March 27, 2018

Submitted electronically

Department of Health and Human Services
Office for Civil Rights
Hubert H. Humphrey Building, Room 509F
200 Independent Avenue SW
Washington, DC 20201

Attn: Conscience NPRM, RIN 0945-ZA03

Re: Proposed New 45 CFR Part 88 Regarding Refusals of Medical Care

The New York Civil Liberties Union submits these comments on the proposed rule published at 83 FR 3880 (January 28, 2018), RIN 0945-ZA03, with the title "Ensuring that the Department of Health and Human Services [the "Department"] Does Not Fund or Administer Programs or Activities that Violate Conscience and Associated Anti-Discrimination Laws" (the "Proposed Rule" or "Rule").

The New York Civil Liberties Union (NYCLU), a nonprofit, nonpartisan organization with eight chapters, regional offices, and more than 200,000 members and supporters across the state, works to defend and promote the fundamental principles, rights and constitutional values embodied in the Bill of Rights of the U.S. Constitution and the Constitution of the State of New York. The NYCLU has a long history of vigorously defending religious liberty. We are equally vigilant in our efforts to safeguard reproductive rights and to end discrimination against those who have historically been excluded or diminished by more powerful actors in society, including in health care settings. The Proposed Rule implicates a host of health care services, including reproductive health services, end-of-life care, HIV/AIDS counseling and treatment, reproductive technology and fertility treatments, and post-sexual assault care. The NYCLU is particularly well-positioned to comment on the Proposed Rule and the serious concerns it raises about access to reproductive and other health care, based on the religious or other beliefs of institutions or individual providers. We steadfastly protect the right to religious freedom. But that right does not include a right to harm others as this Proposed Rule contemplates.

The NYCLU strongly advocates solutions that balance the protection of public health, patient autonomy, and gender equality with the protection of individual religious belief and institutional religious worship. To achieve this balance, we believe it is often possible to

accommodate an individual health care professional's religiously-based refusal to provide a particular health service so long as the professional takes steps to ensure that the patient can receive that service elsewhere. However, because health care providers serve patients and customers of all faiths and backgrounds, a provider's wholesale refusal to provide services poses a much greater risk of harm to those who do not share in those religious beliefs and should not be allowed to trump all other important societal interests.

The proposed regulation threatens to upset the careful balance between the religious freedom of health care providers and patients' ability to access health care services—a balance that has been carefully struck in both New York State and federal law. Since the founding of our Nation, freedom of religion has been one of our most highly prized liberties, and protections for that freedom are enshrined in both the United States and New York State Constitutions. Congress, as well as the state legislatures, have enacted numerous laws to add force to those protections. Both Title VII of the 1964 Civil Rights Act and the New York State Human Rights Law currently protect against discrimination on the basis of religion and in employment.[1] However, in codifying and applying these laws, courts and legislatures have been careful to ensure that in protecting religious liberty, other fundamental rights and freedoms are not unduly burdened. The proposed regulation fails to take the same precautions. New York State, in particular, has a history of balancing these sometimes competing interests to ensure seamless delivery of health care and protect individuals' religious liberty rights. Indeed, the New York Civil Rights Law prevents discrimination against individuals who refuse to perform abortions as against their religious beliefs.[2] Even in the insurance context, New York has created explicit carve outs for religious employers who wish to exclude contraception or abortion from their employees' health plan.[3] These laws represent important steps toward ending gender discrimination, ensuring access to health care that meets the standard of care, as well as ensuring religious objectors have the opportunity to honor their private beliefs.

Without any regulatory authority, the Department has proposed a rule that vastly expands narrow statutory sections in ways Congress never intended, in a manner unsupportable by the terms of the statutes, and in a way that upsets the careful balance struck by other federal laws, all in an effort to grant health care providers unprecedented license to refuse to provide care and information to patients. In so doing, the Proposed Rule does not mention, much less grapple with, the consequences of refusals to provide full information and necessary health care to patients. The denials that the Rule proposes to protect will have significant consequences for individuals in terms of their health and well-being, in addition to financial costs. And, because the Proposed Rule is tied to entities that receive federal funding, those consequences will fall most heavily on poor and low-income people who must rely on government-supported programs and institutions for their care and who will have few, if any, other options if they are denied appropriate care. The Proposed Rule amounts to a license to discriminate, made all the worse because the federal purse will be used to further that discrimination.

