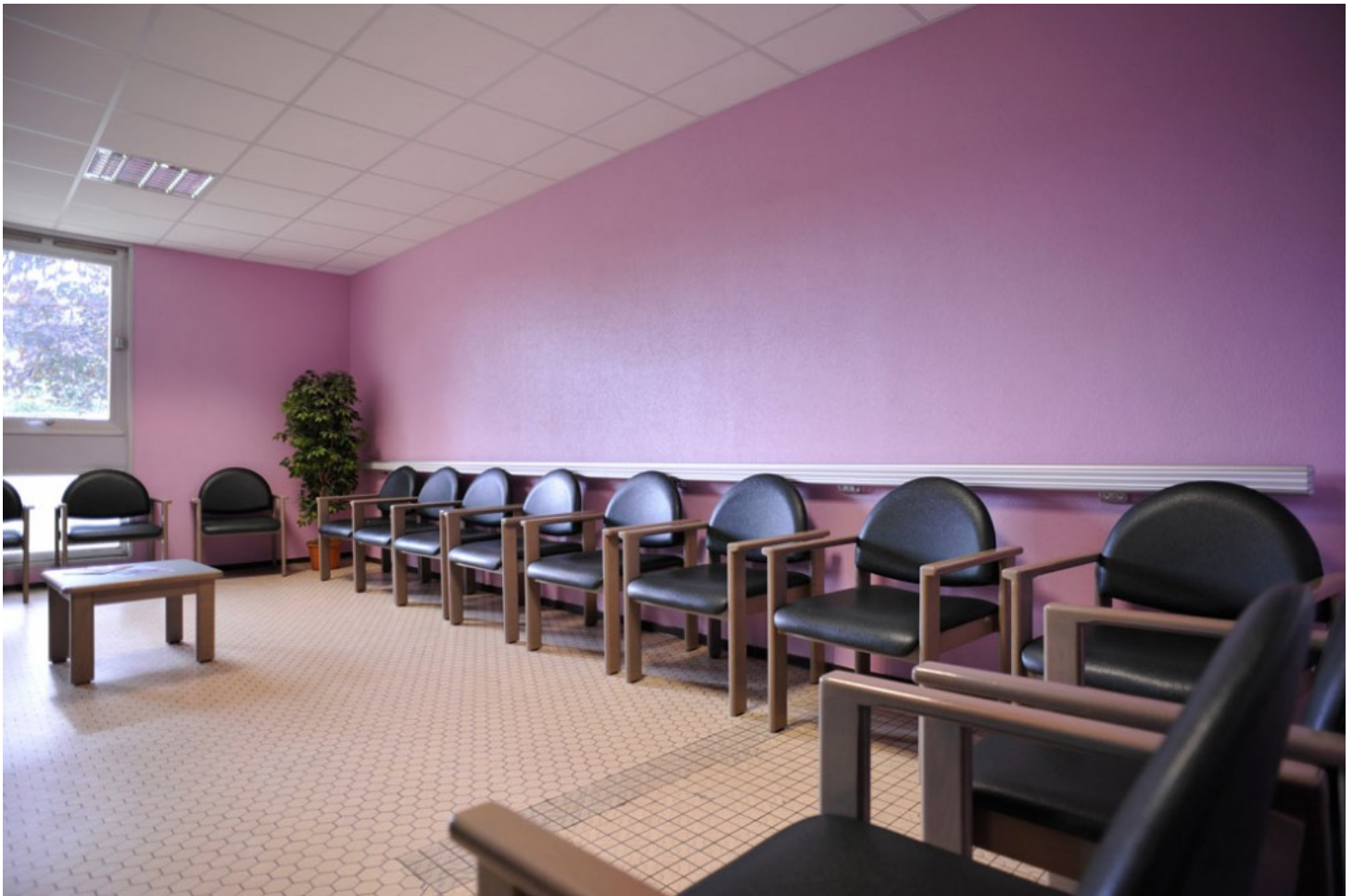
# Center for American Progress



LGBT

## Discrimination Prevents LGBTQ People from Accessing Health Care

By [Shabab Ahmed Mirza](#) and [Caitlin Rooney](#) | Posted on January 18, 2018, 9:00 am



Getty/BSIP, UIG

A waiting room, March 2015.

All people who need medical care should be able to see their doctor without worrying about being mistreated, harassed, or denied service outright. The Affordable Care Act (ACA) helped address this

issue by prohibiting health care providers and insurance companies from engaging in discrimination. As a result of several court rulings and an Obama administration rule, LGBTQ people are explicitly protected against discrimination in health care on the basis of gender identity and sex stereotypes. However, conservative forces and the Trump-Pence administration are seeking to make it easier for health care providers to discriminate against LGBTQ people and women.

Discrimination in health care settings endangers LGBTQ people's lives through delays or denials of medically necessary care. For example, after one patient with HIV disclosed to a hospital that he had sex with other men, the hospital staff [refused to provide his HIV medication](#). In another case, a transgender teenager who was admitted to a hospital for suicidal ideation and self-inflicted injuries was repeatedly misgendered and then discharged early by hospital staff. He later [committed suicide](#). Discrimination affects LGBTQ parents as well: In Michigan, an infant was [turned away from a pediatrician's office](#) because she had same-sex parents. Even though many states, such as Michigan, lack explicit statewide laws against LGBTQ discrimination in health care, Section 1557 of the ACA provides federal protections.

New data from a nationally representative CAP survey conducted in 2017 show that LGBTQ people experience discrimination in health care settings; that discrimination discourages them from seeking care; and that LGBTQ people may have trouble finding alternative services if they are turned away. These data underscore the importance of protecting LGBTQ people from discrimination in health care.

## **LGBTQ people face discrimination and mistreatment at doctors' offices**

Despite existing protections, LGBTQ people face disturbing rates of health care discrimination—from harassment and humiliation by providers to being turned away by hospitals, pharmacists, and doctors. The CAP survey data show the types of discrimination that many LGBTQ people face when seeking health care.

Among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:

- 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation.

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

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

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

## **Discrimination discourages LGBTQ people from seeking health care**

Discrimination—and even the potential for discrimination—can deter LGBTQ people from seeking care in the first place. CAP survey data show that discrimination played a role in preventing a significant number of LGBTQ people from seeking health care. In the year prior to the survey, 8 percent of all LGBTQ people—and 14 percent of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year—avoided or postponed needed medical care because of disrespect or discrimination from health care staff. Among transgender people, 22 percent reported such avoidance. With regard to preventative screenings, 7 percent of

LGBTQ respondents reported avoiding or postponing care in the year prior to the survey, while 17 percent of LGBTQ respondents who had experienced discrimination that year and 19 percent of transgender people reporting avoidance during that period.

An earlier CAP analysis reported other findings from this survey that also indicated the effect of discrimination on LGBTQ people's willingness to seek out health care. In that analysis, 6.7 percent of LGBTQ people reported that they [avoided doctor's offices](#) in the past year out of fear of discrimination. This avoidance behavior is [even more common](#) among LGBTQ people who reported having experienced discrimination in the past year: 18.4 percent reported avoiding doctor's offices to avoid discrimination, nearly seven times the rate of LGBTQ people who had not experienced discrimination in the past year, at 2.7 percent. These CAP data are consistent with other research. The 2015 U.S. Transgender Survey found that nearly 1 in 4 transgender people (23 percent) had [avoided seeking needed health care](#) in the past year due to fear of discrimination or mistreatment due to their gender identity.

## Finding another doctor is not an answer for all LGBTQ patients

The expansion of legislation, lawsuits, and administrative rule-making allowing for broad religious exemptions from providing services puts another impediment in the way of LGBTQ people receiving medical care. For those patients that do seek medical care and are turned away by providers, alternatives may not be easily accessible. This concern is exacerbated by a shortage of medical providers in key areas of treatment (such as mental health care) and geographic areas (such as rural communities).

CAP survey data show that many LGBTQ people would face significant difficulty finding an alternative provider if they were turned away by a health care provider, such as a hospital, clinic, or pharmacy.

- 18 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 17 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 8 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.



LGBTQ people living outside of a metropolitan area report a high rate of difficulty accessing alternative services, which may be because such services could be further away and transportation costs have the potential to be higher.

- 41 percent of nonmetro LGBTQ people said it would be “very difficult” or “not possible” to find the same type of service at a different hospital.
- 31 percent of nonmetro LGBTQ people said it would be “very difficult” or “not possible” to find the same type of service at a different community health center or clinic.
- 17 percent of nonmetro LGBTQ people said it would be “very difficult” or “not possible” to find the same type of service at a different pharmacy.

Transgender people also report difficulty accessing alternatives at a high rate:

- 31 percent of transgender people said it would be “very difficult” or “not possible” to find the same type of service at a different hospital.
- 30 percent of transgender people said it would be “very difficult” or “not possible” to find the same type of service at a different community health center or clinic.
- 16 percent of transgender people said it would be “very difficult” or “not possible” to find the same type of service at a different pharmacy.

Some people may go to LGBTQ community health centers to avoid such discrimination, but they are not widely available across the United States, and many do not provide comprehensive services. A total of 13 states—mainly those in the central United States—[do not have any LGBTQ community health centers](#). On the U.S. Transgender Survey, 29 percent of respondents seeking transition-related care reported [having to travel 25 miles or more](#) to access such care.

## Conclusion

Despite the importance of protecting people from discrimination in health care settings, current regulations are under attack. On August 23, 2016, a group of conservative religious organizations and eight states filed a lawsuit against the U.S. Department of Health and Human Services (HHS), challenging the 1557 rule. They [made dubious claims](#) that the nondiscrimination protections would require doctors to provide treatment that violated their religious beliefs, such as transition-related surgeries for transgender patients. Even though numerous courts have ruled that laws such as 1557

protect LGBTQ people, in December 2016, a single federal judge issued a nationwide injunction prohibiting HHS from enforcing the 1557 rule's prohibition on discrimination on the basis of gender identity. On May 2, 2017, the Trump-Pence administration filed a motion indicating that the 1557 rule was under review, and in August, it announced that HHS had already [written a draft proposal to roll back the rule](#). Given the [Trump-Pence administration's record on LGBTQ issues](#), new regulations will likely deny the existence of protections to LGBTQ people and make equal health care access and treatment more difficult to obtain for this historically marginalized community. While the administration cannot change the protections for LGBTQ people that exist under the law, a regulatory rollback would cause fear and confusion for patients and promote discrimination by providers and insurers.

*Shabab Ahmed Mirza is a research assistant for the LGBT Research and Communications Project at the Center for American Progress. Caitlin Rooney is a Research Assistant for the LGBT Research and Communications Project at the Center.*

## Methodology

To conduct this study, CAP commissioned and designed a survey, fielded by GfK SE, which surveyed 1,864 individuals about their experiences with health insurance and health care. Among the respondents, 857 identified as lesbian, gay, bisexual, and/or transgender, queer, or asexual, while 1,007 identified as heterosexual and cisgender/nontransgender. Respondents came from all income ranges and are diverse across factors such as race, ethnicity, education, geography, disability status, and age. The survey was fielded online in English in January 2017 to coincide with the fourth open enrollment period through the health insurance marketplaces and the beginning of the first full year of federal rules that specifically protect LGBTQ people from discrimination in health insurance coverage and health care. The data are nationally representative and weighted according to U.S. population characteristics. Metro is defined as a metropolitan core-based statistical area and nonmetro is defined as anything else, including micropolitan core-based statistical areas and locations outside of a core-based statistical area.

Additional information about study methods and materials are available in prior analyses and from the authors. Results reported in this column may differ slightly (two-tenths of 1 percent) but not substantively from other analyses of these data due to the statistical program employed.

The authors would like to thank Sharita Gruberg, Frank Bewkes, and Laura E. Durso from the Center for American Progress as well as Harper Jean Tobin, Katie Keith, and Kellan Baker for their contributions to this column.

# Center for American Progress



© 2018 - Center for American Progress

**EXHIBIT 8**

ODPHP | Office of Disease Prevention and Health Promotion | health.gov | healthfinder.gov | HealthyPeople.gov

HealthyPeople.gov

Search HealthyPeople.gov

Log in

Go

Topics & Objectives | Leading Health Indicators | Data Search | Healthy People in Action | Tools & Resources | Webinars & Events | About

[Home](#) » [2020 Topics & Objectives](#) » [Lesbian, Gay, Bisexual, and Transgender Health](#)

 [Print](#)  [Share](#)

## Lesbian, Gay, Bisexual, and Transgender Health New

Overview

Objectives

National Snapshots

### Goal

Improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals.

### Overview

LGBT individuals encompass all races and ethnicities, religions, and social classes. Sexual orientation and gender identity questions are not asked on most national or State surveys, making it difficult to estimate the number of LGBT individuals and their health needs.

Research suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBT persons has been associated with high rates of psychiatric disorders,<sup>1</sup> substance abuse,<sup>2, 3</sup> and suicide.<sup>4</sup> Experiences of violence and victimization are frequent for LGBT individuals, and have long-lasting effects on the individual and the community.<sup>5</sup> Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals.<sup>6</sup>

The LGBT companion document to Healthy People 2010<sup>7</sup> highlighted the need for more research to document, understand, and address the environmental factors that contribute to health disparities in the LGBT community. As part of this work, we need to increase the number of nationally-representative health-related surveys that collect information on sexual orientation and gender identity (SOGI).

### Why Is LGBT Health Important?

Eliminating LGBT health disparities and enhancing efforts to improve LGBT health are necessary to ensure that LGBT individuals can lead long, healthy lives. The many benefits of addressing health concerns and reducing disparities include:

- Reductions in disease transmission and progression
- Increased mental and physical well-being
- Reduced health care costs
- Increased longevity

Efforts to improve LGBT health include:

- Collecting SOGI data in health-related surveys and health records in order to identify LGBT health disparities <sup>8</sup>
- Appropriately inquiring about and being supportive of a patient's sexual orientation and gender identity to enhance the patient-provider interaction and regular use of care<sup>9</sup>
- Providing medical students with training to increase provision of culturally competent care<sup>10</sup>
- Implementing antibullying policies in schools<sup>11</sup>
- Providing supportive social services to reduce suicide and homelessness among youth<sup>11</sup>



View HP2020 Data for:

[▶ Lesbian Gay Bisexual and Transgender Health](#)

Midcourse Review Data Are In!

[Check out our interactive infographic](#) to see progress

toward the Lesbian Gay Bisexual and Transgender Health objectives and other Healthy People topic areas.

- Curbing human immunodeficiency virus (HIV)/sexually transmitted infections (STIs) with interventions that work<sup>12</sup>

## [Back to Top](#)

## Understanding LGBT Health

In order to effectively address LGBT health issues, we need to securely and consistently collect SOGI information in national surveys and health records. This will allow researchers and policy makers to accurately characterize LGBT health and disparities.

