March 6, 2023

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

Attention: Conscience NPRM, RIN 0945-AA18

VIA ELECTRONIC SUBMISSION

Re: Comments on Notice of Proposed Rulemaking on Safeguarding the Rights of Conscience as Protected by Federal Statutes (RIN 0945-AA18)

The Center for Reproductive Rights ("the Center") respectfully submits the following comment on the Notice of Proposed Rulemaking ("the proposed rule" or "NPRM") on Safeguarding the Rights of Conscience as Protected by Federal Statutes, published on January 5, 2023.

Since 1992, the Center for Reproductive Rights has used the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past 30 years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetric care, contraception, safe abortion services, and comprehensive sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where individuals are free to decide whether or when to have children and whether or when to get married; where access to quality reproductive health care is guaranteed; and where every person can make these decisions free from coercion or discrimination.

We commend the Department of Health and Human Services ("the Department" or "HHS") for taking vital steps towards rescinding the harmful 2019 final rule entitled, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" ("2019 rule"). The 2019 rule, which never took effect, violated the Administrative Procedures Act as it was arbitrary and capricious, in excess of statutory authority, and contrary to law. Additionally, the 2019 rule would have resulted in substantial harm to patients by expanding the scope of people and entities who could refuse medical care or services to patients. The impact of this rule would have fallen disproportionately on communities already historically facing discrimination and other barriers to care in the health care system. Lastly, the 2019 rule ran counter to international human rights law by prioritizing health care refusals over patients' well-being and access to care. In the current reproductive health care access crisis, it is vital that the Department take all available steps to eliminate existing barriers to care, including by rescinding this rule. We commend the Department for taking the step of proposing this partial rescission, and recommend that the Department take it one step further to also clarify the coercive enforcement mechanisms still present in the proposed rule.

I. The 2019 rule violated the Administrative Procedures Act ("APA").

Under the APA, any "agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" shall be set aside.[1] An agency must provide

[1] 5 U.S.C.A. § 706(2)(A).

"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 facts found and the choice made."[2] As discussed below, the 2019 rule was arbitrary and capricious, exceeded statutory authority, and was contrary to law.

An agency acts arbitrarily and capriciously when it "entirely fail[s] to consider an important aspect of the problem" or "offer[s] an explanation for its decision that runs counter to the evidence before the agency."[3] At the proposed rule stage, many organizations, including the Center, submitted comments documenting the potential harm of the rule and its deficiencies including the severely harmful impact it would have had on patients, particularly in communities that frequently experience discrimination, as well as the 2018 proposed rule's absolute disregard for care necessary for emergent medical conditions. The 2019 final rule ignored those concerns except to suggest implausibly that HHS would determine the propriety of denials of care in emergent situations on a case-by-case basis. Instead, as Judge Engelmayer of the Southern District of New York recognized, the 2019 rule failed to "seriously and conscientiously consider recipients' reliance interests" in obtaining health care, making the rule arbitrary and capricious.[4]

The 2019 rule was promulgated in excess of the authority granted to the Department under the federal health care refusal statutes. The Department did not have the authority to substantively redefine and add new terms to statutory provisions including "assist in the performance" and "health care entity."[5] Congress did not delegate the authority to expand these definitions. The definitions in the 2019 rule would have expanded the universe of potential objectors[6] and objectionable activities[7] to include individuals and entities far beyond those included in the statutory definitions. Indeed, one of the vacating courts observed that the rule contained "a persistent and pronounced redefinition of statutory terms that significantly expands the scope of protected conscientious objections."[8] In essence, the 2019 rule's expanded definitions were akin to substantive lawmaking.[9]

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[2] *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 42-43 (1983) (citation and internal quotation marks omitted).

[3] *Id.* at 43.

[4] *New York v. United States Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 546 (S.D.N.Y. 2019).

[5] "HHS lacked authority to promulgate a rule that generally regulates the conduct of recipients with regard to conscience objections involving abortion, sterilization, research programs, health service programs, and abortion training—including defining "discrimination," referral," "health care entity," or "assist in the performance" in connection with all such objections." *Id.* at 528.

[6] *Id.* at 525 (explaining that in relation to the definition of "health care entity," the rule's "definitions are broader than that in both statutes": the Weldon and Coats-Snowe Amendments).

[7] "The definition [of "assist in the performance"] expands the coverage of the Church Amendments beyond any previously articulated definition, so as, among other things, to confer refusal rights on persons engaged in activities ancillary to a covered procedure (e.g., scheduling and receptionist services, transportation of a patient, and provision of information relating to the procedure) and activities carried out on days before and after these procedure … Neither the text nor history of the Church Amendments made Congress's intent to reach such activities clear. *Id.* at 525 (citations omitted).

[8] City *& Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1012 (N.D. Cal. 2019).

[9] *See New York v. United States Dep't of Health & Hum. Servs*., 414 F. Supp. 3d 475 (S.D.N.Y. 2019) (finding that "the Rule relocates the metes and bounds—the who, what, when, where, and how—of conscience protection under federal law.").

Moreover, Congress did not grant the Department the authority[10] to impose extensive financial penalties for noncompliance.[11] The 2019 rule included enforcement mechanisms which threatened access to federal funds for entities that prioritize patient care without further clarification or express limitations. While we appreciate the critical changes made by the Department in this NPRM, additional clarification would ensure the enforcement mechanisms will not be unduly coercive. The Department should clarify the terms "relevant funding"[12] and "appropriate action"[13] when describing the measures that the Office of Civil Rights ("OCR") can take against an entity that is in violation of the proposed rule. The final rule should also clarify the limits OCR can put on the federal funding of covered entities. The final rule should articulate a limiting principal for determining "relevant funding" and make clear that it can never include funding essential to the continued operation of a facility or all funding that the entity receives from the Department. Similarly, we recommend that the Department make clear "appropriate action" is limited to enforcement tools encompassed in existing regulations rather than those contemplated in the 2019 rule. In sum, the definitions and penalties in the 2019 rule were inconsistent with the Department's rulemaking authority and enforcement powers[14] and should therefore be rescinded.

The Department's 2019 rule was contrary to law. Congress enacted federal health care refusal statutes to accommodate personal objections in specific and limited contexts.[15] Federal health care refusal statutes were never meant to override laws that require health care providers to treat patients in emergent situations.[16] However, the 2019 rule disregarded and conflicted with such statutory obligations, including EMTALA.[17] We urge the Department to make clear in its final rule that objections may not override the responsibilities providers have to patients who face emergent health conditions. Accordingly, we recommend that the 2019 rule be rescinded.

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[10] In *City & Cnty. Of San Francisco v. Azar,* the court held that "HHS has no authority to add to the requirements of [federal health care refusal] statutes … that while HHS may interpret the statutes in question, those interpretations may not add to or subtract from what the statutes themselves say. … and that the rule in question does exactly that by adding expansive definitions in conflict with the statutes and imposing draconian financial penalties." *City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1024 (N.D. Cal. 2019).

[11] *Washington v. Azar,* 426 F. Supp. 3d 704, 719 (E.D. Wash. 2019) (reaffirming the finding in *New York v. United States Dep't of Health & Hum. Servs*., 414 F. Supp. 3d 475, 519 (S.D.N.Y. 2019) ("HHS lacked rulemaking authority empowering it to terminate all of a recipient's HHS funding in response to a violation of one of these provisions."); *New York v. United States Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 513 (S.D.N.Y. 2019) (explaining that "the maximum penalty the Rule authorizes for a violation of the Conscience Provisions—the termination of all of a recipient's HHS funding, from whatever program derived—is new, too. It does not appear in any of the Conscience Provisions, in any statute governing HHS, or in existing regulations prescribing the remedies available to HHS in the event of a breach by a funding recipient.").

[12] Safeguarding the Rights of Conscience as Protected by Federal Statutes, 88 Fed. Reg.820, 830 § 88.2(c) (proposed Jan. 5, 2023).

