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February 18, 2020

The Honorable Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Shannon Royce, Director
U.S. Department of Health and Human Services
Center for Faith and Opportunity Initiatives
200 Independence Avenue SW
Washington, DC 20201

Re: RIN 0991-AC13 Department of Health and Human Services (HHS): Ensuring Equal Treatment of Faith-Based Organizations

Dear Secretary Azar and Director Royce:

The National Health Law Program (NHeLP) has worked to improve health access and quality through education, advocacy and litigation on behalf of low-income and underserved individuals for over 50 years. We appreciate the opportunity to provide comments on the proposed rule RIN 0991-AC13.

We strongly oppose the proposed rule, which would impede access to health care and other necessary services. The proposed rule would encourage religiously-affiliated providers to refuse to employ non-adherents and require that all employees and applicants for employment conform to the religious tenets of such organization. The rule would also eliminate important protections, including requiring a written notice explaining nondiscrimination rights, and a referral to an alternative provider.

Additionally, the proposed rule opens the door to health care refusals, contrary to established standards of care. If implemented, the rule will exacerbate health disparities, particularly for LGBTQ people, women, persons with disabilities, persons living in rural communities, people of color, and other under-served communities.

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Furthermore, HHS fails to adequately explain the reason for making these changes. Current regulations were developed under a transparent and collaborative process.[1] After a sixty-day comment period and six month review, HHS promulgated final rules designed to ensure access to health care and social services provided by faith-based organizations consistent with the Religious Freedom and Restoration Act and U.S. Constitution.[2] HHS fails to explain why these changes are now needed. Moreover, the proposed thirty-day comment period is insufficient for meaningful public participation, especially given the complex interaction of multiple agencies promulgating related rules.[3]

The proposed rule would encourage religiously-affiliated providers to discriminate against employees who do not adhere to their faith, which will harm already underserved communities

The proposed rule would expand the ability of religious-affiliated providers to refuse to employ persons that do not share the provider's religious beliefs, and to require employees to "conform

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[1] The current regulations are based upon recommendations from the President's Advisory Council on Faith-Based and Neighborhood Partnerships: *A New Era of Partnerships: Report of Recommendations to the President*, https://obamawhitehouse.archives.gov/sites/default/files/docs/ofbnp-council-final-report.pdf; *Implementation of Executive Order 13559 Updating Participation in Department of Health and Human Services Programs by Faith-Based or Religious Organizations and Providing for Equal Treatment of Department of Health and Human Services Program Participants*, 80 Fed. Reg. 47271 (proposed August 6, 2015) (to be codified at 45 C.F.R. pts. 87, 1050); *Fundamental Principles and Policymaking Criteria for Partnerships with Faith-Based and Other Neighborhood Organizations*, 81 Fed. Reg. 19355, 193556 (April 4, 2016) (codified at 45 C.F.R. pts. 87, 1050).

[2] 81 Fed. Reg. 19365.

[3] Equal Opportunity for Religious Organizations in U.S. Department of Agriculture Programs: Implementation of Executive Order 13831, 85 Fed. Reg. 2897 (proposed January 17, 2020) (to be codified at 7 C.F.R. pt. 16); *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Direct Grant Programs, State-Administered Formula Grant Programs, Developing Hispanic-Serving Institutions Program, and Strengthening Institutions Program*, 85 Fed. Reg. 3190 (proposed January 17, 2020) (to be codified at 2 C.F.R. pt. 3474, 34 C.F.R. pts. 75, 76, 106, 606, 607, 608, 609); *Equal Participation of Faith-Based Organizations in Department of Justice's Programs and Activities: Implementation of Executive Order 13831*, 85 Fed. Reg. 2921 (proposed January 17, 2020) (to be codified at 28 C.F.R. pt. 38); Equal Participation of Faith-Based Organizations in USAID's Programs and Activities: Implementation of Executive Order 13831, 85 Fed. Reg. 2916 (proposed January 17, 2020)(to be codified at 22 C.F.R. pt. 205); *Equal Participation of Faith-Based Organizations in DHS's Programs and Activities: Implementation of Executive Order 13831*, 85 Fed. Reg. 2889 (proposed January 17, 2020) (to be codified at 6 C.F.R. pt. 19); *Equal Participation of Faith-Based Organizations in the Department of Labor's Programs and Activities: Implementation of Executive Order 13831*, 85 Fed. Reg. 2929 (proposed January 17, 2020) (to be codified at 29 C.F.R. pt. 2); *Equal Participation of Faith-Based Organizations in HUD Programs and Activities: Implementation of Executive Order 13831*, 85 Fed. Reg. 8215 (proposed February 13, 2020) (to be codified at 24 C.F.R. pts. 5, 92, 578); *Equal Participation of Faith-Based Organizations in Veterans Affairs Programs: Implementation of Executive Order 13831*, 85 Fed. Reg. 2938 (proposed January 17, 2020) (to be codified at 38 C.F.R. pts. 50, 61, 62).