Understanding LGBT health starts with understanding the history of oppression and discrimination that these communities have faced. For example, in part because bars and clubs were often the only safe places where LGBT individuals could gather, alcohol abuse has been an ongoing problem.<sup>14</sup>

Social determinants affecting the health of LGBT individuals largely relate to oppression and discrimination. Examples include:

- Legal discrimination in access to health insurance, employment, housing, marriage, adoption, and retirement benefits
- Lack of laws protecting against bullying in schools
- Lack of social programs targeted to and/or appropriate for LGBT youth, adults, and elders
- Shortage of health care providers who are knowledgeable and culturally competent in LGBT health

The physical environment that contributes to healthy LGBT individuals includes:

- Safe schools, neighborhoods, and housing
- Access to recreational facilities and activities
- Availability of safe meeting places
- Access to health services

LGBT health requires specific attention from health care and public health professionals to address a number of disparities, including:

- LGBT youth are 2 to 3 times more likely to attempt suicide.<sup>15</sup>
- LGBT youth are more likely to be homeless.<sup>16, 17, 18</sup>
- Lesbians are less likely to get preventive services for cancer.<sup>19, 20</sup>
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.<sup>21</sup>
- Lesbians and bisexual females are more likely to be overweight or obese.<sup>22</sup>
- Transgender individuals have a high prevalence of HIV/STDs,<sup>23</sup> victimization,<sup>24</sup> mental health issues,<sup>25</sup> and suicide<sup>26</sup> and are less likely to have health insurance than heterosexual or LGB individuals.<sup>27</sup>
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.<sup>28</sup>
- LGBT populations have the highest rates of tobacco,<sup>29, 30</sup> alcohol,<sup>30, 31</sup> and other drug use.<sup>30, 32, 33</sup>

## Continuing Issues in LGBT Health

A number of issues will need to continue to be evaluated and addressed over the coming decade, including:

- Nationally representative data on LGBT Americans
- Prevention of violence and homicide toward the LGB community, and especially the transgender population
- Resiliency in LGBT communities
- LGBT parenting issues throughout the life course
- Elder health and well-being
- Exploration of sexual/gender identity among youth
- Need for a LGBT wellness model
- Recognition of transgender health needs as medically necessary

## References

### Related Topic Areas

- ▶ [Access to Health Services](#)
- ▶ [Adolescent Health](#)
- ▶ [Cancer](#)
- ▶ [Early and Middle Childhood](#)
- ▶ [Educational and Community-Based Programs](#)

[More](#) ▶



<sup>1</sup>McLaughlin KA, Hatzenbuehler ML, Keyes KM. Responses to discrimination and psychiatric disorders among black, Hispanic, female, and lesbian, gay, and bisexual individuals. *Am J Public Health*. 2010;100(8):1477-84.

<sup>2</sup>Ibanez GE, Purcell DW, Stall R, et al. Sexual risk, substance use, and psychological distress in HIV-positive gay and bisexual men who also inject drugs. *AIDS*. 2005;19(suppl 1):49-55.

<sup>3</sup>Herek GM, Garnets LD. Sexual orientation and mental health. *Annu Rev Clin Psychol*. 2007;3:353-75.

<sup>4</sup>Remafedi G, French S, Story M, et al. The relationship between suicide risk and sexual orientation: Results of a population-based study. *Am J Public Health*. 1998;88(1):57-60.

<sup>5</sup>Roberts AL, Austin SB, Corliss HL, et al. Pervasive trauma exposure among US sexual orientation minority adults and risk of posttraumatic stress disorder. *Am J Public Health*. 2010 Apr 15.

<sup>6</sup>US Department of Health and Human Services. *Healthy People 2010*. [Internet]. Available from: <http://www.hhs.gov>

<sup>7</sup>Gay and Lesbian Medical Association (GLMA). *Healthy People 2010: A companion document for LGBT health* [Internet]. San Francisco: GLMA; 2001 Apr. Available from: [http://www.glma.org/\\_data/n\\_0001/resources/live/HealthyCompanionDoc3.pdf](http://www.glma.org/_data/n_0001/resources/live/HealthyCompanionDoc3.pdf) [PDF =- 2.3 MB]

<sup>8</sup>Cahill SR, Baker K, Deutsch MB, et al. Inclusion of Sexual Orientation and Gender Identity in Stage 3 Meaningful Use Guidelines: A Huge Step Forward for LGBT Health. *LGBT Health*. 2015; 0(0):1-3.

<sup>9</sup>Steele LS, Timmouth JM, Lu A. Regular health care use by lesbians: A path analysis of predictive factors. *Fam Pract*. 2006;23:631-6.

<sup>10</sup>Sanchez NF, Rabatin J, Sanchez JP, et al. Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. *Med Stud Edu*. 2006;38(1):21-7.

<sup>11</sup>Suicide Prevention Resource Center. *Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth*. Newton, MA: Education Development Center, Inc.; 2009. Available from: [http://www.sprc.org/sites/default/files/migrate/library/SPRC\\_LGBT\\_Youth.pdf](http://www.sprc.org/sites/default/files/migrate/library/SPRC_LGBT_Youth.pdf) [PDF - 428 KB]

<sup>12</sup>Centers for Disease Control and Prevention (CDC). *Compendium of HIV prevention interventions with evidence of effectiveness* [Internet]. Atlanta: CDC; 2017. Available from: <https://www.cdc.gov/hiv/research/interventionresearch/compendium/>

<sup>13</sup>Ponce NA, Cochran SD, Pizer JC, et al. The effects of unequal access to health insurance for same-sex couples in California. *Health Affairs*. 2010;29(8):1-10.

<sup>14</sup>Bux DA. The epidemiology of problem drinking in gay men and lesbians: A critical review. *Clin Psych Rev*. 1996;16:277-98.

<sup>15</sup>Garofalo R, Wolf RC, Wissow LS, et al. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med*. 1999;153(5):487-93.

<sup>16</sup>Conron KJ, Mimiaga MJ, Landers SJ. A population-based study of sexual orientation identity and gender differences in adult health. *Am J Public Health*. 2010 Oct;100(10):1953-60.

<sup>17</sup>Kruks, G. Gay and lesbian homeless/street youth: Special issues and concerns. *J Adolesc Health*. 2010;12(7):515-8.

<sup>18</sup>Van Leeuwen JM, Boyle S, Salomonsen-Sautel S, et al. Lesbian, gay, and bisexual homeless youth: An eight-city public health perspective. *Child Welfare*. 2006 Mar-Apr;85(2):151-70.

### Learn More

- ▶ [Centers for Medicare & Medicaid Services: Final Rule on Changes to Hospital Conditions of Participation to Ensure Visitation Rights for All Patients](#)
- ▶ [HealthCare.gov: Health Care Coverage Options for Same Sex Couples](#)
- ▶ [www.stopbullying.gov](#)
- ▶ [U.S. Department of Health and Human Services: Health and Well-Being for Lesbian, Gay, Bisexual and Transgender Americans](#)
- ▶ [National Clearinghouse on Family and Youth: Lesbian, Gay, Bisexual, Transgender, and Questioning Youth](#)

[More](#) ▶

<sup>19</sup>Buchmueller T, Carpenter CS. Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000–2007. *Am J Public Health*. 2010;100(3):489-95.

<sup>20</sup>Dilley JA, Simmons KW, Boysun MJ, et al. Demonstrating the importance and feasibility of including sexual orientation in public health surveys: Health disparities in the Pacific Northwest. *Am J Public Health*. 2010;100(3):460-7.

<sup>21</sup>Centers for Disease Control and Prevention (CDC). HIV among Gay and Bisexual Men [Internet]. Atlanta: CDC; 2017 Feb [cited 2017 Aug 23]. <https://www.cdc.gov/nchstp/newsroom/docs/factsheets/cdc-msm-508.pdf>

<sup>22</sup>Struble CB, Lindley LL, Montgomery K, et al. Overweight and obesity in lesbian and bisexual college women. *J Am College Health*. 2010;59(1):51-6.

<sup>23</sup>Herbst JH, Jacobs ED, Finlayson TJ, et al. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS Behav*. 2008;(12):1-17.

<sup>24</sup>Whitbeck LB, Chen X, Hoyt DR, et al. Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. *J Sex Research*. 2004;41(4):329-42.

<sup>25</sup>Diaz RM, Ayala G, Bein E, et al. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from three US cities. *Am J Public Health*. 2001;91(6):141-6.

<sup>26</sup>Kenagy GP. Transgender health: Findings from two needs assessment studies in Philadelphia. *Health Soc Work*. 2005;30(1):19-26.

<sup>27</sup>National Gay and Lesbian Taskforce. National transgender discrimination survey: Preliminary findings. Washington, DC: National Gay and Lesbian Taskforce; 2009 Nov. Available from:

[http://www.thetaskforce.org/downloads/reports/fact\\_sheets/transsurvey\\_prelim\\_findings.pdf](http://www.thetaskforce.org/downloads/reports/fact_sheets/transsurvey_prelim_findings.pdf) [PDF - 1.17 MB]

<sup>28</sup>Cahill S, South K, Spade J. Outing age: Public policy issues affecting gay, lesbian, bisexual and transgender elders. Washington: National Gay and Lesbian Task Force; 2009 Nov.

<sup>29</sup>Lee GL, Griffin GK, Melvin CL. Tobacco use among sexual minorities in the USA: 1987 to May 2007: A systematic review. *Tob Control*. 2009;18:275-82.

<sup>30</sup>Xavier J, Honnold J, Bradford J. The health, health-related needs, and lifecourse experiences of transgender Virginians. Virginia HIV Community Planning Committee and Virginia Department of Health. Richmond, VA: Virginia Department of Health; 2007. Available from:

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/documents/pdf/THISFINALREPORTVol1.pdf> [PDF - 646 KB]

<sup>31</sup>Hughes TL. Chapter 9: Alcohol use and alcohol-related problems among lesbians and gay men. *Ann Rev of Nurs Res*. 2005;23:283-325.

<sup>32</sup>Lyons T, Chandra G, Goldstein J. Stimulant use and HIV risk behavior: The influence of peer support. *AIDS Ed and Prev*. 2006;18(5):461-73.

<sup>33</sup>Mansergh G, Colfax GN, Marks G, et al. The circuit party men's health survey: Findings and implications for gay and bisexual men. *Am J Public Health*. 2001;91(6):953-8.

[Back to Top](#)

Find us on:



Enter your email for updates:

Sign Up

About  
Contact Us  
Site Map

Accessibility  
Privacy Policy  
Disclaimers

Freedom of Information Act  
Healthy People 2010 Archive  
Nondiscrimination Notice

Web Badges  
Viewers and Players



ODPHP

Site last updated 03/22/18

# **EXHIBIT Y**



City and County of San Francisco  
Mark Farrell  
Mayor

## San Francisco Department of Public Health

Barbara A. Garcia, MPA  
Director of Health

Secretary Alex Azar  
The U.S. Department of Health & Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

RE: Department of Health and Human Services Proposed Rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," Docket ID No. HHS-OCR-2018-0002 (RIN 0945-ZA03)

Dear Secretary Azar,

Thank you for the opportunity to submit comments on "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," Department of Health and Human Services (HHS) proposed rule RIN0945-ZA03, Docket ID No. HHS-OCR-2018-0002. **The San Francisco Department of Public Health (SFDPH) strongly opposes this proposed rule and requests that it be withdrawn.** In support of our position, we offer the information below based on our experience as a safety net provider of direct health services to thousands of insured and uninsured residents of San Francisco, including those most socially and medically vulnerable.

SFDPH, through the San Francisco Health Network (SFHN), provides San Francisco's only complete care system and includes primary care, dental care, emergency and trauma treatment, medical and surgical specialties, diagnostic testing, skilled nursing and rehabilitation, behavioral health services and jail health services. The mission of SFDPH is to protect and promote the health of all San Franciscans. SFDPH is dedicated to reducing health disparities and providing inclusive care to all patients. SFDPH provides this care through its top-rated programs, fifteen primary care community clinics, and hospitals, including Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG). For example, Zuckerberg San Francisco General alone delivers over one thousand babies a year, has been at the forefront of HIV/AIDS care from the beginning of the AIDS crisis, and provides gender-confirmation surgeries to transgender patients.

Zuckerberg San Francisco General cares for approximately one in eight San Franciscans a year, regardless of their ability to pay. As the City's safety net hospital, Zuckerberg San Francisco General provides the highest-quality services, including to many patients covered through Medi-Cal (California's Medicare program). It provides life-saving emergency care as the only level one trauma center in San Francisco, serving a region of more than 1.5 million people. With the busiest emergency room in San Francisco, Zuckerberg San Francisco General receives one-third of all ambulances in the City, and treats nearly four

---

**The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.**

We shall  Assess and research the health of the community  Develop and enforce health policy  Prevent disease and injury   
 Educate the public and train health care providers  Provide quality, comprehensive, culturally-proficient health services  Ensure equal access to all

thousand patients with traumatic injuries, annually. Many of Zuckerberg San Francisco General's programs focus on providing life-saving care in emergency situations.

As a safety net provider, SFDPH is extremely concerned by the proposed rule. HHS recently created the Division of Conscience and Religious Freedom with the purpose of protecting health care workers who refuse to treat patients on the basis of religious and moral objections. This new division and the proposed rule threaten the health of our patients, and are likely to have a particular negative impact on low-income people, women, and the LGBTQ community.

The proposed rule compromises patient care, undermines the oaths sworn to by medical and healthcare professionals, is unnecessary, and is practically unworkable.

First, the proposed rule provides no benefits and imposes only burdens on patients. It fails to take into account the very real costs it imposes on patients' rights to access care, and to do so without being subjected to discrimination. Prioritizing religious freedom over the provision of care allows discrimination and threatens the lives of patients, including women and the LGBTQ community. The proposed rule would undermine San Francisco's long-standing efforts to advance women's health and reproductive rights, prevent domestic violence, address sexual assault and human trafficking, and promote the health and well-being of women and the LGBTQ community through access to health promotion and health care services. The proposed rule threatens patients' constitutional right to access reproductive healthcare services, including abortions. This proposed rule would also exacerbate already enormous deficiencies in health care access among transgender and gender non-conforming individuals. Nearly a quarter of transgender people already report avoiding seeking medical care for fear of being mistreated.<sup>1</sup> This rule could further dissuade transgender people from seeking even the most routine services. The breadth of the rule is such that it is impossible to fully predict how the rule could impact patients—even access to basic care that on its face has no discernable connection to religious observance, such as dental care, could be threatened. Further, it would disproportionately place low-income San Franciscans at risk and threaten San Francisco's ability to provide necessary healthcare services to its residents most in need. The proposed rule completely fails to take into account the very real costs it imposes on patients' rights to access care, and to do so without being subjected to discrimination.

Second, the proposed rule elevates a right of conscience above all other ethical considerations. The proposed rule is in direct violation of the Hippocratic Oath, in which doctors swear to do no harm and to treat the ill to the best of their ability. Its definition of "refer" is so broad that it could potentially prevent SFDPH from ensuring that if one health care provider were unwilling to give certain care, another provider would be able to provide it without delay. When a patient seeks care from one of SFHN's clinics or hospitals, both the patient and SFDPH need to know that the patient is receiving all medically-necessary care.

Third, existing laws and regulations ensure that patients receive the essential health services they need, while adequately protecting the rights of conscience of healthcare workers. Patients have the right to access high-quality, inclusive and comprehensive care without encountering discrimination, and current

---

<sup>1</sup> Sandy E. James et al., The Report of the U.S. Transgender Survey 98 (2016), [www.ustranssurvey.org/report](http://www.ustranssurvey.org/report).



law ensures that access while also allowing accommodations for healthcare workers' religious beliefs. SFDPH is not aware of any employee request for a religious accommodation that it has been unable to provide under existing laws and regulations. Current law is perfectly adequate, and there is no need for the proposed rule.