[13] *Id.*

[14] "HHS has no authority to add to the requirements of [health care refusal] statutes … that while HHS may interpret the statutes in question, those interpretations may not add to or subtract from what the statutes themselves say. … and that the rule in question does exactly that by adding expansive definitions in conflict with the statutes and imposing draconian financial penalties." *City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1024 (N.D. Cal. 2019).

[15] Weldon Amendment, Pub. L. No. 116-94, div. A., § 507(d)(1), 133 Stat. 2534, 2607 (relating to whether a health care professional is willing to participate in abortion care); Coats-Snowe Amendment, 42 U.S.C. § 238n(a)(1)-(2) (relating to training to provide abortion care); Church Amendments, 42 U.S.C. § 300a -7 (addressing objections to participation in abortions or sterilizations and other specified health care activities).

[16] "There is no evidence that Congress intended, sub silentio, for any of the Conscience Provisions to override EMTALA, a separate statute." *New York v. United States Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 538 (S.D.N.Y. 2019).

[17] *Id.* at 577 (finding that "the agency acted contrary to…major existing laws… (EMTALA)" which "vitiates substantive definitions in the Rule affecting the health care … emergency contexts.").

II. The 2019 rule would have resulted in substantial harm to patients, and we support the Department's efforts to rescind the rule.

The 2019 rule aimed to limit access to health care services, including reproductive health care services, by grossly mischaracterizing and expanding federal health care refusal laws beyond any rational reading at the expense of patient care. The rule would have expanded the circumstances in which members of the health care workforce may refuse to provide care. Recognizing the potential harms, courts vacated and enjoined the 2019 rule. Had the rule gone into effect, it would have likely substantially increased the instances of denials of care. In addition, the rule would have created confusion over a provider's obligation to provide care in emergency situations. Although vacated before taking effect, the Department's proposed recission is an important step toward preventing future harm.

a. The 2019 rule vastly expanded the scope of federal health care refusal laws and created confusion about provider obligations in emergency situations.

The 2019 rule should be rescinded because it prioritized the beliefs of anyone in the health care workforce, even those whose work is only remotely related to the health care service itself, over the needs of patients seeking care. The 2019 rule added new definitions vastly expanding the categories of individuals permitted to claim an exemption for performing health care services and therefore the types of services exempted.[18] This would have resulted in an unprecedented expansion of permissible health care denials. For example, the 2019 rule defined activities that "assist in the performance of care" such that the definition could encompass tasks as mundane as scheduling appointments or cleaning and sterilizing an operating room—far removed from the actual provision of the objected to health care.[19] When employees refuse to perform such duties, patient care is likely to be delayed or denied.[20] Similarly, "health care entity" was redefined to include individuals and entities[21] beyond what was included in the underlying

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[18] The 2019 rule broadly redefined "assist in the performance" in the Church Amendments to include any action that has a "specific, reasonable and articulable connection to furthering a procedure or a part of a health service program or research activity." Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23, 264 (May 21, 2019) ("This may include counseling, referral, training, or otherwise making arrangements for the procedure or a part of a health service program or research activity, depending on whether aid is provided by such actions.").

[19] *See City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1014 (N.D. Cal. 2019) ("Under the rule, a clerk scheduling surgeries for an operating room could refuse to reserve slots for abortions and sterilizations. So could an employee who merely sterilizes and places surgical instruments or ensures that the supply cabinets in the operating room are fully stocked in preparation for an abortion.").

[20] This is particularly harmful when the United States health care system is experiencing a nationwide staffing crisis, and a health care entity may not be able to staff their facility in such a way to ensure patients are able to access care despite an objecting health care worker. *See e.g.*, Steven Ross Johnson, *Staff Shortages Choking U.S. Health Care System*, U.S. NEWS & WORLD REPORT (Jul. 28, 2022), https://www.usnews.com/news/health-news/articles/2022-07-28/staff-shortages-choking-u-s-health-care-system. *See also*, NAT'L P'SHIP FOR WOMEN & FAMS., *Paid Sick Days Enhance Women's Abortion Access and Economic Security* (May 2019), https://www.nationalpartnership.org/our-work/resources/health-care/repro/abortion/paid-sick-days-enhance-womens-abortion-access-and-economic-security.pdf ("There is a severe shortage of abortion providers in the United States due to medically unnecessary abortion restrictions.").

[21] The 2019 rule redefined "health care entity" in the Coates-Snow Amendment as "an individual physician or other health care professional, including a pharmacist; health care personnel; a participant in a program of training in the health professions; an applicant for training or study in the health professions; a postgraduate physician training program; a hospital; a medical laboratory; an entity engaging in biomedical or behavioral research; a pharmacy; or any other health care provider or health care facility." Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23, 264 (May 21, 2019); The 2019 rule redefined "health care entity" in the Weldon Amendment to include " a pharmacist, health care personnel, a participant in a program of training in the health professions, an applicant for training or study in the health professions, a postgraduate physician training program, a medical

statutes.[22] This vastly expanded the scope of health care workers who could feel empowered to refuse to perform their duties—even those most tangentially related to health care services—and deny or delay care for patients.

The Department should rescind the 2019 rule because it also would not have adequately protected pregnant patients from denials of care in emergencies. The Emergency Medical Treatment & Labor Act ("EMTALA") is a federal statute requiring that Medicare participating entities provide stabilizing treatment to pregnant patients.[23] Every covered provider—including those who are religiously affiliated[24]—is required to comply with EMTALA. Turning away pregnant people with emergent medical conditions is inconsistent with provider obligations under EMTALA.[25] The 2019 rule, however, failed to clarify how this provision interacts with EMTALA, and did not safeguard emergency care in any way. To the contrary, the 2019 rule would have allowed, for example, an ambulance driver to refuse to transport a patient experiencing an ectopic pregnancy (which may require a lifesaving abortion at the hospital) if the driver objects to that care.[26] This could create confusion and lead some institutions to wrongly assert that they are not required to provide certain life-saving care. Rescinding the 2019 rule would clarify the legal obligations that providers have under EMTALA's requirements.

Importantly, the 2019 rule did not pass legal muster, including with regard to safeguarding emergency care. Federal courts in New York, Washington, and California each vacated the 2019 rule before it could take effect.[27] Judge Engelmayer of the Southern District of New York recognized the potential harm of the rule, noting that "HHS failed adequately to consider…the [r]ule's application to emergencies."[28]]Judge Bastian of the Eastern District of Washington adopted Judge Engelmayer's reasoning, finding that the 2019 rule was "'not in accordance with law' because it conflicts with…EMTALA."[29] Judge Alsup of the Northern District of California agreed, criticizing that the 2019 rule "blessed" the "harsh treatment" of

laboratory, an entity engaging in biomedical or behavioral research; a pharmacy, a health insurance issuer, and a plan sponsor or third-party administrator." Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23, 264 (May 21, 2019).

[22] Coates-Snowe Amendment, 42 U.S.C. 238 (defining "health care entity" as "an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions."); Weldon Amendment, 42 U.S.C. § 18113 (defining "health care entity" as "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.").

[23] *See* Emergency Medical Treatment & Labor Act, 42 U.S.C. § 1395dd(a)-(c).

[24] *See New York v. United States Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 537 (S.D.N.Y. 2019) ("EMTALA does not include any exception for religious or moral refusals to provide emergency care. And courts have declined to read exceptions into EMTALA's mandate.") (citation omitted).

[25] *See* Emergency Medical Treatment & Labor Act, 42 U.S.C. § 1395dd.

[26] *See City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1014 (N.D. Cal. 2019) (quoting HHS oral argument in *New York v. United States Dep't of Health & Hum. Servs*., 414 F. Supp. 3d 475, 495 (S.D.N.Y. 2019) ("the rule protects an ambulance driver's ability not to assist in the performance of a procedure to which the driver has an objection")).