to the religious tenets of the organization."[4] If implemented, this provision would likely exacerbate shortages of health care professions in medically underserved areas by reducing the pool of otherwise qualified care providers. Lack of access to health care and other services due to lack of providers would, in turn, compound health disparities among already underserved communities.

According to Health Resources Services Administration (HRSA), medically underserved areas exist in every state, with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[5] This shortage of health professionals is felt in urban areas as well. A recent Association of American Colleges (AAMC) study noted the shortage of U.S. physicians to reach over 120,000 by the year 2032, with metropolitan areas such as El Paso, Texas showing the highest demand.[6]

Several research studies highlight that members of racial/ethnic minority groups—specifically African Americans—are more likely than Whites to live in medically underserved areas, officially designated by HRSA as Health Professional Shortage Areas (HPSAs).[7] For example, 28% of Latinos and 22% African Americans report having little or no choice in where to seek care from, in comparison to only 15% of Whites reporting this same difficulty.[8]

Living in a HPSA has been associated with higher prevalence of diabetes and hypertension, as well as health risk factors like obesity and smoking.[9] Since African Americans and Latinx persons are more likely to live in these areas, these communities are at an increased risk of

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[4] *Ensuring Equal Treatment of Faith-Based Organizations*, 85 Fed. Reg. 2974-2987 (Jan. 17, 2020) (to be codified at 45 C.F.R. pt. 87)(hereinafter "proposed rule").

[5] HEALTH RES. & SERV. ADMIN, Quick Maps – Medically Underserved Areas/Populations, https://data.hrsa.gov/maps/quick-maps?config=mapconfig/MUA.json; *see also* Malcolm MacDowell et al., *A National View of Rural Health Workforce Issues in the USA,* 10 RURAL REMOTE HEALTH 2, 2–10 (2010).

[6] Gianna Melillo, *Physician Workforce Struggles to Meet Rising Demands Across Urban, Rural Areas*, AJMC (Dec. 10, 2019), https://www.ajmc.com/focus-of-the-week/physician-workforce-struggles-to-meet-rising-demands-across-urban-rural-areas; *see also* U.S. Physician Employment Report 2019, DOXIMITY (Dec. 2019), https://s3.amazonaws.com/s3.doximity.com/press/US_physician_employment_report_2019.pdf

[7] Jamila Taylor, *Racism, Inequality, and Health Care for African Americans*, THE CENTURY FOUNDATION (Dec. 19, 2019), https://tcf.org/content/report/racism-inequality-health-care-african-americans/?agreed=1; *Eliminating Racial/Ethnic Disparities in Health Care: What are the Options?*, KFF (Oct. 20, 2008), https://www.kff.org/disparities-policy/issue-brief/eliminating-racialethnic-disparities-in-health-care-what/.

[8] *Eliminating Racial/Ethnic Disparities in Health Care: What are the Options?*, KFF (Oct. 20, 2008), https://www.kff.org/disparities-policy/issue-brief/eliminating-racialethnic-disparities-in-health-care-what/.

[9] Norrina B. Allen, PhD et al., *The Association of Health Professional Shortage Areas and Cardiovascular Risk Factor Prevalence, Awareness and Control in the Multi-Ethnic Study of Atherosclerosis*, 4 CIRCULATION: CARDIOVASCULAR QUALITY AND OUTCOMES 565, 565–572 (2011).

experiencing negative outcomes.[10] In sum, lack of provider access worsens health disparities already faced by these minority communities.

By encouraging religiously-affiliated providers to "select [its] employees on the basis of their acceptance of or adherence to the religious tenets of the organization," the proposed rule will further limit the pool of otherwise qualified providers able to serve the growing health needs of underserved communities and compound health disparities in these areas.[11]

The proposed rule will impede access to needed care by removing requirements to notify beneficiaries of nondiscrimination protections

Providers receiving federal funding are required to give beneficiaries written notice of their rights, including the right to nondiscrimination based on their religion, that participation in religious activities is voluntary and are provided separately from federally-funded activities, and that they can report a violation of these rights by providers.[12] These protections underscore that religiously-affiliated providers may not impose a litmus test by limiting federally-funded services to adherents, or requiring participation in religious activities as a condition to receiving health care or other services.