[1] 42 U.S.C. § 2000e *et seq.* (2008); N.Y. Executive Law § 296.
[2] N.Y. Civil Rights Law 79-i.
[3] *E.g.*, N.Y. Ins. Law § 3221(l)(16), 4303(cc) (the New York Women's Health and Wellness Act contains an exemption from a contraceptive insurance coverage requirement for religious employers).

The Proposed Rule is not only extremely detrimental to patient health, it is also entirely unnecessary. Individual providers' religious and moral beliefs are already strongly protected by federal and state law that, among other things, forbids religious discrimination and requires employers to provide reasonable accommodation of an employee's religious objections.

Because the Proposed Rule harms patient health, encourages discrimination against patients, and exceeds the Department's rulemaking authority, it should be withdrawn. If the Department refuses to do so, it must, at a minimum, revise the Proposed Rule so that it aligns with the statutory provisions it purports to implement, makes clear that it is not intended to conflict with or preempt other state or federal laws that protect and expand access to health care, and mitigates the Rule's harm to patients' health and well-being.

1. The Proposed Rule Ignores Its Impact on Patients' Health and Invites Harms That Will Disproportionately Fall on Women and Marginalized Populations

The Proposed Rule seeks to immunize refusals of health care, yet utterly fails to consider the harmful impact it would have on patients' health. But this failure to address the obvious consequences of giving federally subsidized providers *carte blanche* to decide whom to treat or not treat based on religious or moral convictions—or indeed, based on any reasoning or none at all[4]—does not mean the harm does not exist. In fact, the harms would be substantial. For example, the Proposed Rule:

- Appears to provide immunities for health care institutions that receive federal funding and professionals who work in federally funded programs to refuse to provide complete information to patients about their condition and treatment options;

- Purports to create new "exemptions," so that patients who rely on federally subsidized health care programs, such as Title X, may be unable to obtain services those programs are required by law to provide;

- Causes confusion about whether hospitals can prevent staff from providing emergency care to pregnant women who are suffering miscarriages or otherwise need emergency abortion care; and

- Invites health care providers to discriminate against individuals based on who they are, for example, by refusing to provide otherwise available services to a patient for the sole reason that the patient is transgender or by refusing to provide medical services to the children of a same sex couple or by refusing care for patients living with HIV, including the option of pre-exposure prophylaxis (PrEP) for those people who are in a sexual relationship with an HIV-positive partner.

[4] Although the Notice of Proposed Rulemaking highlights religious freedom and rights of conscience, a number of the referenced statutes—and the proposed expansions of those in the Rule—do not turn on the existence of any religious or moral justification. The Proposed Rule would empower not only those acting based on conscience, but others acting, for example, out of bare animus toward a patient's desired care or any aspect of their identity.

- Permits health care providers to refuse to honor the advance health care directives of patients who choose a DNR/DNI order or who refuse artificial nutrition or other life-sustaining medical treatment.

These harms would fall most heavily on historically disadvantaged groups and those with limited economic resources. As the ACLU and NYCLU's own cases and requests for assistance reflect, women, LGBT (lesbian, gay, bisexual and transgender) individuals, people of color, immigrants, young people, and members of other groups who continue to struggle for equal rights are those who most often experience refusals of care. Likewise, poor and low-income people will also suffer acutely under the Proposed Rule. They are more likely to rely on health care that is in some manner tied to federal funding, and less likely to have other options at their disposal if they are denied access to care or information. Because it will limit access to health care, harm patients' outcomes, and undermine the central, public health mission of the Department, the Proposed Rule should be withdrawn.

2. The Department Lacks the Authority to Issue the Proposed Rule

The Proposed Rule references the Church Amendments, 42 U.S.C. § 300a-7, the Coats-Snowe Amendment, 42 U.S.C. § 238n, the Weldon Amendment, Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. H, Tit. V, § 507(d), and other similar "protections" or "exemptions," *see* 83 FR 3880, that sometimes allow, under narrow circumstances, health care professionals to avoid providing certain medical procedures or that limit the actions that may be taken against them if they refuse to provide care (collectively, the "Refusal Statutes"). The Preamble to the Rule focuses most extensively on the Church, Coats, and Weldon Amendments (the "Amendments"), and the Rule itself purports to establish extraordinarily expansive new substantive requirements, compliance steps, and enforcement authority under them.