[27] *See City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001 (N.D. Cal. 2019); *New York v. United States Dep't of Health & Hum. Servs*., 414 F. Supp. 3d 475 (S.D.N.Y. 2019); *Washington v. Azar*, 426 F. Supp. 3d 704, (E.D. Wash. 2019).

[28] *See New York v. United States Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 558 (S.D.N.Y. 2019) (holding "that HHS failed adequately to consider…the Rule's application to emergencies.").

[29] *Washington v. Azar*, 426 F. Supp. 3d 704, 721 (E.D. Wash. 2019).

patients in emergencies.[30] These courts recognized the dangerous nature of the 2019 rule and properly identified that the rule must never take effect.[31] We strongly support recission of the 2019 rule.

b. Refusals to provide care cause harm to patients, and the 2019 rule would have exacerbated that harm.

All patients have the right to access the health care they need. When patients are refused or denied access to that care, they experience grave, and sometimes life-threatening, harm. Unfortunately, refusals of care have happened, and they are especially common for patients who need stigmatized health care, including reproductive health care, such as abortion, contraception, and fertility care, as well as gender-affirming care. The harms these patients experience compounds for communities of color, gender non-conforming people, and other populations who experience significant disparities in health care access and social determinants of health, particularly for those who experience complex and intersecting forms of discrimination when seeking care. The 2019 rule would have legitimized and significantly exacerbated these impacts. Any rule regarding the scope of federal health care refusal statutes should not apply them in a fashion that purports to justify such disproportionate harm. This is especially true in the context of the current reproductive health care crisis in the United States.

i. Refusals to provide care occur frequently with reproductive and gender-affirming health care.

Refusals to provide care in the context of reproductive and gender-affirming health care are well-documented.[32] These refusals may happen for many reasons. Most commonly, refusals to provide care are based on religious objections to a type of health care. However, abortion stigma and personal bias can also lead to refusals to provide care. In addition, as an increasing number of states ban abortion care entirely, fears over a provider's legal liability where state and federal laws conflict have led to an increase in refusals of care in emergency situations.[33] Federal health care refusal statutes often facilitate these

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[30] "Under the new rule, to preview just one example, an ambulance driver would be free, on religious or moral grounds, to eject a patient en route to a hospital upon learning that the patient needed an emergency abortion. Such harsh treatment would be blessed by the new rule." *City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1005 (N.D. Cal. 2019).

[31] *See New York v. United States Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 577 (S.D.N.Y. 2019) ("a decision to leave standing isolated shards of the Rule that have not been found specifically infirm would ignore the big picture: that the rulemaking exercise here was sufficiently shot through with glaring legal defects as to not justify a search for survivor.").

[32] *See* Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, ACLU (2016), https://www.aclu.org/wp-content/uploads/legal-documents/healthcaredenied.pdf (documenting stories where religious directives exacerbated harm to patients); *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S LAW CTR. (2020), https://nwlc.org/wp-content/uploads/2017/08/NWLC_FactSheet_Refusals-to-Provide-Health-Care-Threaten-the-Health-and-Lives-of-Patients-Nationwide-2.18.22.pdf (documenting harms of refusals to provide healthcare); Ian Lopez, *Reproductive Rights Clash With Religious Ones in Abortion Wars*, BLOOMBERG LAW (Jan. 30, 2023), https://news.bloomberglaw.com/health-law-and-business/reproductive-rights-clash-with-religious-ones-in-abortion-wars (documenting the increase of entities, including pharmacists, asserting religious rights to argue they shouldn't be forced to provide a range of reproductive medication); *Trans And Gender Nonconforming People Speak Out: Stories of Discrimination*, TRANSGENDER LAW CTR., https://transgenderlawcenter.org/legal/discrimination-stories (last visited Feb. 24, 2023) (documenting the story of a transgender woman denied an orchiectomy at a Catholic hospital).

[33] *See e.g.*, Laura Ungar & Heather Hollingsworth, Despite Dangerous Pregnancy Complications, Abortions Denied, AP (Nov. 20, 2022), https://apnews.com/article/abortion-science-health-business-890e813d85—5b57cf8e92ff799580e7e8 (compiling stories of conflicts between emergent conditions and state bans); Harris Meyer,

refusals, and the 2019 rule's expansive interpretation would lead to outright denials of care. Any rule addressing or implementing these statutes should preserve patients' ability to access care.

The proliferation of Catholic-owned health care facilities, which are required to comply with certain restrictions on the care they provide, contributes to the crisis in access to reproductive health care. The Ethical and Religious Directives for Catholic Healthcare Services ("the Directives") often force providers at Catholic health care institutions—which serve more than one in seven hospital patients nationwide[34]—to refuse medically indicated care.[35] The Directives categorically prohibit Catholic health care providers from performing abortions, providing contraception, family planning, sterilization, and in vitro fertilization (IVF).[36] Separately, individual providers may also choose to refuse such care based on their personal, moral, or religious beliefs.

While refusals to provide abortion care are among the most commonly referenced, patients also frequently experience refusals when attempting to access other forms of reproductive health care. Many patients, particularly young, single, transgender or gender non-conforming people are reporting challenges in locating providers who are willing to provide sterilization via tubal ligation.[37] Some providers have refused to provide this care on the basis of age, marital status, or concerns patients will later regret their choice,[38] and others have required married patients to obtain spousal consent.[39] Pharmacists with religious objections are denying patients access to contraception and emergency

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Patients and Doctors Navigate Conflicting Abortion and Emergency Care Laws, SCIENTIFIC AMERICAN (Aug. 9, 2022), https://www.scientificamerican.com/article/patients-and-doctors-navigate-conflicting-abortion-and-emergency-care-laws (capturing provider concerns about conflicting obligations); Elinor Klibanoff, *Doctors Report Compromising Care Out of Fear of Texas Abortion Law*, TX TRIBUNE (Jun. 23, 2022), https://www.texastribune.org/2022/06/23/texas-abortion-law-doctors-delay-care. *See also*, Amy J. Dilcher & Arushi Pandya, *EMTALA in the Post-Dobbs World*, XIII NAT'L LAW REV. 62 (2022), https://www.natlawreview.com/article/emtala-post-dobbs-world (describing the legal landscape).

[34] *Catholic Healthcare in the United States*, U.S. CATH. HEALTHCARE ASS'N, (2022), https://www.chausa.org/docs/default-source/default-document-library/the-strategic-profile.pdf.

[35] *See* Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, ACLU (2016), https://www.aclu.org/wp-content/uploads/legal-documents/healthcaredenied.pdf (documenting stories where religious directives exacerbated harm to patients); *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S LAW CTR., (2020), https://nwlc.org/wp-content/uploads/2017/08/NWLC_FactSheet_Refusals-to-Provide-Health-Care-Threaten-the-Health-and-Lives-of-Patients-Nationwide-2.18.22.pdf (documenting harms of religious refusals).

[36] U.S. CONF. OF CATH. BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR THE CATH. HEALTH CARE SERVICES, SIXTH ED. (2016), https://usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_3.pdf.

[37] Faith Karimi, *Some People in the US are Rushing to Get Sterilized After the Roe v. Wade Ruling*, CNN (Jul. 25, 2022), https://www.cnn.com/2022/07/25/us/people-getting-sterilized-roe-v-wade-cec/index.html.

[38] *Id.*

[39] Shira Feder, *A Woman Was Told She Needed Her Husband's Permission to Get Her Tubes Tied. Her Story Went Viral, but It's Not Uncommon*, INSIDER (Feb. 25, 2020), https://www.insider.com/a-woman-needed-husbands-consent-to-get-her-tubes-tied-2020-2.

contraception in increasing numbers,[40] making it impossible for some patients to obtain emergency contraception in the appropriate timeframe to prevent pregnancy.[41]

Transgender and gender-nonconforming patients also frequently experience refusals in the health care context. Religiously affiliated hospitals have also refused to perform hysterectomies and orchiectomies on transgender patients.[42] In addition, transgender and gender non-conforming patients face obstacles to receiving hormone therapy due to provider objections.[43]

The 2019 rule would legitimize and significantly exacerbate these troubling incidents. Any rule regarding the scope of federal health care refusal statutes should not apply them in a way that could cause such substantial harm.

ii. Refusals of care have serious consequences for patients, including financial burdens and risk to patient health.