As the President's Advisory Council on Faith-Based and Neighborhood Partnerships ("Council") explained in its report *A New Era of Partnerships: Report of Recommendations to the President*:

> [o]ne cannot assume that those who are seeking aid through the array of federally funded social welfare programs would be aware of their religious liberty rights. Thus, a *notice requirement of those rights to program beneficiaries is essential* and should be provided at the outset of the person's participation in the federally funded program.[13]

The current notice requirements not only protect the religious liberty of beneficiaries, but helps enable beneficiaries' access to services offered by religiously-affiliated providers. For example, a nonreligious person, or a person of another faith may fear being forced to participate in a religious service to obtain care. LGBTQ youth experiencing homelessness may avoid services from a religiously-affiliated provider whose religion condemns them for being Gay. These and other beneficiaries need assurances that they need not participate in religious activity to

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[10] *Id.*
[11] 85 Fed. Reg. 2974, 2986 (Jan. 17, 2020) (to be codified at 45 C.F.R. pt. 87.3(f)).
[12] 45 C.F.R. § 87.3(i).
[13] President's Advisory Council on Faith-Based and Neighborhood Partnerships, *A New Era of Partnerships: Report of Recommendations to the President* (2010) at 141, https://obamawhitehouse.archives.gov/sites/default/files/microsites/ofbnp-council-final-report.pdf. (emphasis added).

receive health care and other services, without discrimination, from a religiously-affiliated provider.

The proposed rule removes the notice requirements, but it does not change the underlying right of beneficiaries to receive services without discrimination. Beneficiaries retain the right to nondiscrimination, to not participate in the provider's religious activities, and to file complaints. However, by eliminating notice, the rule makes it more difficult for beneficiaries to know and exercise these important rights and would ultimately discourage some persons from receiving needed care from religiously-affiliated providers.

HHS also notes that compliance with current written notice places little burden on providers, costing no more than $100 per organization per year.[14] However, eliminating written notice requirements would cause beneficiaries significant harm. We urge HHS to retain the current notice requirements and ensure compliance by federally-funded providers.

The proposed rule impedes access to health care services by eliminating required referrals to alternative providers

Additionally, current protections require federally-funded, faith-based recipients social service programs to undertake reasonable efforts to identify an alternative provider if a beneficiary or prospective beneficiary objects to the religious character of the faith-based organization.[15] If such an alternative provider is available, the entity must refer the beneficiary to an identified alternative provider and to make a record of the referral.[16] The proposed rule removes this requirement, putting the burden on beneficiaries to try to find an alternative provider if they feel uncomfortable receiving care from a religiously-affiliated organization.

Eliminating the alternative referral requirement will especially affect persons with disabilities who may rely on providers for services, such as assistance with activities for daily living. They may rely on providers, such as a case manager, to coordinate necessary services, a transportation provider to get them to appointments, or a personal care attendant to help them take medications and manage their daily activities.

Under the proposed rule, any of these providers could object to providing a necessary service, and refuse to inform the beneficiary where they could obtain that service, including how to find an alternative provider. Due to limited provider networks in some areas and other challenges people with disabilities face in accessing care (described further below), it may be more difficult to find alternate providers if the referral requirement is eliminated.. Moreover, people with disabilities identifying as LGBTQ or belonging to a historically disadvantaged racial or

[14] 85 Fed. Reg. 2984.
[15] 45 C.F.R. § 87.3(i)(iv).
[16] 45 C.F.R. § 87.3(k).

ethnic group may be both more likely to encounter service refusals and also face greater challenges to receive (or even know about) accommodations.

Many rural communities already experience an array of mental health, dental health, and primary care shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.[17] Individuals in rural areas must travel further distances for regular checkups, often on poorer quality roads, and have less access to reliable public transportation.[18] Eliminating the alternative referral provisions will make accessing health care even more difficult for those living in rural communities who do not feel comfortable with obtaining care from religiously-affiliated providers, including those which refuse to provide certain health care services due to religious directives (see discussion below).

