VIA ELECTRONIC TRANSMISSION

March 6, 2023

Melanie Fontes Rainer
Director
Office for Civil Rights
Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Re: RIN 0945-AA18
Safeguarding the Rights of Conscience as Protected by Federal Statutes

Dear Director Fontes Rainer,

The National Health Law Program (NHeLP) is a public interest law firm that works to safeguard and expand equitable access to quality health care for people with low incomes and underserved populations. For over fifty years, we have litigated, engaged in policy advocacy, and provided technical assistance and education to advance this mission. We believe that a health care provider's personal beliefs should never dictate a person or community's access to health care. Thus, we generally support and appreciate the opportunity to comment on the U.S. Department of Health and Human Services (HHS) Office for Civil Rights's (OCR) proposed rule, titled "Safeguarding the Rights of Conscience as Protected by Federal Statutes" (hereinafter "2023 Proposed Rule").[1]

We thank OCR for proposing to largely rescind its 2019 Final rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" ("2019 Final Rule").[2] The 2019 Final Rule was unlawful, unnecessary, and emboldened health care discrimination.[3] By making it easier for institutions and

individuals to refuse to provide health care because of their personal beliefs rather than a patient's needs, the 2019 Final Rule endangered the health and lives of women; lesbian, gay, bisexual, transgender, queer, and intersex ("LGBTQI+") people; people with disabilities; and people in rural communities across the country.

We thank OCR for proposing to largely rescind the 2019 Final Rule's most harmful provisions, including its enforcement provisions. Removing these elements of the 2019 Final Rule is critically important for patients across the country. However, we are concerned that the Proposed Rule fails to provide adequate notice to individuals about which providers and entities refuse to provide critical services. We are also concerned that the Proposed Rule maintains aspects of the 2019 Final Rule's expansion of OCR enforcement authority.

I. The Proposed Rule rescinds some unlawful and unethical parts of the 2019 Final Rule that emboldened refusals of care

We commend OCR for rescinding some parts of the rule that emboldened refusals of care, including current § 88.2 Definitions. By redefining terms included in several federal refusal provisions, the 2019 Final Rule created broad exemptions that would have allowed a broad swath of health care providers and other individuals—from clinicians to receptionists to ambulance drivers—to deny patients essential health care services and information, including in emergencies.

The 2019 Final Rule would have even allowed such individuals to refrain from informing patients about treatment options that they find objectionable—violating principles of medical ethics and informed consent—and to refrain from referring the patient to a health care professional who has no such objection to providing the patient with needed care. In

[1] U.S. Dept. of Health and Human Srvs., *Safeguarding the Rights of Conscience as Protected by Federal Statutes, Notice of Proposed Rulemaking*, 88 Fed. Reg. 820–830 (Jan. 5, 2023), https://www.federalregister.gov/documents/2023/01/05/2022-28505/safeguarding-the-rights-of-conscience-as-protected-by-federal-statutes (hereinafter "2023 Proposed Rule" or "Proposed Rule").
[2] U.S. Dept. of Health and Human Srvs., *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23170–23272 (June 7, 2019), https://www.federalregister.gov/documents/2019/05/21/2019-09667/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority (hereinafter "2019 Final Rule").
[3] New York et al. v. U.S. Dept. of Health & Human Srvs. et al., No. 1:2019cv04676–Document 142 (S.D.N.Y. 2019) (vacating the 2019 Final Rule nationwide).

addition, the 2019 Final Rule abandoned the long-standing balancing framework under Title VII of the Civil Rights Act of 1964 by requiring health care employers to provide absolute accommodation to individuals who refuse to provide certain information and services, including abortions, even when these services are a primary part of their job or in an emergency.