Patients who face delays in obtaining abortion care face serious consequences. As delays increase, the logistical and financial burdens multiply. For example, when a patient is turned away from a doctor's office or a hospital without a referral, they must find a willing provider to access the health care they need. This requires patients to spend significant time researching other available providers and additional time off from work for a new appointment. Prominent provider associations including the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG)

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[40] Pharmacists in at least twenty-four states have refused to sell birth control or emergency contraception to women. *See, e.g.,* Ian Lopez, *Reproductive Rights Clash With Religious Ones in Abortion Wars*, BLOOMBERG LAW (Jan. 30, 2023), https://news.bloomberglaw.com/health-law-and-business/reproductive-rights-clash-with-religious-ones-in-abortion-wars (documenting the increase of entities, including pharmacists, asserting religious rights to argue they shouldn't be forced to provide a range of reproductive medication); Gretchen Borchelt*, Pharmacists Can't Be Allowed to Deny Women Emergency Contraception*, U.S. NEWS & WORLD REP., Oct. 15, 2012, http://www.usnews.com/opinion/articles/2012/10/15/pharmacists-cant-be-allowed-to-deny-women-emergency-contraception. *See also*, *Pharmacy Refusals 101*, NAT'L WOMEN'S LAW CTR (Dec. 17, 2017), https://nwlc.org/resource/pharmacy-refusals-101.

[41] *Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms*, CATH. FOR CHOICE, (Jan. 2002), http://www.catholicsforchoice.org/wp-content/uploads/2013/12/2002secondchancedenied.pdf.

[42] *E.g.*, Evan Minton*, A Hospital Refused to Provide Medically Necessary Surgery Because I Am Transgender*, ACLU (Feb. 27, 2020), https://www.aclu.org/news/lgbtq-rights/a-hospital-refused-to-provide-medically-necessary-surgery-because-i-am-transgender (sharing the story of a patient whose operation was cancelled two days before its scheduled date because the procedure was related to his gender transition); Kristina Marusic, *Trans Man Sues Hospital for Refusing to Perform Surgery on Religious Grounds*, LOGO (Jan. 6, 2017), https://www.logotv.com/news/n4c07d/jionni-conforti-lambda-legal-lawsuit-st-josephs-catholic-hospital-new-jersey; TRANSGENDER LAW CTR., TRANS AND GENDER NONCONFORMING PEOPLE SPEAK OUT: STORIES OF DISCRIMINATION, https://transgenderlawcenter.org/legal/discrimination-stories (last visited Feb. 24, 2023) (documenting the story of a transgender woman denied an orchiectomy at a Catholic hospital); NAT'L WOMEN'S LAW CTR., REFUSALS TO PROVIDE HEALTH CARE THREATEN THE HEALTH AND LIVES OF PATIENTS NATIONWIDE (2020), https://nwlc.org/wp-content/uploads/2017/08/NWLC_FactSheet_Refusals-to-Provide-Health-Care-Threaten-the-Health-and-Lives-of-Patients-Nationwide-2.18.22.pdf (documenting the story of a patient denied a hysterectomy because he is transgender). *Hammons v. Univ. of Maryland Med. Sys. Corp. et al.*, No. 20-2088 (D. Md., Jan. 6, 2023) https://www.aclu.org/cases/hammons-v-umms?document=hammons-v-umms-memorandum-opinion-1; Minton v. Dignity Health, No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017).

[43] *E.g.*, Hilde Hall, *My Pharmacist Humiliated Me When He Refused to Fill My Hormone Prescription*, ACLU (Jul. 19, 2018), https://www.aclu.org/news/lgbtq-rights/my-pharmacist-humiliated-me-when-he-refused-fill-my-hormone (documenting the denial of hormone therapy by a pharmacist); Lambda Legal, *Lambda Legal Sues Doctor and Clinic for Denying Medical Care to Transgender Woman* (Apr. 16, 2014), https://www.lambdalegal.org/blog/20140416_sues-doctor-clinic-for-denying-care-to-transgender-woman (highlighting a lawsuit against a provider denying a transgender woman hormone replacement therapy).

direct providers with conscience objections to provide referrals or assist their patients in finding another clinician.[44] However some objecting providers refuse to do so. Importantly, the 2019 rule would sanction this harmful practice.[45]

Once a patient identifies an alternative provider, they may face logistical obstacles. In areas with a limited number of health care providers, or in states that implemented restrictions on abortion or total bans following the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* to overturn *Roe v. Wade*, a patient may need to travel long distances to access abortion care, requiring additional expenses for travel, overnight stays, and childcare. The additional time and expense fall most heavily on individuals with low incomes and those without the job flexibility to take paid sick time.

Delays also have the effect of increasing the cost of an abortion. And most patients seeking abortion need assistance paying for the procedure because they cannot access state or insurance funding for abortion. This factor poses a profound challenge to the affordability of the procedure for people with lower incomes. As one Utah woman explained even before *Dobbs*: "I knew the longer it took, the more money it would cost … We are living paycheck to paycheck as it is, and if I [had] gone one week sooner, it would have been $100 less."[46] Moreover, delays raise the cost of each step of obtaining an abortion—not just the cost of the procedure. For example, one study found that Utah's mandatory waiting period caused 47% of patients having an abortion to miss an extra day of work.[47] More than 60% were negatively affected in other ways, including increased transportation costs, lost wages by a family member or friend, or being required to disclose the abortion to someone whom they otherwise would not have told.[48] As a result, health care refusals that result in a delay in care can significantly increase the cost of care for a person seeking abortion care, or make it impossible altogether.

There are also serious additional physical and socioeconomic consequences for patients who experience discrimination when seeking abortion care, particularly for those who are unable to obtain a wanted abortion. A groundbreaking study found that participants who were denied wanted abortions and forced to give birth had statistically poorer long-term health outcomes than those who accessed abortions.[49] Participants denied abortion services were more likely to experience serious complications that generally occur at the end of pregnancy, including eclampsia and death; more likely to stay tethered to abusive partners; more likely to suffer anxiety and loss of self-esteem in the short term; and less likely to have aspirational life plans for the coming year.[50] In contrast, study participants who received a wanted abortion were not only less likely to experience serious health problems than those denied a wanted

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[44] *AMA Updates Advice to Doctors with Conscientious Objections*, AMER. MED. ASS'N (Mar. 27, 2019), https://www.ama.com.au/media/ama-updated-advice-doctors-conscientious-objections; *The Limits of Conscientious Refusal in Reproductive Medicine: Committee Opinion No. 385*, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (Nov. 2007), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2007/11/the-limits-of-conscientious-refusal-in-reproductive-medicine (reaffirmed 2016).

[45] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23263 §§ 88.2, 88.3.

[46] Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48 PERSPS. ON SEXUAL & REPROD. HEALTH 179, 184 (2016).

[47] Jessica N. Sanders et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26 WOMEN'S HEALTH ISSUES 483, 485 (2016).

[48] *Id*.

[49] *See* Lauren J. Ralph et al., *Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171 ANNALS OF INTERNAL MED. 238, 238-247 (2019) (finding that 27% of women who gave birth reported fair or poor health compared with 20% of women who had first-trimester abortion and 21% who had second-trimester abortion).