Lastly, the proposed rule is unworkable in many other respects. In addition to ignoring the needs of patients, the proposed rule fails to account for how a health care organization could legally administer it. The proposed rule ignores competing obligations imposed on SFHN by other statutes such as the Emergency Medical Treatment and Active Labor Act and California's Unruh Civil Rights Act. It also ignores SFDPH's contractual obligations to its employees; the proposed rule could create problems with the fair administration of labor contracts between employees asserting conscience rights and those who do not.

The rule also appears to create administrative obstacles to providing employees with religious accommodations. The current draft lacks a requirement that workers seeking to assert a right of conscience inform their organization of their request, and therefore could deny the organization an opportunity to provide the worker with an accommodation. Moreover, the proposed definition of "discrimination" is so broad that even if a worker did request an accommodation, the very act of providing one could be considered discriminatory. If an employee failed to request an accommodation in advance of being presented with a patient who has an immediate need for care, the proposed rule creates a very real risk that the patient could be denied legally required or medically necessary care. Patient care is SFDPH's first and primary priority, but it is worth noting that in addition to harming a patient, such a situation could also potentially expose SFDPH to liability for violations of other laws and for malpractice.

**For these reasons, we respectfully request HHS withdraw the Proposed Rule from consideration.**

Sincerely,



Barbara A. Garcia

Director of Health  
San Francisco Department of Public Health

# **EXHIBIT Z**



March 27, 2018

Roger Severino, Director  
Office of Civil Rights  
Room 509F, HHH Building  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

**Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**  
**RIN 0945-ZA03 Docket ID No. HHS-OCR-2018-0002**

Dear Director Severino:

Family Voices is a national, nonprofit, family-led organization promoting quality health care for all children and youth, particularly those with special health care needs. Working with family leaders and professional partners at the local, state, regional, and national levels since 1992, Family Voices has brought a respected family perspective to improving health care programs and policies and ensuring that health care systems include, listen to, and honor the voices of families.

Throughout the US, there are over 14 million children and youth with special health care needs (CYSHCN), constituting over 19 percent of the child population. More than one in five households with children has at least one child with special health care needs.

We are very concerned that the proposed rule would restrict access to medically necessary care for CYSHCN. It is already difficult to find the appropriate pediatric subspecialists and health care facilities for many children with special health care needs, particularly those with rare conditions, and particularly in rural areas. Many families have to travel long distances to obtain the specialized care their children need. If regulations are implemented to make it more acceptable to withhold health care, we fear that it will be even more difficult for CYSHCN to obtain medically necessary services.

There is already discrimination against some children with disabilities or other special health care needs. For example, some providers do not believe it is appropriate to extend certain services to children with intellectual disabilities (e.g., cochlear implants to improve hearing, or an organ transplant to save the life of a child with Down syndrome).

A more dramatic example of such discrimination might be found in a neonatal intensive care unit. Suppose a nurse has a moral conviction that society should not expend resources on children with severe physical or intellectual disabilities. Should he be protected, on the basis of his moral conviction, if he decides not to respond to an alarm signaling a heart problem for an infant born without legs?

Conversely, suppose a nurse held a religious belief that all measures must be taken to preserve life, and therefore resuscitated a terminally ill patient who had a “Do not resuscitate” order in place. Would the nurse’s employer be prohibited from taking any disciplinary action against her in such a situation?

Religious beliefs can harm patients in more subtle but harmful ways as well. In a rural community, there may be a single physician. If a teen questioning his or her sexual orientation were to bring up the topic with the physician, and the physician indicated a belief that homosexuality was sinful, the teen ultimately may become depressed, despondent, and even suicidal. If an unmarried teen contracts a sexually transmitted infection, he or she may feel uncomfortable going to a physician who is known to disapprove of premarital sex, thus risking serious complications and the chance of passing the infection to others.

In addition to harming patients’ health directly, we are concerned that this proposed rule would hurt families of CYSHCN financially, since it applies to insurers and employers as well as health care professionals and institutions. These entities have a vested interest in denying care in order to save money. This rule could provide them with an excuse to refuse coverage for expensive treatments.

Finally, we think the proposed rule contradicts current antidiscrimination laws and regulations. Will it provide a defense for health care providers or insurers who discriminate against people with disabilities?

The OCR has specifically requested comment on whether this rule would result in unjustified limitation on access to health care or treatments. We submit that it would.

We understand that there are health care professionals and institutions with strong religious or moral convictions that are inconsistent with rendering certain types of care. It is reasonable to accommodate their views, *provided that others are not harmed* in doing so.

At the same time, it is critical to protect patients from discrimination so they can obtain the care they need, particularly in an emergency. If an individual or institution chooses not to provide certain care on the basis of religious beliefs or moral convictions, then that provider should be required to inform prospective or current patients of those limitations in advance or as soon as possible. In addition, the provider should be required to provide information about alternative sources of care in a timely manner, and should be required to provide any treatment needed to stabilize a patient in an emergency situation.

Thank you for your attention to our comments.

Sincerely,

/s/


Nora Wells  
Executive Director

**EXHIBIT AA**



## Comment on FR Doc # 2018-01226

This is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**.

For related information, [Open Docket Folder](#) 

Comment Period Closed  
Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-10190  
**Tracking Number:** 1k2-925x-5y3e

### Document Information

**Date Posted:**  
Mar 28, 2018

**RIN:**  
0945-ZA03

[Show More Details](#) 

### Submitter Information

**Submitter Name:**  
Matthew Alschuler

### Comment

I live in a sparsely populated rural area. Health care providers are few and far between. I am very worried about the proposed legislation that would allow health care providers to deny legal, doctor prescribed, medical care due to their personal religious beliefs.

A medical provider, be they a primary care physician, a pharmacist, a nurse, etc. cannot impose their beliefs on the medical needs of a poorly served area. This will discriminate against the poor, women, minorities, and LGBTQ communities, the very people that are most in need of health care, and are also less able to travel great distances (the nearest hospital is 30 miles away - and if that facility won't treat them, they'd have to drive 50 miles) just to obtain basic medical care, such as filling prescriptions for birth control, etc.


Religious freedom means that the government can't impose a religion on the citizens, it doesn't permit a licensed health care provider to impose their religious beliefs on patients. This rule is draconian, and must be eliminated.





## Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, [Open Docket Folder](#) 

Comment Period Closed  
Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-10240

**Tracking Number:** 1k2-925x-4rwe

### Document Information

**Date Posted:**

Mar 28, 2018

**RIN:**

0945-ZA03

[Show More Details](#) 

### Submitter Information

**Submitter Name:**

Beth Anonymous

### Comment

I have faced discrimination in health services three different times in the past 10 years. I live in a rural community with one hospital owned by Seventh Day Adventists. I have been denied care based on religious prejudices. There has to be a compromise somewhere. A guarantee that health care practitioners can refuse to help (which no health care worker should be able to based on sex, religion, orientation, ethnicity, etc.), but that there are appropriate referral sources available and that those discrimination are made clear beforehand so as to not waste time or resources.

Basically, if a doctor doesn't want to treat a transgender person, they let people know upfront and have a list of referral sources available. That way the doctor can discriminate based on moral objections but patients (1) know beforehand and (2) are provided a list of service providers in their area who would gladly help them.



## Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, [Open Docket Folder](#)

Comment Period Closed  
Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-34784

**Tracking Number:** 1k2-924i-gx0i

### Comment

I write to oppose the proposed rule entitled Protecting Statutory Conscience Rights in Health Care. This rule could encourage discrimination against LGBT people and those seeking reproductive health care, and it inappropriately puts the personal beliefs of health care providers over the health care needs of patients.

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

Access to health care is a critical problem for many people, and HHS should not be making the problem worse by inviting health care institutions and providers to turn people away based on religious or moral reasons. Our nations largest health care agency should not be promoting discrimination. I oppose this proposed rule and urge HHS to withdraw it.

### Document Information

**Date Posted:**

Mar 29, 2018

**RIN:**

0945-ZA03

[Show More Details](#)

### Submitter Information

**Submitter Name:**

Alexandria Koontz



## Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services (HHS)** Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, [Open Docket Folder](#)

Comment Period Closed

Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-34687

**Tracking Number:** 1k2-924e-tb7e

### Document Information

**Date Posted:**

Mar 29, 2018

**RIN:**

0945-ZA03

[Show More Details](#) 

### Submitter Information

**Submitter Name:**

Alexis Long

### Comment

As a transgender individual, I have been refused important treatment at local doctors. I have to drive for 2 hours in order to receive basic medical care, because I cannot find a doctor who will help me in my town. Someday this very well might kill me if I need immediate, life-saving care. The ability for someone's "conscience" to decide whether I live or die is unfair, and horrifying. This rule is going to make my life worse. It is actively discriminating against me. I am strongly against it.

Certain browser plug-ins or extensions, such as Grammarly, may interfere with submitting comments on the comment form. If you have issues, please disable browser plugins and extensions, refresh the page, and try submitting your comment again. If you need additional assistance, please contact the Help Desk at 1-877-378-5457.



## Comment on FR Doc # 2018-01226

This is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, [Open Docket Folder](#)

Comment Period Closed

Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-54505

**Tracking Number:** 1k2-925w-7k8n

### Document Information

**Date Posted:**

Mar 29, 2018

**RIN:**

0945-ZA03

[Show More Details](#)

### Submitter Information

**Submitter Name:**

Carl Knorr

### Comment

Because I am gay and live in a rural area, my son (who is not gay) and I have been refused healthcare by our local clinic. As a result, we have been forced to seek a physician in another town rather than receive treatment from our local provider. This is simply wrong.

Certain browser plug-ins or extensions, such as Grammarly, may interfere with submitting comments on the comment form. If you have issues, please disable browser plugins and extensions, refresh the page, and try submitting your comment again. If you need additional assistance, please contact the Help Desk at 1-877-378-5457.



## Comment on FR Doc # 2018-01226

This is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**.

For related information, [Open Docket Folder](#)

Comment Period Closed

Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-56146

**Tracking Number:** 1k2-926h-eh6q

### Document Information

**Date Posted:**

Mar 29, 2018

**RIN:**

0945-ZA03

[Show More Details](#)

### Submitter Information

**Submitter Name:**

Noah Coleman

### Comment

The effort to provide exemptions for patient protections is dangerously misguided.

Please consider what if any medical provider complaints there are feeling "forced" to treat people that they don't wish to treat compared to those patients who deserve to be treated but who can't be.

I live in a more rural area of the country and worrying about disclosing my sexual preference shouldn't be a concern in trying to obtain health care. I can't imagine what it must be like for a transgender person. Can you?

Faith is personal and thus, one should not take on the study and practice of medical care if one is compelled only by faith that eschews exclusivity and judgment.

A mature society fashions protections for those who are marginalized, not for those who have a choice in what they wish to practice.

Access to healthcare should not be at the cost of a practitioners faith, but rather on need.

Thank you,

Noah Coleman  
State College, PA



## Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, [Open Docket Folder](#) 

Comment Period Closed

Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-64757

**Tracking Number:** 1k2-928e-g37m

### Document Information

**Date Posted:**

Mar 29, 2018

**RIN:**

0945-ZA03

[Show More Details](#) 

### Submitter Information

**Submitter Name:**

Elisa Greco

### Comment

Almost all the clinics in our small rural area have very swlf-proclaimed christian employees. Years ago when I was pregnant at a late age, I wanted to discuss all my options with them. They put me off, beat around the bush, mostly on the abortion option, kept not calling me back, et, etc. When, after a while, I had a miscarriage and they finally took my panicked call, they said, "oh, we thought you might have a miscarriage" REALLY! And why did you refuse to tell me that! Rotten bastids!




Certain browser plug-ins or extensions, such as Grammarly, may interfere with submitting comments on the comment form. If you have issues, please disable browser plugins and extensions, refresh the page, and try submitting your comment again. If you need additional assistance, please contact the Help Desk at 1-877-378-5457.



## Comment on FR Doc # 2018-01226

This is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**.

For related information, [Open Docket Folder](#) 

Comment Period Closed

Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-65403

**Tracking Number:** 1k2-928g-q09e

### Document Information

**Date Posted:**

Mar 29, 2018

**RIN:**

0945-ZA03

[Show More Details](#) 

### Submitter Information

**Submitter Name:**

Carrie-Meghan Quick-Blanco

### Comment

Living in a rural area is hard enough for ANYONE to gain access to care without the government letting healthcare providers claim religious exemption for any reason they want.

Health and Human Services Office of Civil Rights

In health care, patients must always come first. This new proposal from HHS encourages health care providers to abandon the principle of “first, do no harm” in favor of their personal beliefs. This puts transgender patients, people who need reproductive health care, and many others at risk of being denied necessary and even life-saving care. Transgender people already face high levels of discrimination by health care providers: for example, just in the past year, out of respondents to the 2015 U.S. Transgender Survey who saw a health care provider, one-third were denied treatment, turned away, or mistreated.

As a transgender woman in a somewhat rural Texas county, this is a significant restriction on availability of health care. Ethical standards for healthcare demand protection of the patient as the first priority. An example is treatment of battlefield injuries. Those that need the most help are treated first regardless of uniform. If we use that standard for wartime care, surely we can use a patient first standard for marginalized individuals.

Along with medical experts and many people of faith, I oppose the proposed regulation. Promoting discrimination is wrong, it is unnecessary, and can harm millions of people who need access to basic care.

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

Katherine Murray

Lake Jackson , TX 77566

Health and Human Services Office of Civil Rights

In health care, patients must always come first. This new proposal from HHS encourages health care providers to abandon the principle of "first, do no harm" in favor of their personal beliefs. This puts transgender patients, people who need reproductive health care, and many others at risk of being denied necessary and even life-saving care. Transgender people already face high levels of discrimination by health care providers: for example, just in the past year, out of respondents to the 2015 U.S. Transgender Survey who saw a health care provider, one-third were denied treatment, turned away, or mistreated.

As a mother of a teenage transgender son. I was looking for help with anxiety, depression and attempted suicide. We live in the Midwest, so somewhat rural area. We located a psychiatrist only 10 miles away ~ Great! Finally I can get him out of his room and someone will help him, I thought! After completing tons of paperwork and waiting 3 months, for what I thought was going to be an appointment for help, I get a phone call that tells me; "I'm sorry, I don't think Dr. O... would be a very good fit for Alex" Ummm, now what ~ Okay, well try a little further away, 40 miles from home ~ No, sorry we don't accept anyone under 18 Years Old. So as a result, I have to take my child to the University of Iowa, over 100 miles from home, for both psychology and primary healthcare. While we are fortunate to have an excellent facility in th UofI, others are not as fortunate!

Along with medical experts and many people of faith, I oppose the proposed regulation. Promoting discrimination is wrong, it is unnecessary, and can harm millions of people who need access to basic care.