But the Department does not possess *any* legislative rulemaking powers under those Amendments and wholly lacks the authority to promulgate the Proposed Rule as it applies to them. None of those Amendments includes, or references, any explicit delegation of regulatory authority. *Compare, e.g.,* 42 U.S.C. § 2000d-1 (expressly directing all relevant federal agencies to issue "rules, regulations, or orders of general applicability" to achieve the objectives of Title VI). Nor does any implicit delegation of legislative rulemaking authority exist for these provisions. For this reason alone, the Department cannot properly proceed to adopt the Proposed Rule or any similar variation of it.

3. **The Proposed Rule Impermissibly Expands the Narrow Referenced Statutes and Does So In Ways That Ignore The Statutes' Limited Terms and Purposes**

Even if the Department had the necessary rulemaking authority (which it does not), the Proposed Rule's virtually unbounded definition of certain terms and expansions of the Refusal Statutes' reach would broaden the Refusal Statutes beyond reason and recognition, create conflict with federal law, and lead to denials of appropriate care to patients. While we do not attempt to catalogue each way in which the Proposed Rule impermissibly expands the Refusal Statutes, a few examples follow.

A. Assist in the Performance

For example, Subsection (c)(1) of the Church Amendments prohibits recipients of certain federal funds from engaging in employment discrimination against health care providers who have objected to performing or "assist[ing] in the performance of" an abortion or sterilization. 42 U.S.C. § 300a-7(c)(1). Under the Proposed Rule, however, the Department defines "assist in the performance" of an abortion or sterilization to include not only assistance *in the performance* of those actual procedures – the ordinary meaning of the phrase – but also to participation in any other activity with "an articulable connection to a procedure[.]" 83 FD 8892, 3923. Through this expanded definition, the Department explicitly aims to include activities beyond "direct involvement with a procedure" and to provide "broad protection"—despite the fact that the statutory references are limited to "assistance in the performance of" an abortion or sterilization procedure itself. 83 FR 3892; *cf. e.g.,* 42 U.S.C. § 300a-7(c)(1).

This means, for example, that simply admitting a patient to a health care facility, filing her chart, transporting her from one part of the facility to another, or even taking her temperature could conceivably be considered "assist[ing] in the performance" of an abortion or sterilization, as any of those activities could have an "articulable connection" to the procedure. As described more fully below, the Proposed Rule could even be cited by health care providers who withhold basic information from patients seeking information about abortion or sterilization on the grounds that "assist[ing] in the performance" of a procedure "includes but is not limited to counseling, referral, training, and other arrangements for the procedure." 83 FR 3892, 3923.

But the term "assist in the performance" simply does not have the virtually limitless meaning the Department proposes ascribing to it. The Department has no basis for declaring that Congress meant anything beyond actually "assist[ing] in the performance of" the specified procedure—given that it used that phrasing, 42 U.S.C. §§ 300a-7(c)(1)—and instead meant any activity with any connection that can be articulated, regardless of how attenuated the claimed connection, how distant in time, or how non-procedure-specific the activity.

B. Referral or Refer for

Others of the Refusal Statutes provide limited protections to certain health care entities and individuals that refuse to, among other things, "refer for" abortions. For those statutes, the Proposed Rule expands "referral or refer for" beyond recognition, by proposing to define a referral as "the provision of *any* information … by any method … pertaining to a health care service, activity, or procedure … that could provide *any assistance* in a person obtaining, assisting, … financing, or performing" it, where the entity (including a person) doing so "sincerely understands" the service, activity, or procedure to be a "possible outcome[.]" 83 FR 3894-95 (emphasis added), 3924. This wholesale re-definition of the concept of "referral" could have dire consequences for patients. For example, a hospital that prohibits its doctors from even discussing abortion as a treatment option for certain serious medical conditions could attempt to claim that the Rule protects this withholding of critical information because the hospital "sincerely understands" the provision of this information to the patient may provide some assistance to the patient in obtaining an abortion.

Providing a green light for the refusal to provide information that patients need to make informed decisions about their medical care not only violates basic medical ethics, but also far exceeds Congress's language and intent. A referral—as used in common parlance and the underlying statutes—has a far more limited meaning than providing *any* information that *could* provide *any assistance whatsoever* to a person who may ultimately decide to obtain, assist, finance, or perform a given procedure sometime in the future. The meaning of "referral or refer for" in the health care context is to *direct* a patient elsewhere for care. *See* Merriam-Webster, https//www.merriam-webster.com/dictionary/referral ("referral" is "the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment").