[50] *Turnaway Study*, ADVANCING NEW STANDARDS IN REPROD. HEALTH, https://www.ansirh.org/research/turnaway-study (last visited Mar. 3, 2022).

abortion, but were also 50 percent more likely to set an aspirational plan and achieve it—such as finishing their education, getting a better job, giving a good life to their children, and being more financially stable—compared to participants who were denied a wanted abortion.[51] Importantly, as discussed in further detail below, these consequences most heavily impact people who sit at the intersection of identities that face persistent discrimination, including for communities of color, gender non-conforming people, and other populations who experience significant disparities in health care access and social determinants of health.

Delays in care also have negative impacts on the health of people seeking reproductive care. For example, a patient who has a cesarean section birth and wishes to have a post-partum tubal ligation immediately following delivery cannot do so at a Catholic hospital, even though having the procedure at that time is medically recommended,[52] presents fewer risks to the patient, and is more cost-effective than delaying the procedure to a later time. If the patient cannot have the procedure immediately following delivery, they must first recover from the cesarean surgery and then schedule the tubal ligation at least six weeks later when they are busy caring for their newborn. They will be required to go to another hospital and possibly a different doctor, transfer their medical records, and endure another invasive procedure and recovery.[53]

Refusals to provide care are also costly for LGBTQI+ patients. It is a challenge for any patient to seek a new provider when they are turned away. However, it has become increasingly difficult for LGBTQI+ patients to find a provider who will provide the care that they need. Many abortion clinics also provide essential gender-affirming care to their communities.[54] But additional clinic closures in the wake of *Dobbs* are expected to further constrain access to gender-affirming care.[55] As a result, LGBTQI+ patients must incur significant expenses and travel to access care. Even prior to *Dobbs,* over half of transgender individuals needed to travel out of state to access surgical gender-affirming care.[56] A recent study showed that transgender patients from out of state pay more than 50% for gender-affirming care than those who

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[51] Ushma Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-year Plans*, 15 BMC WOMEN'S HEALTH 1, 1-10 (2015), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0259-1.

[52] *Access to Postpartum Sterilization: Committee Opinion No. 827*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Jun. 2021), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/06/access-to-postpartum-sterilization (replaces Committee Opinion 530).

[53] NAT'L WOMEN'S LAW CTR., *When Health Care Providers Refuse: The Impact on Patients of Providers' Religious and Moral Objections to Give Medical Care, Information or Referrals* (Apr. 2009), https://nwlc.org/wp-content/uploads/2015/08/April2009RefusalFactsheet.pdf. *See also*, Debra B. Stulberg et al., *Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences*, 90 CONTRACEPTION 422, 422-28 (2014) ("Cesarean delivery in Catholic hospitals raised frustration for obstetrician-gynecologists when the hospital prohibited a simultaneous tubal ligation and, thus, sent the patient for an unnecessary subsequent surgery. [. . .] Some obstetrician-gynecologists reported that Catholic policy posed greater barriers for low-income patients and those with insurance restrictions.").

[54] Juliana Kim, *How Gender-Affirming Care May Be Impacted When Clinics that Offer Abortions Close*, NPR (Aug. 14, 2022), https://www.npr.org/2022/08/14/1115875421/gender-affirming-care-abortion-clinics ("More than half of all Planned Parenthood health centers offer gender-affirming care including hormone replacement therapy, mental health services and support with legal processes like name changes. Over 35,000 of Planned Parenthood's patients nationwide sought gender-affirming hormone replacement therapy in 2021, and that number doesn't include trans and nonbinary people who relied on other services.").

[55] *Id*.

[56] Samantha Riedel, *Nearly Half of Trans People Travel Out of State for Gender-Affirming Surgery*, THEM (Jul. 8, 2022), https://www.them.us/story/nearly-half-of-trans-people-travel-out-of-state-for-gender-affirming-surgery; Barbara Clements, *Many Trans Patients Must Travel Out of State for Surgery*, UW SCHOOL OF MEDICINE (Aug. 16, 2022), https://newsroom.uw.edu/news/many-trans-patients-must-travel-out-state-surgery.

can obtain care in state.[57] In sum, when providers deny people care, patients must spend time and money to attempt to access it elsewhere. All of these challenges are compounded by the national reproductive health care crisis.

iii. The United States is in the midst of a national reproductive health care crisis, which has only worsened since the Department finalized the 2019 rule.

Rescinding the 2019 rule is crucial as we continue to navigate the current reproductive health care crisis. Since 2011, states have passed more than 500 laws restricting access to reproductive health care, closing clinics and creating a shortage of abortion providers across the country. Even prior to the decision in *Dobbs*, several states had only one clinic that provided abortion care.[58] At that time, eighty-nine percent of counties in the United States did not have a single abortion clinic, and some counties that had a clinic only provided abortion services on certain days.[59]

The proliferation of Catholic health care system mergers has also exacerbated the crisis in accessing reproductive health care. These mergers have resulted in entire regions with limited or no access to certain forms of reproductive health care. Due to the acceleration of these mergers, people living in rural areas, people with low incomes, and communities of color often are only served by the religiously affiliated health care entities which now make up a large part of the U.S. health care system.[60] In fact, women of color disproportionately give birth in Catholic hospitals because of their location, and therefore also experience refusals related to reproductive health care at much higher rates, including when attempting to access hormonal birth control, IUD placement, abortion, sterilization and IVF care.[61] The 2019 rule would have increased these troubling instances of refusals to provide care by exacerbating the prevalence of denials across the health care workforce and system.

The Supreme Court's decision to overturn *Roe v. Wade* has had a devastating impact on the already challenging landscape for abortion access. Post-*Dobbs* abortion bans have devastated access to abortion

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[57] Barbara Clements, *Many Trans Patients Must Travel Out of State for Surgery*, UW SCHOOL OF MEDICINE (Aug. 16, 2022), https://newsroom.uw.edu/news/many-trans-patients-must-travel-out-state-surgery (referencing the study "Spending and Out-of-Pocket Costs for Genital Gender-Affirming Surgery in the US" by JAMA Network).

[58] NAT'L P'SHIP FOR WOMEN & FAMS., BAD MEDICINE: HOW A POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS 13 (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf.

[59] *Id.*

[60] Susan Haigh & David Crary, *Catholic Hospitals' Growth Has an Impact Reproductive Healthcare*, AP NEWS (Jul. 24, 2022), https://apnews.com/article/abortion-health-religion-new-york-oregon-8994d9b5fd0040d40d19fd1e44c313d8; Amy Littlefield, *Women of Color More Likely to Give Birth in Hospitals Where Catholic Beliefs Hinder Care*, REWIRE NEWS GROUP (Jan. 19, 2018), https://rewirenewsgroup.com/2018/01/19/women-color-likely-give-birth-hospitals-catholic-beliefs-hinder-care; Kira Shepherd, et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, COLUMBIA LAW SCHOOL LAW, RIGHTS, AND RELIGION PROJECT (2018), https://lawrightsreligion.law.columbia.edu/bearingfaith; *See also*, U.S. CATHOLIC HEALTHCARE ASSOCIATION, CATHOLIC HEALTHCARE IN THE UNITED STATES (2022), https://www.chausa.org/docs/default-source/default-document-library/the-strategic-profile.pdf; Anna M. Barry-Jester & Amelia Thompson-DeVeaux, *How Catholic Bishops are Shaping Healthcare in Rural Areas*, FIVETHIRTYEIGHT (Jul. 25, 2018), https://fivethirtyeight.com/features/how-catholic-bishops-are-shaping-health-care-in-rural-america.