HHS indicates that provider cost savings in eliminating referrals would be insignificant.[19] Yet, the harm to beneficiaries is significant as it would place the burden of finding an alternative provider solely on beneficiaries, which may prevent them from accessing services altogether.

The proposed rule broadens religious exemptions open the door for refusals to provide evidence-based services as required by the standards of care

The proposed rule adds language throughout the regulation that expands or adds new religious exemptions for faith-based providers. These include modifying program requirements to provide for exemptions or "appropriate religious accommodations."[20] This new language suggests that providers do not have to meet program requirements and perhaps even that providers may refuse to provide services otherwise required by a grant award. By expanding the ability of religiously-affiliated providers to deny medically necessary care, the rule, if implemented, will deny care and exacerbate health disparities among already under-served communities, including women (especially women of color), persons with disabilities, LGBTQ persons, and those living in rural communities. As explained below, these populations already have limited access to access comprehensive and unbiased health care, including sexual and reproductive health information and services.

Any efforts by providers or other health care personnel to bypass standards of care for treatments, and to deprive patients of information and access they are entitled to receive

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[17] Carol Jones et al., Health Status and Health Care Access of Farm and Rural Populations, ECON. RESEARCH SERV. (2009), https://www.ers.usda.gov/publications/pub-details/T?pubid=44427.
[18] Thomas A. Arcury et al., *The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region*, 40 HEALTH SERV. RESEARCH 135, 135–156 (2005).
[19] 85 Fed. Reg. 2984.
[20] 85 Fed. Reg. 2986 (to be codified at 45 C.F.R. pt. 87.3(e)).

through written notice and referral protections is incompatible with consumer choice, informed consent, and individual decision making.

The proposed rule will impede access to care for women of color

Research shows that women of color in many states disproportionately receive their care at Catholic hospitals, subjecting them to treatment that may not comply with the standards of care.[21] In nineteen states, women of color are more likely than white women to give birth in Catholic hospitals.[22] In New Jersey, for example, women of color make up 50 percent of women of reproductive age in the state, yet have twice the number of births at Catholic hospitals compared to their white counterparts.[23] These hospitals as well as many Catholic-affiliated hospitals must follow the Ethical and Religious Directives for Catholic Health Care Services (ERDs) which provide guidance on a wide range of hospital matters, including reproductive health care. In practice, the ERDs prohibit the provision of emergency contraception, sterilization, abortion, fertility services, and some treatments for ectopic pregnancies.[24] Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals and as a result, women were delayed care or transferred to other facilities, risking their health.[25] The proposed rule will give health care providers a license, such as Catholic hospitals, to opt out of evidence-based care that the medical community endorses. This is especially concerning since Catholic institutions are the "sole community hospital" in 46 regions of the United States.[26] If this rule were to be implemented, more women, particularly women of color, will be put in situations where they will have to decide between receiving compromised care, or trying to find another provider to receive quality, comprehensive reproductive health services, if such services are actually available in their communities.

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[21] Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[22] *Id.* at 12.
[23] *Id.* at 9.
[24] See Amy Chen and Hayley Penan, *The Ethical & Religious Directives: What the 2018 Update Means for Catholic Hospital Mergers*, NATIONAL HEALTH LAW PROGRAM, (Jan. 2, 2019), https://healthlaw.org/resource/the-ethical-religious-directives-what-the-2018-update-means-for-catholic-hospital-mergers/.
[25] Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774, 1774–1778 (2008).
[26] Louis Uttley, et al., *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, MERGERWATCH (Dec. 2013), http://static1.1.sqspcdn.com/static/f/816571/24079922/1387381601667/Growth-of-Catholic-Hospitals-2013.pdf?token=bF4aYQwEmGzhblvfzmshTpcU9K8%3D.

The proposed rule would harm LGBTQ persons

LGBTQ people still face discrimination in a wide variety of services affecting access to health care, including reproductive services, adoption and foster care services, child care, homeless shelters, transportation services, and physical and mental health care services, on the basis of their sexual orientation and gender identity.[27] According to the 2015 U.S. Transgender Survey, 23 percent respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[28] The study "When Health Care Isn't Caring" found that 56 percent of LGBT people reported experiencing discrimination from health care providers – including refusals of care, harsh language, or even physical abuse – because of their sexual orientation.[29] These data do not distinguish between religiously-affiliate and secular providers. However, some religiously-affiliated providers have led efforts to invalidate federal regulations affirming nondiscrimination protections based upon gender identity.[30]