C. Discriminate or Discrimination

These expansive definitions are all the more troubling given the Proposed Rule's definition of "discrimination," which purports to provide unlimited immunity for institutions that receive some federal funds to deny abortion care, to block coverage for such care, or to stop patients' access to information, no matter what the patients' circumstances or the mandates of state or federal law. Likewise, the definition appears aimed at providing immunity for employees who refuse to perform central parts of their job, regardless of the impact on the ability of a health care entity to provide appropriate care to its patients. This expansion of "discrimination" would apparently treat virtually any adverse action – including government enforcement of a patient non-discrimination or access-to-care law – against a health care facility or individual as *per se* discrimination. But "discrimination" does not mean any negative action, and instead requires an assessment of context and justification, with the claimant showing unequal treatment on prohibited grounds under the operative circumstances. The Proposed Rule abandons, for example, the nuanced and balanced approach required by Title VII, and also ignores other federal laws, state laws, and providers' ethical obligations to their patients. *See infra* Parts 4-6.

D. Other Expansions of the Scope of the Refusal Statutes

The Proposed Rule not only distorts the definitions of words in the statutes, but also alters the statutes' substantive provisions in other ways to attempt to expand the ability of individuals and entities to deny care in contravention of legal and ethical requirements and to the severe detriment of patients. Again, these comments do not attempt to exhaustively catalogue all of the unauthorized expansions but instead provide a few illustrative examples.

For example, Congress enacted Subsection (d) of the Church Amendment in 1974 as part of Public Law 93-348, a law that addressed biomedical and behavioral research, and appended that new Subsection (d) to the pre-existing subsections of Church from 1973, which all are codified within 42 U.S.C. § 300a-7: the "Sterilization or Abortion" section within the code subchapter that relates to "Population Research and Voluntary Family Planning Programs." Despite this explicit context for Subsection (d), and Congress' intent that it apply narrowly, however, the Proposed Rule attempts to import into this Subsection an unduly broad definition of "health service program," along with the expansive definitions discussed above, to purportedly transform it into a much more general prohibition that would apply to any programs or services administered by the Department, and that would assertedly prevent any entity that receives

federal funding through those programs or services from requiring individuals to perform or assist in the performance of actions contrary to their religious beliefs or moral convictions. *See* 83 FR 3894, 3906, 3925. This erroneous expansion of Church (d), as described in this attempted rule-making, could prevent health care institutions from ensuring that their employees provide appropriate care and information. It would purportedly prevent institutions taking action against members of their workforce who refuse to provide any information or care that they "sincerely understand" may have an "articulable connection" to some eventual procedure to which they object—no matter what medical ethics, their job requirements, Title VII or laws directly protecting patient access to care may require.

The Rule similarly attempts to expand the Coats Amendment beyond its limited provisions, which apply to certain "governmental activities regarding training and licensing of physicians," 42 U.S.C. § 238n (quoting title), to apply *regardless* of context. Thus, rather than being confined to residency training programs as Congress intended, the Proposed Rule purports to give all manner of health care entities, including insurance companies and hospitals, a broad right to refuse to provide abortion and abortion-related care. In addition, the Rule's expansion of the terms "referral" and "make arrangements for" extends the Coats Amendment to shield any conduct that would provide "any information … by any method … that could provide *any assistance* in a person obtaining, assisting, … financing, or performing" an abortion or that "render[s] aid to anyone else reasonably likely" to make an abortion referral. 83 FR 3894-95 (emphasis added), 3924. This expansive interpretation not only goes far beyond congressional intent and the terms of the statute, it also could have extremely detrimental effects on patient health. For example, it would apparently shield, against any state or federal government penalties, a women's health center that required any obstetrician-gynecologist practicing there who diagnosed a pregnant patient as having a serious uterine health condition to refuse to provide her with even the name of an appropriate specialist, because that specialist "is reasonably likely" to provide the patient with information about abortion.