[61] Amy Littlefield, *Women of Color More Likely to Give Birth in Hospitals Where Catholic Beliefs Hinder Care*, REWIRE NEWS GROUP (Jan. 19, 2018), https://rewirenewsgroup.com/2018/01/19/women-color-likely-give-birth-hospitals-catholic-beliefs-hinder-care; Kira Shepherd, et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, COLUMBIA LAW SCHOOL LAW, RIGHTS, AND RELIGION PROJECT (2018), https://lawrightsreligion.law.columbia.edu/bearingfaith.

care, which is now unavailable across entire regions.[62] At the time of this writing, abortion is illegal in 12 states. As a result, wait times for an appointment have increased at clinics in neighboring states, and the average travel distance required to access care has increased greatly. For example, for residents of Texas and Louisiana, the average travel time to the closest provider is now seven or more hours.[63]

Since *Dobbs*, an increasing number of people have been refused life-saving care, in contravention of EMTALA and explicit federal guidance.[64] Providers are confused and fearful about when they may treat patients.[65] Each day, physicians across the country seek guidance from the American College of Obstetricians and Gynecologists and share fears that they cannot make the best health care decisions for their patients following *Dobbs*.[66] Providers urgently need clarity on when they may treat the patients who rely on them for care.[67] Providers have been placed in an impossible situation, where providing the health care their patients need—even emergency care—could potentially expose them to prosecution and civil suit in states that ban abortion.[68]

Pregnant people facing dangerous or emergent medical conditions are plagued by a landscape of fear, uncertainty, and harm. Many pregnant people have shared their stories documenting the harms they faced because of delays and refusals. For example, one woman in Ohio bled for hours after she was denied an emergency procedure for her miscarriage.[69] Despite her life-threatening condition, Ohio doctors did not treat her promptly, fearing legal liability under the state's abortion ban.[70] In another instance, a Texas

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[62] *See* AFTER ROE FELL: ABORTION LAWS BY STATE, CTR FOR REPROD. RIGHTS https://reproductiverights.org/maps/abortion-laws-by-state (last visited Feb. 16, 2023).

[63] Caitlyn Myers et al., *Abortion Access Dashboard*, MIDDLEBURY COLLEGE https://experience.arcgis.com/experience/6e360741bfd84db79d5db774a1147815 (last visited Feb. 26, 2023).

[64] U.S. DEPT. OF HEALTH & HUM. SERVS., HHS SECRETARY LETTER TO HEALTH CARE PROVIDERS ABOUT EMERGENCY MEDICAL CARE (Jul. 11, 2022), https://www.hhs.gov/sites/default/files/emergency-medical-care-letterto-health-care-providers.pdf; WEN W. SHEN, CONG. RSCH. SERV., LSB10851, EMTALA EMERGENCY ABORTION CARE LITIGATION: OVERVIEW AND INITIAL OBSERVATIONS, PART II OF II (Nov. 1, 2022).

[65] *See* Selena Simmons-Duffin, *Doctors Who Want to Defy Abortion Laws Say It's Too Risky*, NPR (Nov. 23, 2022), https://www.npr.org/sections/health-shots/2022/11/23/1137756183/doctors-who-want-to-defy-abortion-laws-say-its-too-risky (documenting provider concerns); Tiffany Stanley, *After Abortion Protections Fell, Their Lives Were Upended*, WASHINGTON POST (Nov. 30, 2022), https://www.washingtonpost.com/magazine/interactive/2022/abortion-laws-patient-stories (sharing patient and provider stories).

[66] A Post Roe America: The Legal Consequences of the Dobbs Decision Before the Sen. Comm. on the Judiciary, 117th Cong. (2022) (oral testimony of Collen P. McNicholas, Chief Medical Officer, Planned Parenthood of the St. Louis Region and Southwest Missouri) https://www.judiciary.senate.gov/meetings/a-post-roe-america-the-legal-consequences-of-the-dobbs-decision (sharing her experience as a leader in the American College of Obstetricians and Gynecologists).

[67] *Id*.

[68] Reese Oxner & María Méndez, *Texas Hospitals are Putting Pregnant Patients at Risk by Denying Care Out of Fear of Abortion Laws, Medical Gro Says*, TEXAS TRIBUNE (July 15, 2022), https://www.texastribune.org/2022/07/15/texas-hospitals-abortion-laws; AP, *Letter Says Texas Hospitals Reportedly Refusing Abortion Care*, NBC DFW (Jul. 15, 2022), https://www.nbcdfw.com/news/local/texas-news/letter-says-texas-hospitals-reportedly-refusing-abortion-care/3015545.

[69] Selena Simmons-Duffin, *Her Miscarriage Left Her Bleeding Profusely. An Ohio ER Sent Her Home to Wait*, NPR (Nov. 15, 2022), https://www.npr.org/sections/health-shots/2022/11/15/1135882310/miscarriage-hemorrhage-abortion-law-ohio.

[70] Under Ohio's "Heartbeat Bill" Health care providers who violate the law face fifth-degree felony charges, up to a year in prison, loss of their medical license, and fines up to $20,000. *See* R.C. § 2919.192 (enjoined by *Preterm-Cleveland v. Yost*, No. A2203203, 2022 WL 16137799, at *1 (Ohio Com.Pl. Oct. 12, 2022)); Selena Simmons-Duffin, *Her Miscarriage Left Her Bleeding Profusely. An Ohio ER Sent Her Home to Wait*, NPR (Nov. 15, 2022), https://www.npr.org/sections/health-shots/2022/11/15/1135882310/miscarriage-hemorrhage-abortion-law-ohio.

woman was denied an abortion after her water broke prematurely until she developed a severe infection.[71] She does not yet know the full extent of the damage that delayed treatment caused.[72] Due to Texas's abortion bans, she had to remain in the ICU for three days while professionals "battled to save [her] life.[73] Also in Texas, a woman sought an abortion when she learned one of her two fetuses had Trisomy 18.[74] Doctors agreed that continuing the pregnancy would endanger the other fetus and her own health.[75] Because of Texas's abortion bans, the woman had to travel 1,000 miles and spend $3,000 to protect her own life and the health of the other fetus.[76] In another example, a Tennessee woman waited hours for ectopic pregnancy care while physicians at her hospital debated the legality of treatment.[77] When providers do not immediately treat an ectopic pregnancy, patients can face life-threatening consequences.[78] Both bans on abortion and provider refusals create dangerous delays and increase costs for patients.

The *Dobbs* decision has also had a ripple effect on the treatment of other health conditions. Some medications that are used to treat a variety of conditions may also interfere with pregnancies, prompting provider concerns about their legal liability in states that have banned abortion.[79] For example, people seeking treatment for autoimmune conditions and arthritis are increasingly facing barriers to filling their methotrexate prescriptions. In one instance, an Arizona pharmacy denied a fourteen-year-old girl her long-standing prescription for methotrexate.[80] In other cases, people are required to prove they are taking

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[71] Amanda Zurawski, *My Pregnancy vs. the State of Texas*, THE METEOR (Oct. 18, 2022), https://wearethemeteor.com/texas-abortion-ban-stopped-doctors-helping-woman-miscarrying (writing "I could wait however long it took to go into labor naturally, if I did at all, knowing that my baby would be stillborn or pass away soon after; I could wait for my baby's heartbeat to stop, and then we could end the pregnancy; or—most alarmingly—I could develop an infection and become so sick that my life would become endangered. Not until one of those things happened would a single medical professional in the state of Texas legally be allowed to act.").

[72] *Id*. (documenting the many tests she will undergo to determine whether her reproductive system was permanently harmed and the surgeries she must have to remove scar tissue caused by her infection.).

[73] *Id*.

[74] 95% of Trisomy 18 pregnancies lead to health problems for the pregnant person as well as miscarriages or still births. Fewer than half of children born survive one month and 10% percent of children live past one year. CLEVELAND CLINIC, EDWARDS SYNDROME (TRISOMY 18), https://my.clevelandclinic.org/health/diseases/22172-edwards-syndrome (last visited Feb. 16, 2023). *See also*, Carter Sherman, A Woman Wanted an Abortion to Save One of Her Twins. She Had to Travel 1,000 Miles., VICE (Nov. 28, 2022), https://www.vice.com/en/article/epz7ap/texas-abortion-ban-woman-travels-to-save-twin; Selena Simmons-Duffin, *To Safeguard Healthy Twin in Utero, She Had to 'Escape' Texas for Abortion Procedure*, NPR (Feb. 28, 2023), https://www.npr.org/sections/health-shots/2023/02/28/1154339942/abortion-texas-laws-twins-selective-reduction.