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

Cynthia Emdia  
2238 190th ave  
Donnellson , IA 52625



## Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services (HHS)** Proposed Rule: **Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, [Open Docket Folder](#)

Comment Period Closed  
Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-71815

**Tracking Number:** 1k2-929d-99ts

### Comment

As a Transgender Woman I have found Health Care access to be limited in my small rural Oregon Community. Allowing individuals to deny me emergency, routine or any health care is discrimination based on sex. I deserve access to health care. The slippery slope of discrimination in dichotomy 28th sex discrimination can result in horrible outcomes and does as is examples is Nation States where even attending school is denied women. My Nation doesn't year people down and leave them at risk through thoughtless discrimination. I urge you to deny discrimination based on sex by allowing the individual to harm another based on religious freedom.

### Document Information

**Date Posted:**

Mar 29, 2018

**RIN:**

0945-ZA03

[Show More Details](#)

### Submitter Information

**Submitter Name:**

Christina Ketcham



### Comment on FR Doc # 2018-01226

This is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, [Open Docket Folder](#)

[Site Data](#)

[Regulatory Agenda](#)

[Agency Report](#)

[Comment Period Closed by Statute](#)  
Mar 27 2018, at 11:59 PM ET

#### Comment

I was denied care by over 50 doctors because I am transgender and then I had to drive 4 hours to get the needed care. Do not allow this type of hate to continue.

**ID:** HHS-OCR-2018-0002-71880  
**Tracking Number:** 1k2-929d-ssd3

#### Document Information

**Date Posted:**  
Mar 29, 2018

**RIN:**  
0945-ZA03

[Show More Details](#)

#### Submitter Information

**Submitter Name:**  
Darlene Fike

Certain browser plug-ins or extensions, such as Grammarly, may interfere with submitting comments on the comment form. If you have issues, please disable browser plugins and extensions, refresh the page, and try submitting your comment again. If you need additional assistance, please contact the Help Desk at 1-877-378-5457.



## Comment on FR Doc # 2018-01226

This is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, [Open Docket Folder](#)

Comment Period Closed  
Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-71960  
**Tracking Number:** 1k2-929e-gkew

### Document Information

**Date Posted:**  
Mar 29, 2018

**RIN:**  
0945-ZA03

[Show More Details](#)

### Submitter Information

**Submitter Name:**  
Jody Huckaby

### Comment

I have a chronic disease that requires quarterly monitoring including blood lab work. I live in an area where I have few health insurance options (currently two). If healthcare providers are allowed to opt out of providing care to me because I am a gay American, My chronic disease could become a much more expensive life threatening disease that would ultimately cost me, other tax payers and/or the government more money for treatment. Seriously, after all of the progress this country has made on ending discrimination (which research clearly illustrates is bad for our economy) would be a major step backward. If this Admonistration wants to make America great again, then keep no discrimination as a primary value that sets our country apart from much of the rest of the globe. If we don't, we could find ourselves living in a country where male, white, heavy set, old people could find themselves without anyone willing to provide them with healthcare. Is they really what this president and his administration envisions when he said he wants to "make America great again"? Discrimination is about exclusion. Discrimination may not feel like a threat until it starts excluding you. Allow discrimination in healthcare today, and watch what classifications of Americans get added next. This country deserves better than this. I demand better than this for myself, for my family, for all of my loved ones, and for those I don't know who won't take the time time write today.



## Comment on FR Doc # 2018-01226

The is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

For related information, [Open Docket Folder](#)

Comment Period Closed

Mar 27 2018, at 11:59 PM ET

**ID:** HHS-OCR-2018-0002-71973

**Tracking Number:** 1k2-929e-guzz

### Document Information

**Date Posted:**

Mar 29, 2018

**RIN:**

0945-ZA03

[Show More Details](#)

### Submitter Information

**Submitter Name:**

Monica Sicard

### Comment

I am a 100% disabled veteran who lives in a rural area with no doctors. I have to use non-VA doctors in Astoria Oregon for care using community care. So this legislation would leave me health care what so ever!! Is this how I am thanked for serving?? This legislation is an atrocity filled with hate. This is not what I fought for as a soldier in the US Army. I fought for everyone of you so your rights would be preserved on my watch. NOW where are you when mine are threatened... Who Will STAND for me???? I pray it's you.



Ms. Jacqueline Klein  
1328 N Blomberg Rd  
Exeland, WI 54835-4119  
(715) 415-5485

Feb 1, 2018

Planned Parenthood

Subject: Stop discrimination against patients

Dear Planned Parenthood,

I'm writing about the proposed rule that allows providers and other health care workers to deny access to basic health care services, including -- though certainly not limited to -- transgender health services, abortion, and even birth control. This rule, coupled with the newly created "Conscience and Religious Freedom" division within the Office of Civil Rights, would turn the office charged with protecting people throughout the country from discrimination into an office that gives health care workers a license to discriminate against people, simply because of who they are or the services they seek.

If this rule is adopted, it would result in people not getting the care they need -- from people living with HIV seeking treatment to women seeking safe, legal abortions to LGBTQ patients getting basic care for themselves or their families.

I live in a rural community in northern Wisconsin where there is already difficulty in accessing healthcare. This is an egregious attempt to promote discrimination and restrict access to health care, particularly for vulnerable communities like mine that already have trouble accessing it. I urge you to withdraw this dangerous and shameful proposed rule and instead focus your office on protecting access to care.

Sincerely,  
Ms. Jacqueline Klein

1 XAVIER BECERRA, State Bar No. 118517  
Attorney General of California  
2 KATHLEEN BOERGERS, State Bar No. 213530  
Supervising Deputy Attorney General  
3 NELI N. PALMA, State Bar No. 203374  
Deputy Attorney General  
4 1300 I Street, Suite 125  
Sacramento, CA 94244-2550  
5 Telephone: (916) 210-7913  
Fax: (916) 324-5567  
6 E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
7 through Attorney General Xavier Becerra*

8  
9 IN THE UNITED STATES DISTRICT COURT  
10 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
11

12 **STATE OF CALIFORNIA, BY AND  
13 THROUGH ATTORNEY GENERAL XAVIER  
14 BECERRA,**

Plaintiff,

15 v.

16 **ALEX M. AZAR, II, IN HIS OFFICIAL  
17 CAPACITY AS SECRETARY OF THE U.S.  
18 DEPARTMENT OF HEALTH & HUMAN  
19 SERVICES; U.S. DEPARTMENT OF  
DOES 1-100,**

Defendants,  
20  
21

4:19-cv-02769-HSG

**DECLARATION OF FRANCES  
PARMELEE IN SUPPORT OF  
PLAINTIFF'S MOTION FOR  
PRELIMINARY INJUNCTION**

**Date:** October 10, 2019  
**Time:** 2:00 P.M.  
**Dept:** 2, 4<sup>th</sup> Floor  
**Judge:** The Honorable Haywood S.  
Gilliam, Jr.  
**Trial Date:** Not set  
**Action Filed:** May 21, 2019

22 I, Frances Parmelee, declare:

23 1. I have served as the Assistant Vice Chancellor of College Finance and Facilities  
24 Planning Division with the California Community Colleges (CCC) since September 2016. In this  
25 role, I oversee and support the Budget Unit, Fiscal Services Unit, Fiscal Standards and  
26 Accountability Unit, and Facilities Planning Unit. Prior to joining the Chancellor's Office, I  
27 worked as an auditor, audit supervisor and audit manager with the Department of Finance for  
28 more than two decades. During this time, I led teams on a variety of financial and performance

1 audits, as well as organization-wide professional development activities. I earned a Bachelor of  
2 Science degree in Business Administration, Accounting and Finance from California State  
3 University, Sacramento and am an active CPA.

4 2. The California Community Colleges (CCC) is the largest system of higher  
5 education in the nation, with 2.1 million students attending 115 colleges. With a wide range of  
6 educational offerings, the colleges provide workforce training, basic courses in English and math,  
7 certificate and degree programs and preparation for transfer to four-year institutions. The  
8 colleges thus play a critical role in the state's public education system.

9 3. I am familiar with the final rule entitled "Protecting Statutory Conscience Rights  
10 in Health Care; Delegations of Authority" (the Rule), published in the Federal Register on May  
11 21, 2019.

12 4. The Rule places at risk federal funds CCC receives from the U.S. Department of  
13 Health and Human Services, the U.S. Department of Education, and the U.S. Department of  
14 Labor, if California is determined to be in violation of the Rule.

15 5. Federal funding comes to CCC from appropriations acts approved by Congress  
16 and signed by the president. The Department of Defense and Labor, Health and Human Services,  
17 and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Public Law  
18 115-245, which was enacted September 28, 2019, makes appropriations that provide funding to  
19 CCC. In fiscal year 2018-2019, CCC received \$83.4 million which may be at risk.

20 6. The following funding sources are at risk:

- 21 a. CalWORKs Services. These funds are 0.14% of the overall budget and used  
22 for the purpose of assisting welfare recipient students and those in transition  
23 off of welfare to achieve long-term self-sufficiency through coordinated  
24 student services offered at community colleges including: work study, job  
25 placement, child care, coordination, curriculum development and redesign,  
26 and under certain conditions post-employment skills training, and  
27 instructional services.  
28

1                   b. Foster Care Education Program. These funds are 0.11% of the overall budget  
2                   and used for provide quality education and support opportunities to caregivers  
3                   of children and youth in out-of-home care so that these providers may meet  
4                   the educational, emotional, behavioral and developmental needs of children  
5                   and youth in the foster care system.

6                   c. Vocational Education. These funds are 1.15% of the overall budget and is  
7                   aimed at increasing the quality of career technical education statewide.

8           7.        In developing its budget, CCC does so in the expectation that it will receive the  
9           federal funds placed at risk under the rule, to which it is entitled under agreements with federal  
10           agencies. A sudden disruption in anticipated federal funds would cause budgetary and operational  
11           chaos.

12           8.        Loss of federal funding will have a deleterious impact on CCC. CCC will be  
13           unable to absorb such a large loss of funding without reducing staffing, programs, and services.

14           9.        If CCC were to lose federal funding, students who rely on CalWORKS services,  
15           the Foster Care Education Program, and our Vocational Education programs would be impacted  
16           and would be less able to receive a quality education.

17           10.       The Rule may also necessitate programmatic changes. For example, some  
18           colleges have a pre-nursing program requirement that states that all incoming nursing students  
19           need to have completed a series of immunizations/vaccinations (including some vaccinations that  
20           the Rule appears to call into question, including MMR (Measles, Mumps & Rubella), Polio, and  
21           Varicella (chicken pox). If the community college has a course for pre-med or pre-nursing  
22           students wherein the students would be required to do training on vaccines or some other  
23           “procedure” that he/she finds objectionable, then the college could not require that the student  
24           “assist in the performance” of that procedure. The colleges would need to make changes to their  
25           programs to account for such refusals.

26           ///

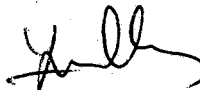
27           ///

28           ///

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 30, 2019 in Sacramento, CA.



---

Frances Parmelee  
Assistant Vice Chancellor  
California Community Colleges

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
 Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra

8 IN THE UNITED STATES DISTRICT COURT  
 9 FOR THE NORTHERN DISTRICT OF CALIFORNIA

11 **STATE OF CALIFORNIA, BY AND**  
 12 **THROUGH ATTORNEY GENERAL XAVIER**  
 13 **BECERRA,**

Plaintiff,

v.

14  
 15  
 16 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
**CAPACITY AS SECRETARY OF THE U.S.**  
**DEPARTMENT OF HEALTH & HUMAN**  
 17 **SERVICES; U.S. DEPARTMENT OF**  
**HEALTH AND HUMAN SERVICES;**  
 18 **DOES 1-100,**

Defendants,

4:19-cv-02769-HSG

**DECLARATION OF DENISE PINES IN**  
**SUPPORT OF PLAINTIFF'S MOTION**  
**FOR PRELIMINARY INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S.  
 Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

20  
 21 I, DENISE PINES, declare:

22 1. I am the President of the Medical Board of California (Board). I was appointed as  
 23 a public member to the Board by Governor Edmund Gerald Brown, Jr., on August 29, 2012, and  
 24 was elected President of the Board on July 26, 2018. I make this declaration in my official  
 25 capacity as President of the Board and make this declaration of my own personal knowledge.

26 2. The Board is a state governmental agency established to protect the public by  
 27 regulating the practice of physicians and surgeons and certain allied health care professionals,  
 28



1 including licensed midwives; it is a component of the California Department of Consumer  
2 Affairs. Cal. Bus. & Prof. Code §§ 101, 2004. The Board is responsible for the implementation  
3 and enforcement of the Medical Practice Act, the state laws related to medical education,  
4 licensure, practice, and discipline. Cal. Bus. & Prof. Code § 2000 *et seq.* The Board's  
5 authorizing statutes designate its highest priority as the protection of the public. Cal. Bus. & Prof.  
6 Code § 2001.1.

7         3. The Board's enforcement statute, California Business and Professions Code  
8 section 2234, directs that the Board shall take action against any licensee who is charged with  
9 unprofessional conduct. Unprofessional conduct under California Business and Professions  
10 Code section 2234 is conduct which breaches the rules or ethical code of the medical profession,  
11 or conduct which is unbecoming a member in good standing of the medical profession, and which  
12 demonstrates an unfitness to practice medicine. *Shea v. Board of Medical Examiners* (1978) 81  
13 Cal.App.3d 564, 575.

14         4. To carry out its mission of protecting the public, the Board performs a number of  
15 functions, including but not limited to:

- 16             a. Evaluating licensure applications to determine whether the applicant meets  
17                 the criteria for licensure;
- 18             b. Enforcing state law by taking appropriate disciplinary action against  
19                 physicians and surgeons and other allied health care professionals who violate  
20                 the Medical Practice Act; and
- 21             c. Adopting regulations and guidance to clarify the performance, practice, and  
22                 disciplinary standards for its licensees.

23         5. The Board is mandated to protect consumers from licensees who practice in a  
24 manner that may be unsafe or unprofessional. The Board has authority to revoke, suspend, or  
25 place on probation any license if the licensee has violated a provision of the law governing the  
26 profession. Cal. Bus. & Prof. Code § 2220.

27

28



1           6.       Physicians and surgeons and licensed midwives have a duty to obtain informed  
2 consent of patients before performing or ordering a procedure or treatment for which informed  
3 consent is required. See, e.g., 22 Cal. Code of Regs. § 72528.

4           7.       The Board has a statutory responsibility to discipline a licensee if, because of a  
5 characteristic protected by California's Unruh Civil Rights Act, the licensee refuses to perform  
6 the licensed activity, if the licensee incites another licensee to refuse to perform the licensed  
7 activity, or if the licensee makes any discrimination or restriction in performing the licensed  
8 activity. Cal. Bus. & Prof. Code § 125.6(a)(1). Characteristics protected under the Unruh Civil  
9 Rights Act are sex, race, color, religion, ancestry, national origin, disability, medical condition,  
10 genetic information, marital status, sexual orientation, citizenship, primary language, and  
11 immigration status. Cal. Civ. Code § 51(b). "Sex" is defined to include, but not be limited to,  
12 gender, gender identity, gender expression, pregnancy, childbirth, and medical conditions related  
13 to pregnancy or childbirth. Cal Civ. Code § 51(e)(5).