Similarly, as written, the Weldon Amendment is no more than a bar on particular appropriated funds flowing to a "Federal agency or program, or State or local government," if any of those government institutions discriminate on the basis that a health care entity does not provide, pay for, provide coverage of, or refer for abortion. Pub. L. No. 115-31, Div. H, Tit. V, § 507(d)(1). Yet again, however, the Proposed Rule attempts to vastly increase its reach by (i) expanding the scope of the federal funding streams to which the Weldon Amendment prohibition reaches and (ii) binding "any entity" that receives such funding—not just the government entities listed in the Amendment—to its proscriptions. 83 FR 3925. These unauthorized expansions, combined with the expansive definitions discussed *supra*, can lead to broad and harmful denials of care. For example, under this unduly expansive interpretation of Weldon, an organization that refuses to discuss the option of abortion with people who discover they are pregnant may claim a right to participate in the Title X program, despite the fact that both federal law and medical ethics require that Title X patients be provided with counseling about all of their options. *See, e.g.*, 42 C.F.R. § 59.5(a)(5).

The Department should withdraw the Rule to prevent it from impeding health care and harming patients. But if it does not do so, each of the definitions must be clarified and revert to

the terms' proper meaning, and each of the substantive requirements should track only those provisions actually found in the Refusal Statutes themselves.

4. The Rule Undermines Legal and Ethical Requirements of Fully Informed Consent

The Proposed Rule appears to allow institutional and individual health care providers to manipulate and distort provider-patient communications and deprive patients of critical health care information about their condition and treatment options. While the Proposed Rule's Preamble suggests the Rule will improve physician-patient communication because it will purportedly "assist patients in seeking counselors and other health-care providers who share their deepest held convictions," 83 FR 3916-17, the notion that empowering health care providers to deny care to and withhold information from some patients is somehow necessary to enable other patients to identify like-minded providers strains credulity: Patients are already free to inquire about their providers' views and patients' own expressions of faith and decisions based on that faith must already be honored. *Cf. id.* Allowing *providers* to decide what information to share– or not share—with patients, regardless of the patient's needs or the requirements of informed consent and professional ethics would gravely harm trust and open communication in health care, rather than aiding it.

New York State Public Health Law requires physicians to obtain informed consent before provision of any procedure, and defines informed consent as including advice as to the foreseeable risks and benefits of a proposed treatment, as well as any alternatives.[5] And, as the American Medical Association's Code of Medical Ethics ("AMA Code") explains, the relationship between patient and physician "gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest[.]" AMA Code § 1.1.1. Even in instances where a provider's beliefs are opposed to a particular course of action, the provider must "[u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects." *Id.* § 1.1.7(e).

By erroneously expanding the meaning of "assist in the performance of," "refer for" and "make arrangements for," as described above, however, the Proposed Rule purports to allow health care providers to refuse to provide basic information to patients in ways that were never contemplated by the underlying statutes. As described above, these broad definitions may be used to immunize the denial of basic information about a patient's condition as well as her treatment options.

Withholding this vital information from patients violates fundamental legal and ethical principles, deprives patients of the ability to make informed decisions, and leads to negligent care. If the Department moves forward with the Proposed Rule, it should, among other necessary changes, modify it to make clear that it does not subvert basic principles of medical ethics and does not protect withholding information from a patient about her condition or treatment options.

5. By Failing to Acknowledge Other Federal Laws, the Proposed Rule Will Lead to Confusion, Denials for Care, and Harm to Patients

[5] See N.Y. Public Health Law § 2805(d).

A. Title VII

The Proposed Rule is not only unauthorized and harmful to patients, it is also unnecessary to accommodate individual workers—federal law already amply protects individuals' religious freedom in the workplace. For more than four decades, Title VII has required employers to make reasonable accommodations for current and prospective employers' religious beliefs so long as doing so does not pose an "undue hardship" to the employer. 42 U.S.C. §§ 2000e(j), 2000e-(2)(a); *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 84 (1977); EEOC Guidelines, 29 C.F.R. § 1605.2(e)(1).[6] Thus, Title VII—while protecting freedom of religion—establishes an essential balance. It recognizes that an employer cannot subject an employee to less favorable treatment because of that individual's religion and that generally an employer must accommodate an employee's religious practices. However, it does not require accommodation when the employee objects to performing core job functions, particularly when those objections harm patients, depart from the standard of care, or otherwise constitute an undue hardship. *Id.* This careful balance between the needs of employees, patients, and employers is critical to ensuring that religious beliefs are respected while at the same time health care employers are able to provide quality health care to their patients.