Refusals implicate standards of care that are vital to LGBTQ health. For example, the proposed rule could allow religiously affiliated hospitals to refuse to provide gender affirming care, which is a medically necessary procedure—sometimes even life-saving—for many transgender people. Medical professionals should provide LGBTQ individuals with the same quality of care as they would anyone else. The American Medical Association recommends that providers use culturally appropriate language and have basic familiarity and competency

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[27] HUMAN RIGHTS WATCH, *All We Want is Equality: Religious Exemptions and Discrimination Against LGBT People in the United States*, (Feb. 19, 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people; *see also* Ning Hsieh & Matt Ruther, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care*, 36 HEALTH AFFAIRS 1786, 1786–1794 (2017). In fact, the Department's Healthy People 2020 initiative itself expressly recognizes, "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights." *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

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

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

[30] See, *e.g.*, *Franciscan Alliance v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016), seeking to invalidate nondiscrimination protections based upon gender identity in *Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and Health Programs or Activities Administered by the Department of Health and Human Services or Entities Established under Title I of the Patient Protection and Affordable Care Act*, 45 C.F.R. Part 92, 81 Fed. Reg. 31376 (May 18, 2016).

with LGBTQ issues as they pertain to any health services provided.[31] The World Professional Association for Transgender Health guidelines provide that gender-affirming interventions are medically necessary and part of the standard of care.[32] The American College of Obstetricians and Gynecologists warns that failure to provide gender-affirming treatment can lead to serious health consequences for transgender individuals.[33] LGBTQ individuals already experience significant health disparities, and denying medically necessary care on the basis of sexual orientation or gender identity exacerbates these disparities.

Refusals to treat individuals according to medical standards of care put patients' health at risk. Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care impairs the ability of patients to make a health decision that expresses their self-determination.

The proposed rule harms people with disabilities

Many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously-affiliated providers. Historically, people with disabilities relying on these services have faced discrimination, exclusion, and loss of autonomy due to provider objections. Group homes have, for example, refused to allow married residents with intellectual disabilities to live together.[34] Individuals with HIV—a recognized disability under the ADA—have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. Per the broad language of the proposed rule, a case manager might refuse to set up a routine appointment with a gynecologist because contraceptives might be discussed. An interpreter for a deaf individual could refuse to mediate a conversation with a doctor about abortion. In these

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[31] *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*, GAY LESBIAN BISEXUAL & TRANSGENDER HEALTH ACCESS PROJECT, http://www.glbthealth.org/CommunityStandardsofPractice.htm (last visited Feb. 11, 2020); *Creating an LGBTQ-friendly Practice*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/population-care/creating-lgbtq-friendly-practice#Meet%20a%20Standard%20of%20Practice. (last visited Feb. 11, 2020).

[32] *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, WORLD PROF. ASS'N FOR TRANSGENDER HEALTH (2011), https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf

[33] *Committee Opinion 512: Health Care for Transgender Individuals*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Dec. 2011), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals.

[34] See *Forziano v. Independent Grp. Home Living Prog.*, No. 13-cv-00370 (E.D.N.Y. Mar. 26, 2014) (dismissing lawsuit against group homes, including a religiously affiliated group home, that refused to allow married couples with intellectual disabilities live together). Recent regulations have reinforced protections to ensure available choice of roommates and guests. 42 C.F.R. §§ 441.301(c)(4)(vi)(B) & (D).

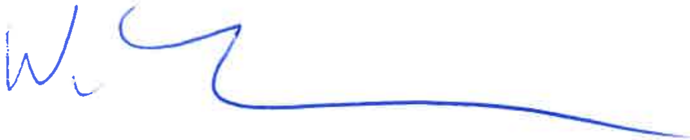
cases, a denial based on someone's personal moral objection can potentially impact every facet of life for a person with disabilities, including rights to medically necessary care, and autonomy.

Conclusion

We recognize that many faith-based organizations provide important social services for people in need and they have been partnering with the government for years. However, such providers should not be allowed to take government funds and then place religious litmus tests on who they hire, who they serve, or which services they provide with those funds. Nor may they include religious content in their programs funded directly by the government. Therefore, we strongly urge HHS to withdraw the proposed rule.

We appreciate the opportunity to provide comments. If you have any questions, please contact me at (202) 289-7661 or via email (turner@healthlaw.org).

Sincerely,



Wayne Turner
Senior Attorney