[75] Carter Sherman, *A Woman Wanted an Abortion to Save One of Her Twins. She Had to Travel 1,000 Miles*., VICE (Nov. 28, 2022), https://www.vice.com/en/article/epz7ap/texas-abortion-ban-woman-travels-to-save-twin.

[76] *Id*.

[77] Steve Cavendish, *Sarah Needed an Abortion. Her Doctors Needed Lawyers.*, NASHVILLE SCENE (Dec. 20, 2022), https://www.nashvillescene.com/news/citylimits/sarah-needed-an-abortion-her-doctors-needed-lawyers/article_472a621e-7fdb-11ed-bf8d-0797b6012be2.html.

[78] *Facts Are Important: Understanding Ectopic Pregnancy*, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS https://www.acog.org/advocacy/facts-are-important/understanding-ectopic-pregnancy (last visited Feb. 14, 2023).

[79] Katie Shepherd & Frances Stead Sellers, *Abortion Bans Complicate Access to Drugs for Cancer, Arthritis, Even Ulcers*, WASHINGTON POST (Aug. 8, 2022), https://www.washingtonpost.com/health/2022/08/08/abortion-bans-methotrexate-mifepristone-rheumatoid-arthritis.

[80] Although crucial to the girl's health, a pharmacist said she denied it because the girl was 14 years old, which is considered "a childbearing age." María Luisa Paúl, *14-Year-Old's Arthritis Meds Denied After Ariz. Abortion Ban, Doctor Says*, WASHINGTON POST (Oct. 5, 2022), https://www.washingtonpost.com/nation/2022/10/05/abortion-arizona-arthritis-prescription-refill.

birth control before a pharmacy is willing to fill a methotrexate prescription.[81] This is a recurring issue, resulting in the American College of Rheumatology to issue an urgent call for pharmacists to continue filling methotrexate in states with abortion bans.[82]

The current public health crisis with regard to abortion access has made it more urgent than ever to eliminate existing barriers to care. The Department should take any and all steps to mitigate this crisis, including by rescinding any policies that undermine patients' access to essential reproductive and other health care services that remain in its guidance documents or in the Federal Code of Regulations. Accordingly, we support the recission of this rule.

iv. People at the intersection of identities that frequently experience discrimination or other structural barriers in the health care system disproportionately bear the burden of federal health care refusal laws, and the 2019 rule would have exacerbated those burdens.

People who can become pregnant and LGBTQI+ individuals experience harm when they are refused care, and that harm is compounded for those individuals who are at the intersection of identities that frequently experience discrimination in the health care system or are otherwise marginalized. This includes patients who are Black, Indigenous, or People of Color, immigrants, people with disabilities, young people, people living on low incomes and people living in rural areas. The 2019 rule would have made these outcomes worse by potentially encouraging more people—even those only tangentially related to the provision of care—to deny care and any other services they deem objectionable.

People of color, particularly Black birthing people, experience systemic race discrimination within health care.[83] Discrimination throughout pregnancy and the postpartum period is common, especially for Black, Indigenous, Latinx, Asian American and Pacific Islander (AAPI), and other people of color, people with disabilities, and others who already face significant disparities in health care access.[84] Such discrimination

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[81] Katie Shepherd & Frances Stead Sellers, *Abortion Bans Complicate Access to Drugs for Cancer, Arthritis, Even Ulcers*, WASHINGTON POST (Aug. 8, 2022), https://www.washingtonpost.com/health/2022/08/08/abortion-bans-methotrexate-mifepristone-rheumatoid-arthritis; María Luisa Paúl, *14-Year-Old's Arthritis Meds Denied After Ariz. Abortion Ban, Doctor Says*, WASHINGTON POST (Oct. 5, 2022), https://www.washingtonpost.com/nation/2022/10/05/abortion-arizona-arthritis-prescription-refill.

[82] AM. COLL. OF RHEUMATOLOGY, GUIDING PRINCIPLES FOR POLICYMAKERS ON METHOTREXATE ACCESS FOLLOWING THE DOBBS DECISION (July 25, 2022), https://www.rheumatology.org/Portals/0/Files/Methotrexate-Guidance-Policymakers.pdf.

[83] *See* NAT'L P'SHIP FOR WOMEN & FAMS., BLACK WOMEN'S MATERNAL HEALTH: A MULTIFACETED APPROACH TO ADDRESSING PERSISTENT AND DIRE HEALTH DISPARITIES (Apr. 2018), https://www.nationalpartnership.org/our-work/resources/health-care/maternity/black-womens-maternal-health-issue-brief.pdf; Joan Harrigan-Farrelly, *For Black Women, Implicit Racial Bias in Medicine May Have Far-Reaching Effects*, U.S. DEPARTMENT OF LABOR BLOG (Feb. 7, 2022), https://blog.dol.gov/2022/02/07/for-black-women-implicit-racial-bias-in-medicine-may-have-far-reaching-effects; Khiara Bridges, *Implicit Bias and Racial Disparities in Health Care*, AM. BAR ASS'N: HEALTHCARE IN THE U.S., https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care.

[84] *E.g.*, Saraswathi Vedam et al., The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States, 16 Reprod. Health 77 (2019); ABORTION CARE NETWORK ET AL., SYSTEMIC RACISM AND REPRODUCTIVE INJUSTICE IN THE UNITED STATES: A REPORT FOR THE UN COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION (2022), https://reproductiverights.org/wp-content/uploads/2022/08/2022-CERD-Report_Systemic-Racism-and-Reproductive-Injustice.pdf; Emily DiMatteo, *Reproductive Justice for Disabled Women: Ending Systemic Discrimination*, CENTER FOR AMERICAN PROGRESS (Apr. 13, 2022), https://www.americanprogress.org/article/reproductive-justice-for-disabled-women-ending-systemic-discrimination.

includes mistreatment during labor and delivery.[85] These disparities in care are compounded in certain religiously affiliated systems, which categorically refuse to provide certain health care services.[86] Importantly, across thirty-three states, pregnant people of color are more likely to give birth than their white counterparts in hospitals governed by religious directives.[87] A recent report concluded that "women of color in many states are at increased risk of having their health needs subordinated to theological standards of health care. Such disparities threaten to compound the many disparities women of color already face in accessing quality reproductive health care."[88] Expanding the scope of refusals under the 2019 rule would likely have exacerbated these racial disparities.

LGBTQI+ individuals also face particularly acute barriers to receiving the health care they need, which would be compounded by unlimited expansion of federal health care refusal laws. More than one in eight LGBTQI+ people live in states where doctors can refuse to treat them due to personal objections under state laws.[89] Nearly one in five LGBTQI+ 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.[90] Beyond seeking gender-affirming care, nearly one-quarter of transgender individuals report delaying or avoiding medical care when sick or injured, at least partially due to medical providers' discrimination and disrespect.[91] In addition, states are increasingly banning health care for transgender and gender non-conforming individuals.[92] Treatment for young people is particularly impacted, as some states are imposing criminal penalties on health care providers[93]—against the recommendations of the

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[85] ABORTION CARE NETWORK ET AL., SYSTEMIC RACISM AND REPRODUCTIVE INJUSTICE IN THE UNITED STATES: A REPORT FOR THE UN COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION (2022), https://reproductiverights.org/wp-content/uploads/2022/08/2022-CERD-Report_Systemic-Racism-and-Reproductive-Injustice.pdf; Mariëlle Heidevelde-Gerritsen et al., *Maternity Care Experiences Of Women With Physical Disabilities: a Systematic Review*, 96 MIDWIFERY 102938 (2021).