The New York State Human Rights and Civil Rights laws similarly afford protection against religious discrimination by employers, including on the grounds that a health care provider refuses to provide abortion.[7] However, the New York courts have also applied a balancing test, and have stopped short of requiring employers to offer accommodations that would impede their mission or interfere with their ability to conduct business[8]. In the health care context, this has meant that employers whose mission is providing health care to the public have not been required to accommodate the religious beliefs of their employees if the accommodation sought would impede their ability to serve patients promptly and respectfully.[9]

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[6] Religion for purposes of Title VII includes not only theistic beliefs, but also non-theistic "moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." Equal Employment Opportunity Commission ("EEOC") Guidelines, 29 C.F.R. §1605.1.

[7] *See* N.Y. Executive Law § 296; N.Y. Civil Rights Law § 79-I; *Larson v. Albany Med. Ctr*., 252 A.D.2d 936 (N.Y. App. Div., 3d Dep't 1998).

[8] *See Eastern Greyhound Lines v. New York State Div. of Human Rights*, 27 N.Y.2d 279, 284 (1970) (holding uniformly applied policy requiring all employees to be clean-shaven was not an unlawful discriminatory practice as applied to a Muslim employee whose religion required him to have a beard); *Harmon v. General Electric Co*., 72 A.D.2d 903, 904 (N.Y. App. Div., 3d Dep't 1979) (finding termination of employee who refused to continue working in employer's machinery apparatus operation based on pacifist views, which are part of his Catholic faith, was not an unlawful discriminatory practice). While the NYCLU may not agree with the outcome in each of these cases, we cite them merely to illustrate that the courts have adopted a balancing test that appears to be completely absent from the proposed regulation's terms.

[9] *See Shelton v. Univ. of Med. & Dentistry of N.J*., 223 F.3d 220, 228 (3d Cir. 2000) (finding hospital's offer to move nurse who objected to performance of abortions from labor and delivery to infant ICU constituted reasonable accommodation of religious beliefs); *Noesen v. Med. Staffing Network, Inc*., 232 Fed. Appx. 581, 584, 2007 WL 1302118, at *3 (7th Cir. 2007) (finding that pharmacy was not required to offer accommodation to pharmacist who objected to provision of birth control removing him from all contact with patients because such accommodation would pose undue hardship on employer); *Grant v. Fairview Hosp. and Healthcare Servs*., 2004 WL 326694, at *5 (D. Minn. 2004) (holding hospital had offered reasonable accommodation to ultrasound technician who disapproved of abortion by taking steps to avoid him coming into contact with patients contemplating abortion, but that it was not required to permit him to provide pastoral counseling to all pregnant patients receiving ultrasounds).

Despite this long-standing balance and the lack of any evidence that Congress intended the Refusal Statutes to disrupt it, the Proposed Rule does not even mention these basic federal or New York State legal standards or the need to ensure patient needs are met. Instead, by presenting a seemingly unqualified definition of what constitutes "discrimination," 83 FR 3892-93, 3923-24, and expansive refusal rights, the Department appears to attempt to provide complete immunity for religious refusals in the workplace, no matter how significantly those refusals undermine patient care, informed consent, or the essential work of institutions established for the purpose of promoting health. Indeed, the Rule is explicit in seeking not simply a "level playing field" and reasonable accommodation, but rather an unlimited ability for individuals to "be[] free not to act contrary to one's beliefs," regardless of the harm it causes others and without any repercussions. *Id.* Such an interpretation could have a drastic impact on the nation's safety-net providers' ability to provide high quality care by requiring, for example, a family planning provider to hire a counselor to provide pregnancy options counseling even if the counselor refuses to comply with ethical and legal obligations to inform patients of the availability of abortion. If the Department does not withdraw the entire Rule, therefore, it should explicitly limit its reach and make clear that Title VII provides the governing standard for employment situations.

B. EMTALA

The Proposed Rule also puts patients at risk by ignoring the federal Emergency Medical Treatment and Labor Act ("EMTALA") and hospitals' obligations to care for patients in an emergency. As Congress has recognized, a refusal to treat patients facing an emergency puts their health and, in some cases, their lives at serious risk. Through EMTALA, Congress has required hospitals with an emergency room to provide stabilizing treatment to any individual experiencing an emergency medical condition or to provide a medically beneficial transfer. 42 U.S.C. § 1395dd(a)-(c). New York also has many protections in place to ensure medical care for patients in need, such as professional misconduct laws prohibiting abandonment of a patient in need of care,[10] and state laws requiring emergency treatment for patients at hospital emergency rooms.[11] The proposed rule casts doubt on the State's continued authority to enforce such provisions.