14           8.       I am familiar with the final rule Protecting Statutory Conscience Rights in Health  
15 Care; Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and  
16 Human Services and published in the Federal Register on May 21, 2019 (the Rule).

17           9.       The Rule creates a broad exemption for medical professionals and personnel to opt  
18 out of any healthcare service based on a moral or religious ground. Specific scenarios are  
19 included in the Rule, including abortion, sterilization, euthanasia, certain vaccinations if there is  
20 an "aborted fetal tissue" connection (rubella, polio, Hep A, chickenpox, small pox),  
21 contraception, gender transition/gender dysphoria (counseling, administering hormone  
22 prescriptions, etc.), tubal ligations, hysterectomies, assisted suicide, and referrals for advanced  
23 directives.

24           10.      Under the Rule, there is not any exception provided for emergency situations.  
25 This is notable because even in the exercise of a physician's conscience, "[p]hysicians are  
26 expected to provide care in emergencies, honor patients' informed decisions to refuse life-  
27 sustaining treatment, and respect basic civil liberties and not discriminate against individuals in  
28 deciding whether to enter into a professional relationship with a new patient." American Medical

1 Association, Policy E-1.1.7, "Physician Exercise of Conscience." Code of Medical Ethics.  
2 Adopted 2016. *See also* Cal. Health & Saf. Code § 123420(d) (stating that California's abortion  
3 conscience refusal law does not apply to medical emergency situations and spontaneous  
4 abortions); Cal. Health & Saf. Code § 1317 (a) & (e) (requiring that any health facility that  
5 operates an emergency department provide emergency services to patients for any condition in  
6 which the person is in danger of loss of life, or serious injury or illness); *see also* 42 U.S.C. §  
7 1395dd(a).

8 11. Under the Rule, physicians and surgeons can refuse medical care without any  
9 information about the patient's medical condition or treatment options, not just on the basis of  
10 federally protected conscience protections, but also on the basis of "ethical or other reasons." A  
11 provider can do this without any supporting evidence, without notifying a supervisor of the denial  
12 of service, even in emergency situations, and without providing notice or alternative options  
13 and/or referrals to patients in need.

14 12. The Rule if implemented may thus impact the work and mission of the Board.

15 13. If, as a result of the Rule's requirements, patients file complaints against  
16 physicians and surgeons who deny care or fail to provide them with timely, accurate, and  
17 complete information, or if there is a complaint of denial of care due to an allegation of  
18 discrimination, then the Board will have to investigate such complaints.

19 14. Furthermore, the Board is responsible for enforcing California law through  
20 disciplinary proceedings. Thus, the Board may face an increase in disciplinary matters for  
21 physicians and surgeons if these complaints are substantiated.

22 I declare under penalty of perjury under the laws of the United States and the State of  
23 California that the foregoing is true and correct to the best of my knowledge.

24 Executed on June 3, 2019, in Los Angeles, CA

25  
26 

27 Denise Pines  
28 President  
Medical Board of California

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra*

8 IN THE UNITED STATES DISTRICT COURT  
 9 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 10

11  
 12 **STATE OF CALIFORNIA, BY AND**  
**THROUGH ATTORNEY GENERAL XAVIER**  
**BECERRA,**  
 13  
 14 Plaintiff,  
 15 v.  
 16  
 17 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
**CAPACITY AS SECRETARY OF THE U.S.**  
**DEPARTMENT OF HEALTH & HUMAN**  
**SERVICES; U.S. DEPARTMENT OF**  
**HEALTH AND HUMAN SERVICES;**  
 18 **DOES 1-100,**  
 19  
 20 Defendants,  
 21

4: 19-cv-02769-HSG

**DECLARATION OF STIRLING PRICE  
 IN SUPPORT OF PLAINTIFF'S  
 MOTION FOR PRELIMINARY  
 INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S.  
 Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

22 I, Stirling Price, declare:

23 1. The matters stated in this declaration are true based upon my own personal  
 24 knowledge, except as to those matters stated on information and belief, and as to those matters, I  
 25 believe them to be true, and if called as a witness, I would competently so testify.

26 2. I am employed by the California Department of State Hospitals (DSH). Since my  
 27 appointment in September 2018, I have been the DSH Chief Deputy Director (A). I report to the  
 28 Director of the Department of State Hospitals. In my position as the Chief Deputy Director of

1 DSH, my duties include briefing the Director on any significant matters pertaining to DSH. As  
2 the Acting Chief Deputy Director, five executive directors of the five state hospitals report to me.  
3 In addition, the deputy directors of the following DSH's divisions report to me: Legal, Forensic  
4 Services, Statewide Quality Improvement, Hospital Strategic Planning and Implementation,  
5 Administrative Services, Clinical Operations, Office of Protective Services and Technology  
6 Services. My current duties as the Chief Deputy Director include the following: I attend all the  
7 DSH executive team meetings regarding DSH policy and procedures. I am involved in DSH  
8 matters concerning the Health and Human Services Agency, other DSH control agencies, and  
9 public and private stakeholders. I also attend budget hearings before the state legislature.

10 3. Prior to being appointed as DSH's Acting Chief Deputy Director, I was the  
11 Executive Director of DSH-Atascadero. I was in this position from January 1, 2015 to August 31,  
12 2018. Prior to working at DSH-Atascadero, I was the interim Deputy Director, Forensic Services.  
13 Prior to that, I was the Executive Director for DSH-Stockton. I was in this position when the  
14 hospital opened on July 22, 2013. This facility is now under the jurisdiction of the California  
15 Department of Corrections and Rehabilitation (CDCR). Prior to working at DSH-Stockton, in  
16 2011 I was the Executive Director at the DSH-Vacaville Psychiatric Program and the acting  
17 Executive Director at DSH-Salinas Valley Psychiatric Program, both of which are currently under  
18 the jurisdiction of CDCR. In May 1981, I earned an Associate of Arts degree from Los Angeles  
19 Valley College. In May 1989, I earned a Bachelor of Arts Degree from California State  
20 University, Sacramento. In May 1991, I earned a Master's Degree in Social Work from California  
21 State University, Sacramento. In 1994, I became a California Licensed Clinical Social Worker  
22 (LCSW).

23 4. DSH is one of 16 departments and offices in the California Health and Human  
24 Services Agency. DSH manages the California state hospital system, which provides mental  
25 health services to patients admitted into DSH facilities. The department strives to provide  
26 effective treatment in a safe environment and in a fiscally responsible manner. DSH oversees  
27 five state hospitals: Atascadero, Coalinga, Metropolitan (in Los Angeles County), Napa and  
28



1 Patton. As of 2018, the department employs more than 11,000 staff and serves more than 12,000  
2 patients annually in a 24/7 hospital system.

3 5. In the last ten years, the population demographics of DSH has shifted from fewer  
4 civil court commitments to primarily a forensic population committed through the criminal court  
5 system. Approximately 91 percent of the patient population is forensic. The remaining 9% are  
6 patients admitted in accordance with the Lanterman-Petris-Short (LPS) Act (mental health  
7 confinements).

8 6. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care;  
9 Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human  
10 Services (HHS) on May 2, 2019 (Rule), and published in the Federal Register on May 21, 2019.

11 7. The Rule will impose an immediate cost on DSH due to its notice, assurance and  
12 certification, recordkeeping, and reporting requirements. The Rule has already imposed costs on  
13 DSH as DSH has been required to spend approximately fifteen hours reading and analyzing the  
14 Rule, and attempting to determine its impact on DSH programs and whether programmatic  
15 changes are necessitated.

16 8. The Rule creates a broad exemption for medical professionals and personnel to opt  
17 out of healthcare services based on a moral or religious ground. Specifically, personnel may opt  
18 out of healthcare services involving abortion, sterilization, and euthanasia. Further, the rule  
19 appears to enable objections to providing a broad range of healthcare services, including certain  
20 vaccinations if there is an “aborted fetal tissue” connection (rubella, polio, Hep A, chickenpox,  
21 small pox), contraception, gender transition/gender dysphoria (counseling, administering  
22 hormone prescriptions, etc.), tubal ligations, hysterectomies, and assisted suicide. There does not  
23 appear to be any exception provided for emergency situations under the Rule.

24 9. DSH does not deny medically necessary care for its patients. Thus as a result of  
25 the Rule, DSH would be required to adopt a Policy Directive that would enforce the patient’s  
26 legal right to necessary medical treatment (even though it may be against an employee’s religious  
27 beliefs). Specifically, the policy would state that any legally and medically required service with  
28 patient consent or a court order, shall be provided by DSH staff or DSH contractors.

1           10.       Currently, if staff were to refuse to perform work due to a religious belief,  
2 substitute staff is brought in to perform the objected-to service. But the Rule expands the scope  
3 of objections that can be made to include objections on the basis of “conscience, religious beliefs,  
4 or moral convictions” to not just services such as abortion, sterilization, and euthanasia (none of  
5 which DSH performs), but also “other health services.” 84 Fed. Reg. 23170, 23228. And the  
6 Rule will be unworkable if it permits a medical provider to refuse “other health services” without  
7 notifying a supervisor of the denial of service, or without providing notice or alternative options  
8 and/or referrals to patients.

9           11.       The notification provision of the Rule will impose costs on DSH. Although the  
10 Rule indicates that the notice provisions are now voluntary (unlike in the proposed rule), the Rule  
11 also states that adherence to the notice provisions will be taken into consideration when assessing  
12 whether an agency is in compliance. To provide notice, DHS will need to: (1) post the notice in  
13 Appendix A (or similar text) at each DSH establishment where notices to the public and  
14 workforce are customarily posted, and thereafter continuously take steps to ensure that the notice  
15 is not altered, defaced, or covered by other materials, (2) include the notice on each of its  
16 websites, and (3) include the notice in its personnel manuals, applications, and benefits and  
17 training materials, as inclusion in these materials will be a factor in determining whether DSH is  
18 in compliance. The estimated costs of compliance with these notification provisions is  
19 approximately \$600 per hospital, due to the necessary changes to websites, physical postings at  
20 all five hospitals and administrative facilities, as well as costs associated with updates to training  
21 manuals, new employee documentation, internship materials, and updates to benefits handbooks.

22           12.       The Rule will require DSH to create and draft a new policy in response to its  
23 requirements. DSH estimates the cost of creating this new policy at \$2,000, taking into account  
24 preparation costs and legal review. In addition the Rule will require DSH legal staff to interpret  
25 and give advice, especially in the first year. DSH estimates costs of \$4,000 for these services in  
26 the first year.

27           13.       However, the aforementioned figures do not include costs that may be associated  
28 with the assurance, certification, and record-keeping requirements, to the extent that they apply,



1 that should be included with all applications, reapplications, and amendments and modifications.  
2 Notably, under the compliance provision, if a sub-recipient (as defined by the Rule) is found in  
3 violation, DSH will be subject to remedial action. This Rule thus places some oversight  
4 obligation on DSH which could result in additional staffing costs to engage in this sub-recipient  
5 monitoring component. This is significant because DSH contracts out for several health services  
6 for its patients to off-site entities.

7 14. The Rule places at risk federal funds DSH receives from the U.S. Department of  
8 Health and Human Services. In fiscal year 2017-2018, DSH received \$4.6 million in Medicare  
9 revenue; only about \$429,000 of this was Medicare Part B funding and not considered Federal  
10 Financial Assistance under the Rule. Loss of approximately \$4.2 million of federal funding  
11 would have a grave impact on DSH operations and its ability to continue to provide services to its  
12 population. DSH would be unable to absorb such a large loss of funding without a reduction in  
13 staffing and services.

14 15. On the contrary, DSH already operates under a constrained budget and continues  
15 to seek solutions to address the significant growth in its patient population. As of December 31,  
16 2018, DSH has a total of 1,101 patients pending placement, of which 815 are Incompetent to  
17 Stand Trial (IST). DSH continues to explore alternatives both in the state hospitals and through  
18 contracted facilities to address the waitlist. Thus, a loss of funding in the magnitude of \$4.2  
19 million (either because it, a sub-recipient, or another California agency is found in violation)  
20 would only further diminish DSH's ability to serve its population.

21 16. In developing its annual budget, DSH did so with the expectation that it would  
22 receive the federal funds which are put at risk under the Rule, and to which it is entitled to under  
23 its agreements with federal agencies.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 28, 2019 in Sacramento, CA.



---

Stirling Price  
Chief Deputy Director (A)  
California Department of State Hospitals

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
 Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra

8 IN THE UNITED STATES DISTRICT COURT  
 9 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 10

11  
 12 **STATE OF CALIFORNIA, BY AND**  
 13 **THROUGH ATTORNEY GENERAL XAVIER**  
 14 **BECERRA,**

Plaintiff,

15 v.

16 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
 17 **CAPACITY AS SECRETARY OF THE U.S.**  
 18 **DEPARTMENT OF HEALTH & HUMAN**  
 19 **SERVICES; U.S. DEPARTMENT OF**  
 20 **HEALTH AND HUMAN SERVICES;**  
 21 **DOES 1-100,**

Defendants,

4:19-cv-02769-HSG

**DECLARATION OF JAY STURGES IN**  
**SUPPORT OF PLAINTIFF'S MOTION**  
**FOR PRELIMINARY INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S.  
 Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

22 I, Jay Sturges, declare:

23 1. I am the Associate Secretary, Fiscal Policy and Administration, for the California  
 24 Labor and Workforce Development Agency (LWDA). I serve as the primary advisor to the  
 25 Agency Secretary on the interpretation, development, evaluation and implementation of Agency-  
 26 level fiscal policies and for ensuring the fiscal integrity of the departments, boards and panels  
 27 within the LWDA.  
 28

1           2.       The LWDA is an agency in the executive branch, and the Secretary is a member of  
2 the Governor's Cabinet. LWDA oversees seven major departments, boards and panels that serve  
3 California businesses and workers: the Agricultural Labor Relations Board, the California  
4 Employment Development Department, the California Public Employment Relations Board, the  
5 California Unemployment Insurance Appeals Board, the California Workforce Development  
6 Board, the Department of Industrial Relations, and the Employment Training Panel. LWDA  
7 programs and services touch the lives of all members of the state's workforce and their families.

8           3.       I am familiar with the rule Protecting Statutory Conscience Rights in Health Care;  
9 Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human  
10 Services (HHS) on May 2, 2019, and published in the Federal Register on May 21, 2019 (the  
11 Rule).

12           4.       The Rule has already imposed costs on California. LWDA and the departments  
13 within the agency have already spent more than 11 hours reading and analyzing the Rule and  
14 attempting to determine its potential impacts on our programs and workforce.

15           5.       The Rule jeopardizes federal funds departments within the LWDA receive from  
16 the U.S. Department of Labor, if California is determined to violate the Rule. Loss of federal  
17 funding will have a deleterious impact on California, the nation's most populous state, by  
18 hampering workplace safety, stifling economic development, and harming efforts to assist  
19 unemployed individuals. LWDA and the departments and offices it oversees will be unable to  
20 absorb such a tremendous loss of funding without a reduction in staffing, programs and services.

21           6.       In developing the state's annual budget, the departments within the LWDA did so  
22 with the expectation that they would receive the federal funds placed at risk under the Rule, and  
23 to which they are entitled to under agreements with federal agencies. A sudden disruption in  
24 anticipated federal funds would create budgetary and operational chaos.