[86] Kira Shepherd, et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, COLUMBIA LAW SCHOOL LAW, RIGHTS, AND RELIGION PROJECT 5 (2018), https://lawrightsreligion.law.columbia.edu/sites/default/files/content/BearingFaith.pdf. *See also*, U.S. CONF. OF CATH. BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR THE CATH. HEALTH CARE SERVICES, SIXTH ED. (2016), https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixthedition-2016-06.pdf (outlining health care prohibitions).

[87] Kira Shepherd, et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, COLUMBIA LAW SCHOOL LAW, RIGHTS, AND RELIGION PROJECT 12 (2018), https://lawrightsreligion.law.columbia.edu/sites/default/files/content/BearingFaith.pdf.

[88] *Id*.

[89] While lawmakers insist that refusal laws exempt categories of health care and are not targeting patients, LGBTQI+ patients are disproportionately impacted. Jo Yurcaba, *More Than 1 in 8 LGBTQ People Live in States Where Doctors Can Refuse to Treat Them*, NBC NEWS (Jul. 28, 2022), https://www.nbcnews.com/nbc-out/out-health-and-wellness/1-8-lgbtq-people-live-states-doctors-can-refuse-treat-rcna39161.

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

[91] NAT'L CTR. FOR TRANSGENDER EQUALITY, THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY: EXECUTIVE SUMMARY 3 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf; 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), https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf.

[92] *See* Hannah Schoenbaum, *States Target Transgender Health Care in First Bills Of 2023*, AP NEWS (Jan. 7, 2023) (reporting that at least 11 states have introduced anti-trans health care bills), https://apnews.com/article/politics-health-texas-state-government-tennessee-minnesota-878a9217fa434f3ecd83738a71e40572.

[93] Democracy Maps, *Healthcare Laws and Policies: Youth Medical Care Bans*, LGBT MOVEMENT ADVANCEMENT PROJECT, https://www.lgbtmap.org/equality-maps/healthcare_youth_medical_care_bans/youth_medical_care_bans (tracking bans on transgender youth health care) (last visited Mar. 3, 2023).

American Medical Association[94] and the American Academy of Pediatrics[95]—for providing gender-affirming care to transgender young people. The 2019 rule could have potentially exacerbated this crisis in health care access by inviting health care providers to prioritize their own beliefs at the expense of the well-being of patients.

By significantly expanding the reach of federal health care refusal laws without preserving access to care, the 2019 rule threatened harm to all patients, but would particularly increase the harm to communities that already experience discrimination and structural barriers in the health care system. As Judge Bastian noted, under the 2019 rule, "access to care [would] deteriorate, especially for those individuals in vulnerable populations who will be the target of the religious or moral objections."[96] For this reason, we support rescinding the 2019 rule.

III. International human rights law supports the recission of the 2019 rule.

The government is obligated under international human rights law to ensure nondiscriminatory access to care, regardless of whether providers avail themselves of any existing health care refusal laws.

International human rights law requires that the right of religious freedom by one individual cannot justify infringement on the human rights of others, including women, lesbian, gay, bisexual, transgender or intersex persons, and racial or ethnic minorities.[97] The UN Special Rapporteur on Freedom of Religion or Belief has expressed concern over the use of religion to justify the refusal of providing goods and services women, lesbian, gay, bisexual, transgender and intersex persons.[98] Countries have an obligation to ensure that their legal frameworks do not discriminate based on sexual orientation and gender identity and to protect against discrimination by third parties.[99]

UN Human Rights experts have emphasized that abortion is essential health care and expressed explicit concern over backlash of religious freedom and traditional values on access to abortion.[100] Where religious refusals are permitted, they cannot be allowed to infringe on a patient's access to care.[101] Indeed,

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[94] *AMA Reinforces Opposition to Restrictions on Transgender Medical Care*, AM. MED. ASS'N (Jun. 15, 2022), https://www.ama-assn.org/press-center/press-releases/ama-reinforces-opposition-restrictions-transgender-medical-care.

[95] *AAP Policy Statement Urges Support and Care of Transgender and Gender-Diverse Children and Adolescents*, AM. ACAD. OF PEDIATRICS (Sept. 17, 2018), https://www.aap.org/en/news-room/news-releases/aap/2018/aap-policy-statement-urges-support-and-care-of-transgender-and-gender-diverse-children-and-adolescents.

[96] *Washington v. Azar*, 426 F. Supp. 3d 704, 721 (E.D. Wash. 2019).

[97] Special Rapporteur on Freedom of Religion or Belief, Interim Rep. of The Special Rapporteur on Freedom of Religion or Belief, para. 46, U.N. Doc. A/72/365 (Aug. 28, 2017).

[98] Special Rapporteur on Freedom of Religion or Belief, Interim Rep. of The Special Rapporteur on Freedom of Religion or Belief, para. 37, U.N. Doc. A/72/365 (Aug. 28, 2017).

[99] Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 41, U.N. Doc. E/C.12/GC/22 (2016) (stating that the "obligation to respect also requires States to repeal, and refrain from enacting, laws and policies that create barriers to access to sexual and reproductive health services. This includes third-party authorization requirements, such as parental, spousal and judicial authorization requirements for access to sexual and reproductive health services and information, including for abortion and contraception.").

[100] U.N. Office of the High Commissioner for Human Rights, Abortion is Essential Healthcare and Women's Health Must Be Prioritized Over Politics (Sept. 28, 2021), https://www.ohchr.org/en/statements/2021/09/abortion-essential-healthcare-and-womens-health-must-be-prioritized-over.

[101] Committee on Economic, Social and Cultural Rights, General comment No. 22 (2016) on the right to sexual and reproductive health (art. 12 of the International Covenant on Economic, Social and Cultural Rights), para. 14; U.N. Doc. E/C.12/GC/22 (2016) CEDAW Committee, General Recommendation No. 24; Article 12 of the Convention

at the conclusion of its 2015 fact-finding visit to the United States, the UN Working Group on Discrimination Against Women emphasized that:

> *We encourage steps to reconcile U.S. laws on religious or conscience-based refusals to provide reproductive health care with international human rights law and to prohibit refusal to provide sexual and reproductive health services on grounds of religious freedom, where such refusal will effectively deny women immediate access to the health care to which they are entitled under both international human rights law and US law.*[102]

The World Health Organization's 2022 Abortion Care Guideline reiterates "the human rights obligation to ensure conscientious objection does not hinder access to quality abortion care."[103] The Guideline also states that "[i]f it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible."[104]

The 2019 rule ran counter to international human rights law, and instead would have prioritized health care refusals over patients' well-being and access to care. The Department's proposal to rescind the 2019 rule would bring us one step closer to alignment with international human rights standards.

IV. Conclusion

We appreciate the opportunity to comment on this NPRM, and we commend the department for taking these vital steps to rescind the 2019 rule. If you require any additional information about the issues raised in this letter, please contact Freya Riedlin, Federal Policy Counsel, at friedlin@reprorights.org.

Signed,
The Center for Reproductive Rights

(women and health), para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008). *See also*, CEDAW Committee, Concluding Observations: Croatia, para. 31(a), U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015); Human Rights Committee, Concluding Observations: Poland, para. 23-24, U.N. Doc. CCPR/C/POL/CO/7 (2016).

[102] U.N. Office of the High Commissioner, *UN Working Group on the Issue Of Discrimination Against Women in Law and in Practice Finalizes Country Mission to the United States* (Dec. 15, 2015), https://www.ohchr.org/en/statements/2015/12/un-working-group-issue-discrimination-against-women-law-and-practice-finalizes.

[103] WORLD HEALTH ORG., ABORTION CARE GUIDELINE 60, (Mar. 8, 2022), https://www.who.int/publications/i/item/9789240039483.

[104] *Id*.