The Refusal Statutes do not override the requirements of EMTALA or similar state laws, such as EMSRA, that require health care providers to provide abortion care to a woman facing an emergency. *See, e.g.*, *California v. U.S.*, Civ. No. 05-00328, 2008 WL 744840, at *4 (N.D. Cal. March 18, 2008) (rejecting notion "[t]hat enforcing [a state law requiring emergency departments to provide emergency care] or the EMTALA to require medical treatment for emergency medical conditions would be considered 'discrimination' under the Weldon Amendment if the required medical treatment was abortion related services").

It is particularly troubling, therefore, to have the Department use attempts to require hospitals to comply with their obligations under EMTALA in its Preamble as *justification* for

[10] *See* 8 NYCRR § 29.2 (2008) (including abandoning patient in need of care in definition of professional misconduct for medical professionals).
[11] *See* New York State Emergency Medical Services Reform Act (EMSRA), N.Y. Public Health Law §2805-b; 10 NYCRR Part 800.

expanding the Refusal Statutes. 83 FR 3888-89. For example, the Preamble discusses the case brought by the ACLU on behalf of Tamesha Means who at 18 weeks of pregnancy began to miscarry and sought care, not once but three times, at her local hospital. 83 FR 3888-89. Despite the fact that she was bleeding, in severe pain, and had developed a serious infection, the hospital repeatedly sent her away and never told her that her health was at risk and that having an abortion was the safest course for her. *See* Health Care Denied 9-10 (May 2016), *available at* https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied. But the ethical imperative is the opposite: "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." 83 FR 3888 (quoting American Congress of Obstetricians and Gynecologists ("ACOG") Committee Opinion No. 365) (reaffirmed 2016).

The Proposed Rule suggests that hospitals like the one who put Ms. Means' health at risk should be given a free pass. Yet doing so would not only violate EMTALA, but also other legal, professional, and ethical principles governing access to health care in this country. For that reason, if not withdrawn in its entirety, the Proposed Rule should, at minimum, clarify that it does not disturb health care providers' obligations to provide appropriate care in an emergency.

C. Section 1557

The Proposed Rule also puts patients at risk by ignoring the federal Patient Protection and Affordable Care Act ("ACA"), which explicitly confers on patients the right to receive nondiscriminatory health care in any health program or activity that receives federal funding. 42 U.S.C. § 18116. Incorporating the prohibited grounds for discrimination described in other federal civil rights laws, the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. *Id.* at § 18116(a).

The Refusal Statutes must be read to coexist with the statutory nondiscrimination requirements of the ACA and similar state nondiscrimination laws. If a nondiscrimination requirement has any meaning in the healthcare context, it must mean that a patient cannot be refused care simply because of her race, color, national origin, sex, age, or disability. And as courts have recognized, the prohibition on sex discrimination under the federal civil rights statutes should be interpreted to prohibit discrimination against transgender people. *See Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1049-50 (7th Cir. 2017) (discrimination against transgender students violates Title IX, which is the basis for the ACA's prohibition on sex discrimination);); *see also EEOC v. R.G. & G.R. Funeral Homes, Inc.*, 2018 WL 1177669 at *5-12 (6th Cir. Mar. 7, 2018) (Title VII). Notwithstanding these protections, as well as explicit statutory protections from discrimination based on gender identity and sexual orientation in many states (as discussed below), the Proposed Rule invites providers to discriminate against LGBT patients, particularly transgender people.

6. The Rule Also Appears Aimed at Pre-Empting State Laws That Expand Access to Health Care or Otherwise Immunizing Violations of State Law

The Proposed Rule creates even more concern with regard to its intended effect on state law. The Preamble devotes extensive discussion to "Recently Enacted State and Local health Government Health Care Laws" that have triggered some litigation by "conscientious objectors," 83 FR 3888, characterizing those disputes as part of the rationale for the Rule. Although the Department states it "has not opined on or judged the legal merits of any of the" catalogued state and local laws, it uses these laws "to illustrate the need for clarity" concerning the Refusal Statutes that are the subject of the Proposed Rule. 83 FR 3889.