25           7.       Federal funding comes to the departments within the LWDA from appropriations acts  
26 approved by Congress and signed by the president. The Department of Defense and Labor, Health  
27 and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations  
28 Act, 2019, Public Law 115-245, which was enacted September 28, 2019, makes appropriations



1 for the following programs (among others), which provide funding to the departments within the  
2 LWDA:

- 3 • Title III of the Social Security Act, (the State Unemployment Insurance Program), to  
4 provide payments to laid-off workers;
- 5 • The Workforce Innovation and Opportunity Act, including grants to states for adult  
6 employment and training activities, youth activities, and dislocated worker  
7 employment and training activities;
- 8 • The Wagner-Peyser Act of 1933 to establish a nationwide system of public  
9 employment offices to assist individuals seeking employment;
- 10 • The Occupational Safety and Health Act, section 23(g), to assist states in  
11 administering and enforcing programs for occupational safety and health;
- 12 • The Jobs for Veterans State grants program under 38 U.S.C. 4102A(b)(5) to support  
13 disabled veterans' outreach program specialists; and
- 14 • The National Apprenticeship Act to expand apprenticeship and on-the-job training  
15 programs.

16 8. Federal funding supports numerous programs within the LWDA, including dollars  
17 that support state operations or are passed through to local workforce development boards. With  
18 regard to the programs within LWDA (among others) that are jeopardized by the Rule, the state's  
19 2019-20 Governor's Budget anticipates receiving federal funding in state fiscal year 2018-19 for  
20 the following programs:

- 21 • The California Employment Development Department provides short-term income  
22 replacement for individuals who are unemployed through no fault of their own  
23 through the administration of the Unemployment Insurance benefit payment program,  
24 allocates funding to local workforce development boards and provides direct services  
25 that benefit job seekers and employers statewide (\$899.9 million);
- 26 • The California Unemployment Insurance Appeals Board conducts impartial hearings  
27 and issues decisions to resolve disputed unemployment insurance determinations  
28 (\$66.5 million);

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

- The California Workforce Development Board, which collaborates with both state and local partners to establish and continuously improve the state workforce system, with an emphasis on California’s economic vitality and growth (\$4.8 million);
- The Department of Industrial Relations (DIR), which is responsible for enforcing workers’ compensation insurance laws, adjudicating workers’ compensation claims, and working to prevent industrial injuries and deaths, as well as promulgating regulations and enforcing laws relating to wages, hours, and conditions of employment, promoting apprenticeship and other on-the-job training, and analyzing and disseminating statistics which measure the condition of labor in the state (\$38.3 million);

9. Within DIR, federal funding supports numerous programs and subprograms, including the following:

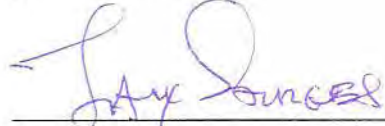
- The Division of Occupational Safety and Health, which promotes and enforces measures to protect the health and safety of workers on the job and the safe operation of elevators, amusement rides, aerial passenger tramways, and pressure vessels for the benefit of the general public, is authorized through the state budget to receive a total of \$36.4 million in federal funding in 2018-19. This supports the Compliance subprogram (\$25.9 million), the Mining and Tunneling subprogram (\$433,000), the Occupational Safety and Health Appeals Board (\$2.3 million), the Occupational Safety and Health Standards Board (\$1.2 million), and Consultation Services (\$6.6 million);
- The Division of Labor Standards Enforcement, for the Retaliation subprogram (\$504,000); and
- The Division of Apprenticeship Standards, to increase the number of apprenticeships in California (\$1.4 million).

///  
///  
///

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on May 22, 2019 in Sacramento, California.



---

Jay Sturges  
Associate Secretary, Fiscal Policy and  
Administration  
California Labor & Workforce Development  
Agency



1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGER, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
 Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra

8  
 9 IN THE UNITED STATES DISTRICT COURT  
 10 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 11

12 **STATE OF CALIFORNIA, BY AND**  
 13 **THROUGH ATTORNEY GENERAL XAVIER**  
 14 **BECERRA,**  
 Plaintiff,  
 15  
 16 v.  
 17 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
**CAPACITY AS SECRETARY OF THE U.S.**  
**DEPARTMENT OF HEALTH & HUMAN**  
 18 **SERVICES; U.S. DEPARTMENT OF**  
**HEALTH AND HUMAN SERVICES;**  
 19 **DOES 1-100,**  
 20 Defendants,  
 21

4:19-cv-02769-HSG

**DECLARATION OF DIANA TOCHE,**  
**D.D.S., IN SUPPORT OF PLAINTIFF’S**  
**MOTION FOR PRELIMINARY**  
**INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S.  
 Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

22 I, Diana Toche, D.D.S., declare:

23 1. The matters stated in this declaration are true based on my own personal  
 24 knowledge, except as to those matters stated on information and belief, and as to those matters, I  
 25 believe them to be true, and if called as a witness, I would competently so testify.

26 2. I am the Undersecretary for Health Care Services, California Department of  
 27 Corrections and Rehabilitation (CDCR) and have been serving in this capacity since May 13,  
 28 2014. Previously, I served CDCR as the Acting Undersecretary for Administration and Offender



1 Services, Acting Director of the Division of Health Care Services and Deputy Director, Division  
2 of Health Care Services, Dental Programs. Some of my current duties as Undersecretary for  
3 Health Care Services include directing the management and supervision of medical, mental  
4 health, dental and ancillary health care services for inmates under the jurisdiction of CDCR.

5 3. In conjunction with Clark Kelso, the federal Receiver appointed under the federal  
6 class action of *Plata v. Brown*, I lead California Correctional Health Care Services (CCHCS), the  
7 state entity responsible for providing health care services to CDCR's adult prison population.  
8 The CCHCS provides medical, dental, and mental health care services to California's prison  
9 inmate population of approximately 129,000 in 35 CDCR institutions and contracted facilities. It  
10 is also responsible for monitoring and directing the care for about 4000 inmates at CDCR's  
11 contracted facilities. CCHCS has almost 18,000 state civil service positions authorized in Fiscal  
12 Year 2018-2019, primarily located at the 35 prisons, at its headquarters in Elk Grove, California,  
13 and at CDCR headquarters in Sacramento, California. In addition to state funding, CCHCS is  
14 eligible to receive federal Medicaid funds for the inpatient hospitalization of some inmates  
15 through the California Department of Health Care Service Medi-Cal program, pursuant to  
16 California Penal Code sections 5072 and 2065.

17 4. I am familiar with the rule, "Protecting Statutory Conscience Rights in Health  
18 Care; Delegations of Authority," RIN 0945-AA10, issued by the U.S. Department of Health and  
19 Human Services (the Rule), published in the Federal Register on May 21, 2019.

20 5. The Rule will impose an immediate cost on CCHCS due to its notice, assurance  
21 and certification, recordkeeping, and reporting requirements. The Rule has already imposed costs  
22 on CCHCS as CCHCS has been required to spend twenty hours reading and analyzing the Rule,  
23 and attempting to determine its impact on CCHCS programs and whether programmatic changes  
24 are necessitated.

25 ///

26 ///

27 ///

28 ///

1           6.       The Rule allows health care staff and ancillary personnel to refuse to provide care  
2 on religious or moral grounds for wide range of services, including but not limited to abortion,  
3 sterilization and euthanasia. Objections could apparently also impact providing vaccinations,  
4 treatment for gender dysphoria and delivering end-of-life care.

5           7.       CCHCS was established in order for the state to better coordinate its continuing  
6 remedial efforts with those of the court-appointed Receiver in the *Plata* case. Inmates in the  
7 custody of CDCR are entitled to receive medical, dental and mental health care in a  
8 nondiscriminatory and timely manner under both federal and state law. California Penal Code  
9 sections 3402 through 3409 mandate services for female inmates, including contraception, birth  
10 control and abortion. Under the Eighth and Fourteenth Amendments, CCHCS is obliged to  
11 provide transgender inmates with medical and mental health care services. As noted by the  
12 Supreme Court in *Brown v. Plata*, 563 U.S. 493 (2011), mental health and medical care in CDCR  
13 were determined to fall below Eighth Amendment standards in 1995 and 2001, respectively.  
14 Providing timely access to emergency, routine and specialty care and ensuring inmates receive  
15 competent, effective services as required for CCHCS and CDCR to comply with the continuing  
16 orders of the federal district court cases are key linchpins of CCHCS' efforts.

17           8.       Ensuring there are sufficient numbers of providers, nurses and support staff  
18 available to provide inmate care within the California prison system and that they effectively  
19 coordinate with community specialty and hospital services are essential components of a  
20 constitutionally adequate correctional health care delivery system. In addition, custody and  
21 transportation staff must be available and ready to ensure security for in-prison care and  
22 especially for off-site services and hospitalizations. The Rule appears to allow a medical provider  
23 to deny care for an uncertain range of health services without providing notice or making  
24 alternative options available. It is not clear whether objections could be lodged by the  
25 correctional staff whose assistance is critical to the delivery of a contested medical service.  
26 Having to arrange for substituted provider staff and rescheduling appointments and transportation  
27 will increase risks in the delivery of inmate health care services. Delays by themselves can put  
28 CCHCS out of compliance with court orders. Additional staff and contractors will be added to

1 ensure sufficient redundant capabilities are available for unexpected objections to provide care.  
2 Modifications to workforce policies regarding the expected performance, procedures for  
3 conducting employee investigations and modifications to bargaining unit agreements are  
4 anticipated, particularly during the first year of the Rule.

5       9.       The notification provisions of the Rule will impose further costs on CCHCS.  
6 Although the Rule indicates that the notice provisions are now voluntary (unlike in the proposed  
7 rule), the Rule also states that adherence to the notice provisions will be taken into consideration  
8 when assessing whether an agency is in compliance. To provide notice, CCHCS will need to: (1)  
9 post the notice in Appendix A (or similar text) at each CCHCS establishment where notices to the  
10 public and workforce are customarily posted, and thereafter continuously take steps to ensure that  
11 the notice is not altered, defaced, or covered by other materials, (2) include the notice on each of  
12 its websites, and (3) include the notice in its personnel manuals, applications, and benefits and  
13 training materials, as inclusion in these materials will be a factor in determining whether CCHCS  
14 is in compliance. The estimated costs of compliance with these notification provisions is  
15 approximately \$10,000 due to the necessary changes to websites, physical postings at medical  
16 facilities and administrative facilities, as well as costs associated with updates to training  
17 manuals, new employee documentation, internship materials, and updates to benefits handbooks.

18       10.       The Rule also includes an assurance and certification requirement that should be  
19 included with all applications, reapplications, and amendments and modifications. The provision  
20 also places an obligation on CCHCS to take actions to come into compliance. Notably and under  
21 the compliance provision, if a sub-recipient (as defined by the Rule) is found in violation,  
22 CCHCS will be subject to remedial action. The Rule requires CCHCS to undertake some  
23 additional oversight obligations regarding its hundreds of contracted health care providers  
24 working both within CDCR institutions and in the community which would require CCHCS to  
25 utilize additional staff time to perform this sub-recipient monitoring component.

26       11.       In addition to responding to complaints and investigations, the compliance  
27 provision of the Rule includes a recordkeeping and reporting requirement applicable to all  
28 recipients and sub-recipients which obligates CCHCS to include information concerning any

1 compliance reviews or complaints to the Office of Civil Rights within the last five years as part of  
2 the application process. The costs of responding to any complaints and any resulting  
3 recordkeeping and reporting requirements is unknown but hard costs and staff time could be  
4 significant depending on the number of complaints submitted.

5  
6 12. The Rule places at risk federal funds CCHCS receives from the U.S. Department  
7 of Health and Human Services. In the past two fiscal years, CCHCS has received over \$89  
8 million dollars from Medi-Cal, funds critically necessary to support the current level of care by  
9 civil service and contracted staff and facilities. The appointment of the federal Receiver was, in  
10 large part, due to the state's inability to adequately ensure a sufficient number of CDCR providers  
11 and arrange for an available network of community specialists and facilities. A loss of federal  
12 funding would materially undermine the efforts of CCHCS and CDCR to provide a constitutional  
13 level of health care for California inmates.

14  
15 I declare under penalty of perjury under the laws of the United States and the State of  
16 California that the foregoing is true and correct to the best of my knowledge.

17 Executed on June 4, 2019, in Sacramento, California.

18  
19 

20 Diana Toche, DDS  
21 Undersecretary  
22 California Department of Corrections and  
23 Rehabilitation  
24  
25  
26  
27  
28

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra*

8  
 9 IN THE UNITED STATES DISTRICT COURT  
 10 FOR THE NORTHERN DISTRICT OF CALIFORNIA  
 11

12 **STATE OF CALIFORNIA, BY AND**  
 13 **THROUGH ATTORNEY GENERAL XAVIER**  
 14 **BECCERRA,**

Plaintiff,

15 v.

16 **ALEX M. AZAR, II, IN HIS OFFICIAL**  
 17 **CAPACITY AS SECRETARY OF THE U.S.**  
 18 **DEPARTMENT OF HEALTH & HUMAN**  
 19 **SERVICES; U.S. DEPARTMENT OF**  
 20 **HEALTH AND HUMAN SERVICES;**  
 21 **DOES 1-100,**

Defendants,

4:19-cv-02769-HSG

**DECLARATION OF CHRISTOPHER M. ZAHN, MD IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION**

Date: October 10, 2019  
 Time: 2:00 P.M.  
 Dept: 2, 4<sup>th</sup> Floor  
 Judge: The Honorable Haywood S. Gilliam, Jr.  
 Trial Date: Not set  
 Action Filed: May 21, 2019

22 I, Christopher M. Zahn, MD, declare:

23 1. I am the Vice President, Practice Activities at the American College of  
 24 Obstetricians and Gynecologists (ACOG). I received my medical degree from Uniformed  
 25 Services University of the Health Sciences and I am a retired Air Force Officer. Prior to working  
 26 at ACOG, I was a Professor and Chair of Obstetrics and Gynecology at the Uniformed Services  
 27 University of the Health Sciences (USUHS), and a staff physician in the Departments of  
 28



1 Obstetrics and Gynecology and Pathology at Walter Reed National Military Medical Center in  
2 Bethesda, Maryland.

3 2. ACOG is the specialty's premier professional membership organization dedicated  
4 to the improvement of women's health. With more than 58,000 members, the College is a  
5 501(c)(6) organization and its activities include producing practice guidelines and other  
6 educational material.

7 3. ACOG periodically releases Committee Opinions. Committee Opinions represent  
8 an ACOG committee's assessment of emerging issues in obstetric and gynecologic practice and  
9 are reviewed regularly for accuracy.

10 4. ACOG Committee Opinion 385, "The Limits of Conscientious Refusal in  
11 Reproductive Medicine" was released by the ACOG Committee on Ethics in November 2007 and  
12 was reaffirmed in 2016. A true and correct copy of Committee Opinion 385 is attached as Exhibit  
13 A.

14 5. Per Committee Opinion 385, "[t]hose who choose the profession of medicine (like  
15 those who choose the profession of law or who are trustees) are bound by special *fiduciary duties*,  
16 which oblige physicians to act in good faith to protect patients' health—particularly to the extent  
17 that patients' health interests conflict with physicians' personal or self-interest." (Italics in  
18 original.)

19 6. Per Committee Opinion 385, "[p]roviding complete, scientifically accurate  
20 information about options for reproductive health, including contraception, sterilization, and  
21 abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision  
22 making in reproductive medicine. Providers refusing to provide such information on the grounds  
23 of moral or religious objection fail in their fundamental duty to enable patients to make decisions  
24 for themselves."

25 7. Per Committee Opinion 385, "[p]atients rightly expect care guided by best  
26 evidence as well as information based on rigorous science. When conscientious refusals reflect a  
27 misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part,  
28 by the strength or weakness of the science on which refusals are based. In other words, claims of

1 conscientious refusal should be considered invalid when the rationale for a refusal contradicts the  
2 body of scientific evidence.”

3 8. Per Committee Opinion 385, “[p]ersons intending conscientious refusal should  
4 consider the degree to which they create or reinforce an unfair distribution of the benefits of  
5 reproductive technology. For instance, refusal to dispense contraception may place a  
6 disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single,  
7 affluent professional might experience such a refusal as inconvenient and seek out another  
8 physician, a young mother of three depending on public transportation might find such a refusal  
9 to be an insurmountable barrier to medication because other options are not realistically available  
10 to her. She thus may experience loss of control of her reproductive fate and quality of life for  
11 herself and her children. Refusals that unduly burden the most vulnerable of society violate the  
12 core commitment to justice in the distribution of health resources.”

13 9. Per Committee Opinion 385, “[l]egitimizing refusals in reproductive contexts may  
14 reinforce the tendency to value women primarily with regard to their capacity for reproduction  
15 while ignoring their interests and rights as people more generally.”

16 10. In Committee Opinion 385, the ACOG Committee on Ethics makes the  
17 recommendation that “[i]n the provision of reproductive services, the patient’s well-being must be  
18 paramount. Any conscientious refusal that conflicts with a patient’s well-being should be  
19 accommodated only if the primary duty to the patient can be fulfilled.”

20 11. In Committee Opinion 385, the ACOG Committee on Ethics makes the  
21 recommendation that “[h]ealth care providers must impart accurate and unbiased information so  
22 that patients can make informed decisions about their health care. They must disclose  
23 scientifically accurate and professionally accepted characterizations of reproductive health  
24 services.”

25 12. In Committee Opinion 385, the ACOG Committee on Ethics makes the  
26 recommendation that “[w]here conscience implores physicians to deviate from standard practices,  
27 including abortion, sterilization, and provision of contraceptives, they must provide potential  
28 patients with accurate and prior notice of their personal moral commitments.”





# **EXHIBIT A**

# ACOG COMMITTEE OPINION

Number 385 • November 2007

## The Limits of Conscientious Refusal in Reproductive Medicine

Committee on Ethics

Reaffirmed 2016

**ABSTRACT:** Health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. In resource-poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

Physicians and other providers may not always agree with the decisions patients make about their own health and health care. Such differences are expected—and, indeed, underlie the American model of informed consent and respect for patient autonomy. Occasionally, however, providers anticipate that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience. In such cases, some providers claim a right to refuse to provide certain services, refuse to refer patients to another provider for these services, or even decline to inform patients of their existing options (1).

Conscientious refusals have been particularly widespread in the arena of reproductive medicine, in which there are deep divisions regarding the moral acceptability of pregnancy termination and contraception. In Texas, for example, a pharmacist rejected a rape victim's prescription for emergency

contraception, arguing that dispensing the medication was a "violation of morals" (2). In Virginia, a 42-year-old mother of two was refused a prescription for emergency contraception, became pregnant, and ultimately underwent an abortion she tried to prevent by requesting emergency contraception (3). In California, a physician refused to perform intrauterine insemination for a lesbian couple, prompted by religious beliefs and disapproval of lesbians having children (4). In Nebraska, a 19-year-old woman with a life-threatening pulmonary embolism at 10 weeks of gestation was refused a first-trimester pregnancy termination when admitted to a religiously affiliated hospital and was ultimately transferred by ambulance to another facility to undergo the procedure (5). At the heart of each of these examples of refusal is a claim of conscience—a claim that to provide certain services would compromise the moral integrity of a provider or institution.



**The American College  
of Obstetricians  
and Gynecologists**  
*Women's Health Care  
Physicians*

In this opinion, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics considers the issues raised by conscientious refusals in reproductive medicine and outlines a framework for defining the ethically appropriate limits of conscientious refusal in reproductive health contexts. The committee begins by offering a definition of conscience and describing what might constitute an authentic claim of conscience. Next, it discusses the limits of conscientious refusals, describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care. It then outlines options for public policy regarding conscientious refusals in reproductive medicine. Finally, the committee proposes a series of recommendations that maximize accommodation of an individual's religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.

### Defining Conscience

In this effort to reconcile the sometimes competing demands of religious or moral freedom and reproductive rights, it is important to characterize what is meant by conscience. *Conscience* has been defined as the private, constant, ethically attuned part of the human character. It operates as an internal sanction that comes into play through critical reflection about a certain action or inaction (6). An appeal to conscience would express a sentiment such as "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night." According to this definition, not to act in accordance with one's conscience is to betray oneself—to risk personal wholeness or identity. Thus, what is taken seriously and is the specific focus of this document is not simply a broad claim to provider autonomy (7), but rather the particular claim to a provider's right to protect his or her *moral integrity*—to uphold the "soundness, reliability, wholeness and integration of [one's] moral character" (8).

Personal conscience, so conceived, is not merely a source of potential conflict. Rather, it has a critical and useful place in the practice of medicine. In many cases, it can foster thoughtful, effective, and humane care. Ethical decision making in medicine often touches on individuals' deepest identity-conferring beliefs about the nature and meaning of creating and sustaining life (9). Yet, conscience also may conflict with professional and ethical standards and result in inefficiency, adverse outcomes, violation of patients' rights, and erosion of trust if, for example, one's conscience limits the information or care provided to a patient. Finding a balance between respect for conscience and other important values is critical to the ethical practice of medicine.

In some circumstances, respect for conscience must be weighed against respect for particular social values. Challenges to a health care professional's integrity may occur when a practitioner feels that actions required by an

external authority violate the goals of medicine and his or her fiduciary obligations to the patient. Established clinical norms may come into conflict with guidelines imposed by law, regulation, or public policy. For example, policies that mandate physician reporting of undocumented patients to immigration authorities conflict with norms such as privacy and confidentiality and the primary principle of nonmaleficence that govern the provider-patient relationship (10). Such challenges to integrity can result in considerable moral distress for providers and are best met through organized advocacy on the part of professional organizations (11, 12). When threats to patient well-being and the health care professional's integrity are at issue, some individual providers find a conscience-based refusal to comply with policies and acceptance of any associated professional and personal consequences to be the only morally tenable course of action (10).

Claims of conscience are not always genuine. They may mask distaste for certain procedures, discriminatory attitudes, or other self-interested motives (13). Providers who decide not to perform abortions primarily because they find the procedure unpleasant or because they fear criticism from those in society who advocate against it do not have a genuine claim of conscience. Nor do providers who refuse to provide care for individuals because of fear of disease transmission to themselves or other patients. Positions that are merely self-protective do not constitute the basis for a genuine claim of conscience. Furthermore, the logic of conscience, as a form of self-reflection on and judgment about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say "I would have a guilty conscience if she did 'x.'" Although some have raised concerns about complicity in the context of referral to another provider for requested medical care, the logic of conscience entails that to act in accordance with conscience, the provider need not rebuke other providers or obstruct them from performing an act (8). Finally, referral to another provider need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees (14).

The authenticity of conscience can be assessed through inquiry into 1) the extent to which the underlying values asserted constitute a core component of a provider's identity, 2) the depth of the provider's reflection on the issue at hand, and 3) the likelihood that the provider will experience guilt, shame, or loss of self-respect by performing the act in question (9). It is the genuine claim of conscience that is considered next, in the context of the values that guide ethical health care.

### Defining Limits for Conscientious Refusal

Even when appeals to conscience are genuine, when a provider's moral integrity is truly at stake, there are clear-



ly limits to the degree to which appeals to conscience may justifiably guide decision making. Although respect for conscience is a value, it is only a *prima facie* value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance. Professional ethics requires that health be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and nondiscriminatory. By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice (15). Thus, with professional privileges come professional responsibilities to patients, which must precede a provider's personal interests (16). When conscientious refusals conflict with moral obligations that are central to the ethical practice of medicine, ethical care requires either that the physician provide care despite reservations or that there be resources in place to allow the patient to gain access to care in the presence of conscientious refusal. In the following sections, four criteria are highlighted as important in determining appropriate limits for conscientious refusal in reproductive health contexts.

### 1. Potential for Imposition

The first important consideration in defining limits for conscientious refusal is the degree to which a refusal constitutes an imposition on patients who do not share the objector's beliefs. One of the guiding principles in the practice of medicine is respect for patient autonomy, a principle that holds that persons should be free to choose and act without controlling constraints imposed by others. To respect a patient's autonomy is to respect her capacities and perspectives, including her right to hold certain views, make certain choices, and take certain actions based on personal values and beliefs (17). Respect involves acknowledging decision-making rights and acting in a way that enables patients to make choices for themselves. Respect for autonomy has particular importance in reproductive decision making, which involves private, personal, often pivotal decisions about sexuality and childbearing.

It is not uncommon for conscientious refusals to result in imposition of religious or moral beliefs on a patient who may not share these beliefs, which may undermine respect for patient autonomy. Women's informed requests for contraception or sterilization, for example, are an important expression of autonomous choice regarding reproductive decision making. Refusals to dispense contraception may constitute a failure to respect women's capacity to decide for themselves whether and under what circumstances to become pregnant.

Similar issues arise when patients are unable to obtain medication that has been prescribed by a physician. Although pharmacist conduct is beyond the scope of this document, refusals by other professionals can have an important impact on a physician's efforts to provide

appropriate reproductive health care. Providing complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine. Providers refusing to provide such information on the grounds of moral or religious objection fail in their fundamental duty to enable patients to make decisions for themselves. When the potential for imposition and breach of autonomy is high due either to controlling constraints on medication or procedures or to the provider's withholding of information critical to reproductive decision making, conscientious refusal cannot be justified.

### 2. Effect on Patient Health

A second important consideration in evaluating conscientious refusal is the impact such a refusal might have on well-being as the patient perceives it—in particular, the potential for harm. For the purpose of this discussion, harm refers to significant bodily harm, such as pain, disability, or death or a patient's conception of well-being. Those who choose the profession of medicine (like those who choose the profession of law or who are trustees) are bound by special *fiduciary duties*, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest (16). Although conscientious refusals stem in part from the commitment to “first, do no harm,” their result can be just the opposite. For example, religiously based refusals to perform tubal sterilization at the time of cesarean delivery can place a woman in harm's way—either by putting her at risk for an undesired or unsafe pregnancy or by necessitating an additional, separate sterilization procedure with its attendant and additional risks.

Some experts have argued that in the context of pregnancy, a moral obligation to promote fetal well-being also should justifiably guide care. But even though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients. Indeed, in the vast majority of cases, the interests of the pregnant woman and fetus converge. For situations in which their interests diverge, the pregnant woman's autonomous decisions should be respected (18). Furthermore, in situations “in which maternal competence for medical decision making is impaired, health care providers should act in the best interests of the woman first and her fetus second” (19).

### 3. Scientific Integrity

The third criterion for evaluating authentic conscientious refusal is the scientific integrity of the facts supporting the objector's claim. Core to the practice of medicine is a commitment to science and evidence-based practice.

Patients rightly expect care guided by best evidence as well as information based on rigorous science. When conscientious refusals reflect a misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part, by the strength or weakness of the science on which refusals are based. In other words, claims of conscientious refusal should be considered invalid when the rationale for a refusal contradicts the body of scientific evidence.

The broad debate about refusals to dispense emergency contraception, for example, has been complicated by misinformation and a prevalent belief that emergency contraception acts primarily by preventing implantation (20). However, a large body of published evidence supports a different primary mechanism of action, namely the prevention of fertilization. A review of the literature indicates that Plan B can interfere with sperm migration and that preovulatory use of Plan B suppresses the luteinizing hormone surge, which prevents ovulation or leads to the release of ova that are resistant to fertilization. Studies do not support a major postfertilization mechanism of action (21). Although even a slight possibility of postfertilization events may be relevant to some women's decisions about whether to use contraception, provider refusals to dispense emergency contraception based on unsupported beliefs about its primary mechanism of action should not be justified.

In the context of the morally difficult and highly contentious debate about pregnancy termination, scientific integrity is one of several important considerations. For example, some have argued against providing access to abortion based on claims that induced abortion is associated with an increase in breast cancer risk; however, a 2003 U.S. National Cancer Institute panel concluded that there is well-established epidemiologic evidence that induced abortion and breast cancer are not associated (22). Refusals to provide abortion should not be justified on the basis of unsubstantiated health risks to women.

Scientific integrity is particularly important at the level of public policy, where unsound appeals to science may have masked an agenda based on religious beliefs. Delays in granting over-the-counter status for emergency contraception are one such example. Critics of the U.S. Food and Drug Administration's delay cited deep flaws in the science and evidence used to justify the delay, flaws these critics argued were indicative of unspoken and misplaced value judgments (23). Thus, the scientific integrity of a claim of refusal is an important metric in determining the acceptability of conscience-based practices or policies.

#### 4. Potential for Discrimination

Finally, conscientious refusals should be evaluated on the basis of their potential for discrimination. Justice is a complex and important concept that requires medical professionals and policy makers to treat individuals fairly and to provide medical services in a nondiscriminatory

manner. One conception of justice, sometimes referred to as the *distributive paradigm*, calls for fair allocation of society's benefits and burdens. Persons intending conscientious refusal should consider the degree to which they create or reinforce an unfair distribution of the benefits of reproductive technology. For instance, refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not realistically available to her. She thus may experience loss of control of her reproductive fate and quality of life for herself and her children. Refusals that unduly burden the most vulnerable of society violate the core commitment to justice in the distribution of health resources.

Another conception of justice is concerned with matters of oppression as well as distribution (24). Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well. Consider, for instance, refusals to provide infertility services to same-sex couples. It is likely that such couples would be able to obtain infertility services from another provider and would not have their health jeopardized, *per se*. Nevertheless, allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult, namely reinforcing the scientifically unfounded idea that fitness to parent is based on sexual orientation, and, thus, reinforcing the oppressed status of same-sex couples. The concept of oppression raises the implications of all conscientious refusals for gender justice in general. Legitimizing refusals in reproductive contexts may reinforce the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally. As the place of conscience in reproductive medicine is considered, the impact of permissive policies toward conscientious refusals on the status of women must be considered seriously as well.

Some might say that it is not the job of a physician to "fix" social inequities. However, it is the responsibility, whenever possible, of physicians as advocates for patients' needs and rights not to create or reinforce racial or socioeconomic inequalities in society. Thus, refusals that create or reinforce such inequalities should raise significant caution.