But no clarity, only more questions ensue, because the Proposed Rule does not explain how its requirements interact with state and local law (nor does it provide any statutory authority on which those requirements rest under federal law, as discussed above). The Rule's expansion of definitions, covered entities, and enforcement mechanisms appears to impermissibly invite institutions and individuals to violate state law, and to attempt somehow to inhibit states from enforcing their own laws that require institutions to provide care, coverage, or even just information. The Proposed Rule also includes a troubling preemption provision, which specifies only that state and local laws that are "equally or more protective of religious freedom" should be saved from preemption, 83 FR 3931, and ignores the importance of maintaining the protection of other state laws, such as laws mandating non-discrimination in the provision of health care or requiring that state funding be available for certain procedures.

Thus, the Proposed Regulation and its treatment of state and local laws puts at risk provisions of New York State and local laws that prohibit medical facilities and providers from discriminating against anyone on the basis of certain characteristics, such as race, sex, sexual orientation, marital status or disability.[12]

The Rule, if it survives in any fashion, should clarify that it creates no new preemption of state or local laws. That is because any preemption must be limited to that which already existed, if any, by virtue of the extremely limited, pre-existing Refusal Statutes. These regulations cannot create some new gutting of state and local mandates.

7. The Rule Would Violate the Establishment Clause Because It Forces Unwilling Third Parties to Bear Serious Harms From Others' Religious Exercise

The Proposed Rule imposes the significant harms on patients identified above in service of institutional and individual religious objectors. It purports to mandate that their religious choices take precedence over providing medical information and health care to patients. But the First Amendment forbids government action that favors the free exercise of religion to the point of forcing unwilling third parties to bear the burdens and costs of someone else's faith. As the Supreme Court has emphasized, "[t]he principle that government may accommodate the free exercise of religion does not supersede the fundamental limitation imposed by the Establishment Clause." *Lee v. Weisman,* 505 U.S. 577, 587 (1992); *accord Bd. of Educ. of Kiryas Joel Village School Dist. v. Grumet*, 512 U.S. 687, 706 (1994) ("accommodation is not a principle without limits").

[12] *See e.g.* N.Y. Human Rights Law, N.Y. Executive Law Article 15, § 290 *et seq.* and N.Y.C. Human Rights Law, N.Y.C. Admin. Code Title 8, § 8-801 *et seq.*.

Because the Rule attempts to license serious patient harms in the name of shielding others' religious conduct, it is incompatible with our longstanding constitutional commitment to separation of church and state. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 708-10 (1985) (rejecting, as Establishment Clause violation, law that freed religious workers from Sabbath duties, because the law imposed substantial harms on other employees); *see also Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 14, 18 n.8 (1989) (plurality opinion) (invalidating sales tax exemption for religious periodicals, in part because the exemption "burden[e]d nonbeneficiaries markedly" by increasing their tax bills). The Department should withdraw the Rule to avoid its violation of the Establishment Clause.

8. The Rule Unnecessarily Expands Compliance Tools, Without Clear Due Process Protections, and Risks Overzealous Enforcement That Would Harm Patient Care

Finally, the Department provides no evidence that existing enforcement mechanisms are insufficient to educate providers, investigate and conduct compliance reviews, and address any meritorious complaints under the Refusal Statutes. Yet the Department itself, in a woefully inadequate and low estimation, concedes that at least hundreds of millions of dollars will be spent by health care providers to attempt to comply with the new requirements the Proposed Rule purports to create. Moreover, the Rule proposes ongoing reporting requirements for five years after any investigation of a complaint or compliance review, regardless of its outcome; purports to empower the Department to revoke federal funding before any opportunity for voluntary compliance occurs; allows punishment of grantees for acts, no matter how independent, of sub-recipients; and lacks clarity as to any procedural protections that a grantee may have in contesting enforcement actions. If the entire Rule is not withdrawn, its enforcement powers and obligations should be substantially scaled back, and full due process protections should clearly be identified and provided if any funding impact is threatened, *see, e.g.*, 45 C.F.R. §§ 80.8-80.10 (Title VI due process protections).

The Rule contemplates an enormous outlay of funds to implement a complex, extreme compliance scheme that will only serve to divert funds away from the provision of high-quality health care to those who need it most.

* * *

For all these reasons, the Department should withdraw the Proposed Rule. If it fails to do

so, it must substantially modify the Proposed Rule so as, at a minimum, not to exceed the terms of and congressional intent behind the underlying statutes.

Sincerely,

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