#### Institutional and Organizational Responsibilities

Given these limits, individual practitioners may face difficult decisions about adherence to conscience in the context of professional responsibilities. Some have offered, however, that "accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences" (1). Rather, institutions and

professional organizations should work to create and maintain organizational structures that ensure nondiscriminatory access to all professional services and minimize the need for individual practitioners to act in opposition to their deeply held beliefs. This requires at the very least that systems be in place for counseling and referral, particularly in resource-poor areas where conscientious refusals have significant potential to limit patient choice, and that individuals and institutions “act affirmatively to protect patients from unexpected and disruptive denials of service” (13). Individuals and institutions should support staffing that does not place practitioners or facilities in situations in which the harms and thus conflicts from conscientious refusals are likely to arise. For example, those who feel it improper to prescribe emergency contraception should not staff sites, such as emergency rooms, in which such requests are likely to arise, and prompt disposition of emergency contraception is required and often integral to professional practice. Similarly, institutions that uphold doctrinal objections should not position themselves as primary providers of emergency care for victims of sexual assault; when such patients do present for care, they should be given prophylaxis. Institutions should work toward structures that reduce the impact on patients of professionals’ refusals to provide standard reproductive services.

### Recommendations

Respect for conscience is one of many values important to the ethical practice of reproductive medicine. Given this framework for analysis, the ACOG Committee on Ethics proposes the following recommendations, which it believes maximize respect for health care professionals’ consciences without compromising the health and well-being of the women they serve.

1. In the provision of reproductive services, the patient’s well-being must be paramount. Any conscientious refusal that conflicts with a patient’s well-being should be accommodated only if the primary duty to the patient can be fulfilled.
2. Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.
3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in con-

science provide the standard reproductive services that their patients request.

5. In an emergency in which referral is not possible or might negatively affect a patient’s physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider’s personal moral objections.
6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients’ rights to health care services.
7. Lawmakers should advance policies that balance protection of providers’ consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.

### References

1. Charo RA. The celestial fire of conscience—refusing to deliver medical care. *N Engl J Med* 2005;352:2471–3.
2. Denial of rape victim’s pills raises debate: moral, legal questions surround emergency contraception. New York (NY): Associated Press; 2004. Available at: <http://www.msnbc.msn.com/id/4359430>. Retrieved July 10, 2007.
3. L D. What happens when there is no plan B? *Washington Post*; June 4, 2006. p. B1. Available at: <http://www.washingtonpost.com/wp-dyn/content/article/2006/06/02/AR2006060201405.html>. Retrieved July 10, 2007.
4. Weil E. Breeder reaction: does everyone now have a right to bear children? *Mother Jones* 2006;31(4):33–7. Available at: [http://www.motherjones.com/news/feature/2006/07/breeder\\_reaction.html](http://www.motherjones.com/news/feature/2006/07/breeder_reaction.html). Retrieved July 10, 2007.
5. American Civil Liberties Union. Religious refusals and reproductive rights: ACLU Reproductive Freedom Project. New York (NY): ACLU; 2002. Available at: <http://www.aclu.org/FilesPDFs/ACF911.pdf>. Retrieved July 10, 2007.
6. Childress JF. Appeals to conscience. *Ethics* 1979;89:315–35.
7. Wicclair MR. Conscientious objection in medicine. *Bioethics* 2000;14:205–27.
8. Beauchamp TL, Childress JF. Principles of biomedical ethics. 5th ed. New York (NY): Oxford University Press; 2001.
9. Benjamin M. Conscience. In: Reich WT, editor. *Encyclopedia of bioethics*. New York (NY): Simon & Schuster Macmillan; 1995. p. 469–73.
10. Ziv TA, Lo B. Denial of care to illegal immigrants. Proposition 187 in California. *N Engl J Med* 1995;332:1095–8.
11. American College of Obstetricians and Gynecologists. Code of professional ethics of the American College of Obste-



- tricians and Gynecologists. Washington, DC: ACOG; 2004. Available at: [http://www.acog.org/from\\_home/acogcode.pdf](http://www.acog.org/from_home/acogcode.pdf). Retrieved July 10, 2007.
12. American Medical Association. Principles of medical ethics. In: Code of medical ethics of the American Medical Association: current opinions with annotations. 2006–2007 ed. Chicago (IL): AMA; 2006. p. xv.
  13. Dresser R. Professionals, conformity, and conscience. *Hastings Cent Rep* 2005;35:9–10.
  14. Blustein J. Doing what the patient orders: maintaining integrity in the doctor-patient relationship. *Bioethics* 1993;7:290–314.
  15. Brody H, Miller FG. The internal morality of medicine: explication and application to managed care. *J Med Philos* 1998;23:384–410.
  16. Dickens BM, Cook RJ. Conflict of interest: legal and ethical aspects. *Int J Gynaecol Obstet* 2006;92:192–7.
  17. Faden RR, Beauchamp TL. A history and theory of informed consent. New York (NY): Oxford University Press; 1986.
  18. Maternal decision making, ethics, and the law. ACOG Committee Opinion No. 321. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2005;106:1127–37.
  19. International Federation of Gynecology and Obstetrics. Ethical guidelines regarding interventions for fetal well being. In: *Ethical issues in obstetrics and gynecology*. London (UK): FIGO; 2006. p. 56–7. Available at: <http://www.figo.org/docs/Ethics%20Guidelines.pdf>. Retrieved July 10, 2007.
  20. Cantor J, Baum K. The limits of conscientious objection—may pharmacists refuse to fill prescriptions for emergency contraception? *N Engl J Med* 2004;351:2008–12.
  21. Davidoff F, Trussell J. Plan B and the politics of doubt. *JAMA* 2006;296:1775–8.
  22. Induced abortion and breast cancer risk. ACOG Committee Opinion No. 285. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2003;102:433–5.
  23. Grimes DA. Emergency contraception: politics trumps science at the U.S. Food and Drug Administration. *Obstet Gynecol* 2004;104:220–1.
  24. Young IM. Justice and the politics of difference. Princeton (NJ): Princeton University Press; 1990.
- 
- Copyright © November 2007 by the American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, posted on the Internet, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher. Requests for authorization to make photocopies should be directed to: Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400.
- The limits of conscientious refusal in reproductive medicine. ACOG Committee Opinion No. 385. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2007;110:1203–8.

1 XAVIER BECERRA, State Bar No. 118517  
 Attorney General of California  
 2 KATHLEEN BOERGERS, State Bar No. 213530  
 Supervising Deputy Attorney General  
 3 NELI N. PALMA, State Bar No. 203374  
 Deputy Attorney General  
 4 1300 I Street, Suite 125  
 Sacramento, CA 94244-2550  
 5 Telephone: (916) 210-7913  
 Fax: (916) 324-5567  
 6 E-mail: Neli.Palma@doj.ca.gov  
*Attorneys for Plaintiff the State of California, by and  
 7 through Attorney General Xavier Becerra*

8  
 9 IN THE UNITED STATES DISTRICT COURT  
 10 FOR THE NORTHERN DISTRICT OF CALIFORNIA

11  
 12 **STATE OF CALIFORNIA, BY AND**  
**THROUGH ATTORNEY GENERAL XAVIER**  
**BECERRA,**  
 13  
 14 Plaintiff,  
 15  
 16 **v.**  
 17  
**ALEX M. AZAR, II, IN HIS OFFICIAL**  
**CAPACITY AS SECRETARY OF THE U.S.**  
**DEPARTMENT OF HEALTH & HUMAN**  
**SERVICES; U.S. DEPARTMENT OF**  
**HEALTH AND HUMAN SERVICES;**  
**DOES 1-100,**  
 19  
 20 Defendants,

4:19-cv-02769-HSG

**DECLARATION OF MARI CANTWELL  
IN SUPPORT OF PLAINTIFF'S  
MOTION FOR PRELIMINARY  
INJUNCTION**

21 I, Mari Cantwell, declare:

22  
 23 1. I am the Medicaid Director for the State of California and Chief Deputy Director  
 24 of Health Care Programs at the California Department of Health Care Services (DHCS). I have  
 25 held the Chief Deputy position since 2013 and the State Medicaid Director position since 2015. I  
 26 have worked in the field of health care policy and finance for almost 20 years. Prior to the  
 27 positions I hold now, I served as the Deputy Director of Health Care Financing for DHCS, and  
 28 previously as the Vice President of Finance Policy for the California Association of Public

1 Hospitals and Health Systems. I hold a B.A. in Public Policy from Brown University, and a  
2 Masters in Public Policy with a focus in Health Policy from the University of California, Los  
3 Angeles.

4       2.       DHCS has the mission to provide Californians with access to affordable,  
5 integrated, high-quality health care, including medical, dental, mental health, substance use  
6 treatment services, and long-term care. Our vision is to preserve and improve the overall health  
7 and well-being of all Californians. DHCS administers and oversees multiple federally-funded  
8 health care programs, including Medicaid, Children’s Health Insurance Program, and several  
9 health-related federal grants. DHCS funds health care services for approximately 13 million  
10 members of Medi-Cal, California’s Medicaid program. About one-third of Californians receive  
11 health care services through programs financed and administered by DHCS, making the  
12 department the largest health care purchaser in California. Among the programs administered by  
13 DHCS, some of which are mandated and/or financed by the federal government and others  
14 required by state law, are: Community Mental Health Block Grant; Substance Use Abuse  
15 Prevention and Treatment Block Grant; Medi-Cal Access Program; California Children’s  
16 Services program; Child Health and Disability Prevention program; the Genetically Handicapped  
17 Persons Program; the Newborn Hearing Screening Program; the Family Planning, Access, Care,  
18 and Treatment program; Program of All-Inclusive Care for the Elderly, and Every Woman  
19 Counts. DHCS also administers programs for underserved Californians, including farm workers  
20 and American Indian communities.

21       3.       I am familiar with the final rule entitled “Protecting Statutory Conscience Rights  
22 in Health Care; Delegations of Authority” (the Rule), published in the Federal Register on May  
23 21, 2019.

24       4.       I anticipate that the Rule will increase costs for DHCS and all related sub-  
25 recipients, and will likely have negative impacts to health care access in the State.

26       5.       The Rule will impose immediate costs on DHCS, which will be incurred across the  
27 fee-for-service and managed care Medi-Cal delivery systems and various other health care  
28 programs administered by DHCS. This includes, but is not necessarily limited to, the following



1 activities: changes to various DHCS webpages; preparation and physical posting of revised  
2 notices at all DHCS locations, including both for the public and for DHCS workforce; preparation  
3 and publication of revisions to DHCS applications, policy guidance and similar materials for  
4 providers, health plans, beneficiaries, other contractors or sub-recipients, and DHCS workforce;  
5 and providing notice to and overseeing implementation by all political subdivisions of the State,  
6 various DHCS contractors such as managed care plans, and various other sub-recipients of the  
7 implicated federal funds. As a preliminary estimate, DHCS projects immediate costs in the range  
8 of \$3.5 Million to \$4.5 Million (total funds). Such costs include projected staff and contractor  
9 expenses, as well as information technology/system costs over a variety of Medi-Cal delivery  
10 systems and other DHCS health care programs.


11 6. The Rule imposes significant ongoing recordkeeping and compliance costs on  
12 DHCS, particularly considering the many sub-recipients across various Medi-Cal delivery  
13 systems and separate DHCS-administered health care programs. Medi-Cal sub-recipients include  
14 independent political subdivisions of the State, such as counties. In order to comply with the  
15 Rule's assurance/certification and compliance processes, DHCS will need to develop and  
16 maintain a comprehensive system for tracking and monitoring compliance at DHCS, as well as  
17 compliance status of all sub-recipients to DHCS in the State. This system will require dedicated  
18 staff and contractor resources to fulfill the many compliance activities required in the Rule  
19 including, but not limited to: maintaining complete and accurate records of compliance with the  
20 Rule, including sub-recipients; tracking all accommodation requests and complaints across  
21 multiple programs; facilitating investigation of DHCS or any sub-recipient; implementing, or  
22 overseeing sub-recipient implementation of, any corrective action required under the Rule; and  
23 providing ongoing oversight of and training to the many sub-recipients across the State. As a  
24 preliminary estimate, DHCS projects annual recordkeeping and compliance costs in the range of  
25 \$1 Million to \$2 Million (total funds). Such costs include projected staff and contractor expenses,  
26 as well as information technology/system costs over a variety of Medi-Cal delivery systems and  
27 other DHCS health care programs.

1           7. The Rule places at risk all federal funds DHCS receives from the U.S. Department  
2 of Health and Human Services, as well as from the U.S. Department of Education and the U.S.  
3 Department of Labor. The approximated total amount of federal funds DHCS received in the  
4 2018-19 State Fiscal Year was \$63.68 Billion. Further, it is my understanding that a sub-  
5 recipient's violation of the Rule similarly places all federal funds at risk, in addition to DHCS  
6 compliance as a recipient.

7           8. The Rule will likely make it more difficult for beneficiaries of DHCS-administered  
8 programs to access an array of covered and medically appropriate services. Given the Rule's  
9 breadth, the potential for impeded access is not just with respect to a health care entity's ability to  
10 refuse to provide an affected service. Rather, that ability to abstain seemingly extends broadly  
11 and includes referrals and information sharing with a patient. Because of this, I believe it is likely  
12 the Rule will constrain provider supply and impede access to certain service categories,  
13 particularly in rural or otherwise underserved regions of the State. In addition, the potential for  
14 negative impacts would likely be disproportionately borne by vulnerable population groups, such  
15 as low-income women and the LGBTQ community. Further, these potential, negative impacts to  
16 access would be significantly exacerbated in the event a sizable portion of federal funds is  
17 withheld due to a violation by DHCS or one of its many sub-recipients.

18  
19 I declare under penalty of perjury under the laws of the United States and the State of California  
20 that the foregoing is true and correct to the best of my knowledge.

21  
22 Executed on May 23, 2019 in Sacramento, CA.

23  
24   
25 Mari Cantwell  
26 Chief Deputy Director, Health Care Programs  
27 California Department of Health Care Services  
28

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF CALIFORNIA

**STATE OF CALIFORNIA, by and through  
ATTORNEY GENERAL XAVIER  
BECERRA,**  
  
Plaintiff,  
  
v.  
  
**ALEX M. AZAR, in his official capacity as  
Secretary of the U.S. DEPARTMENT OF  
HEALTH & HUMAN SERVICES; U.S.  
DEPARTMENT OF HEALTH AND  
HUMAN SERVICES; DOES 1-100,**  
  
Defendants.

4:19-cv-02769-HSG

**[PROPOSED] ORDER GRANTING  
PLAINTIFF’S MOTION FOR A  
PRELIMINARY INJUNCTION**

Having considered the Plaintiff’s motion for a preliminary injunction, IT IS HEREBY ORDERED that: The federal defendants are enjoined from enforcing the final rule, “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority,” 84 Fed. Reg. 23170 (May 21, 2019). Until resolution of this case, 76 Fed. Reg. 9968, 9971 (Feb. 23, 2011) shall remain in effect.

IT IS SO ORDERED.

Dated:

\_\_\_\_\_  
HAYWOOD S. GILLIAM, JR.  
United States District Judge