Informed consent is a necessary principle of patient-centered decision-making. Health care refusals that are grounded in personal and religious beliefs rather than scientific evidence send us back in time to now-discredited models of paternalistic health care that deprived patients the capacity to make informed decisions.[4] Informed consent depends upon the disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their health care treatment or refuse treatment altogether. This right hinges on two factors: access to relevant and medically accurate information about treatment choices and alternatives, and provider guidance based on generally accepted standards of practice. Without informed consent, patients are unable to make health care decisions grounded in agency, their beliefs and preferences, and their individual needs. This is particularly problematic as many communities, including Black, Indigenous, and other people of color (BIPOC), people with disabilities, and LGBTQI+ individuals, have disproportionately experienced abuse and trauma at the hands of providers and institutions. We agree with OCR's decision to rescind parts of the rule that emboldened health care refusals and would have compromised the principles of informed consent.

The 2019 Final Rule's expansion of health care refusals weakened the quality of U.S. health care by allowing health care professionals to opt out of providing services, disregarding evidence-based standards of care. Standards of care are "the practices that are medically necessary and the services that any practitioner under any circumstances should be expected to render."[5] Unlike "best practices," which consider the highest level of care a person can receive, standards of care "establish a baseline of professionally agreed-upon practices."[6] A health care provider's primary commitment and highest duty is

[4] Amy Chen, Nat'l Health Law Prog., *Health Care Refusals & How They Undermine Standards of Care Part I: An Overview* (Jun. 13, 2022), *available at* https://healthlaw.org/health-care-refusals-how-they-undermine-standards-of-care-part-i-an-overview/.
[5] *Id*.
[6] *Id*.

to provide the best care possible for their patients. Failure to adhere to prevailing standards of care harms their patients, undermines the quality of the U.S. health care system, and jeopardizes the health of the general public.

The health services impacted by refusals–sexual and reproductive health care from gender-affirming care to abortions, as well as broader health care provided to LGBTQI+ individuals–often jeopardize patients from receiving services that conform to these standards of care. For example, information, counseling, referral and provisions of contraceptive and abortion services are part of the standard of care for a range of common medical conditions, such as heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[7] People of all sexual orientations and gender identities, and with all variations of sex characteristics, seek assisted reproduction. Gender-affirming care has long been governed by consensus standards of care accepted by every major medical association as part of a holistic treatment plan.[8] Refusals interfere with health care providers' ability to provide evidence-based treatment in all of these scenarios.[9]

The 2019 Final Rule's overly broad scope would also have been devastating to people with substance use disorder (SUD). Rather than promoting the evidence-based standard of care, the rule could allow anyone from practitioners to insurers to refuse to provide, or even recommend, medications for opioid use disorders (MOUD) and other evidence-based interventions due simply to a personal objection. The opioid overdose epidemic continues to claim too many lives. According to the Centers for Disease Control and Prevention, over

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[7] *See* Am. Diabetes Ass'n, *Standards of Medical Care in Diabetes – 2017*, 40 DIABETES CARE S115, S117 (2017), *available at* http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf; ACOG, *ACOG Practice Bulletin No. 212: Pregnancy and Heart Disease*, 133 OBSTETRICS & GYNECOLOGY 5, e320-e356, (2019); Mary M. Canobbio et al., *Management of Pregnancy in Patients With Complex Congenital Heart Disease*, 135 CIRCULATION e1-e39 (2017), *available at* http://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/01/24/14/40/management-of-pregnancy-in-patients-with-complex-chd.

[8] *See Medical Organization Statements on Transgender Health Care*, TRANSGENDER LEGAL DEF. & EDUC. FUND, *available at* https://transhealthproject.org/resources/medical-organization-statements/ (last visited Mar. 3, 2023).

[9] *See* Amy Chen, *supra* note 4; Amy Chen, Nat'l Health Law Prog., *Health Care Refusals & How They Undermine Standards of Care Part II: The Impact of Health Care Refusals, Discrimination, and Mistreatment on LGBTQ Patients and Families* (Jun. 13, 2022), *available at* https://healthlaw.org/health-care-refusals-how-they-undermine-standards-of-care-part-ii-the-impact-of-health-care-refusals-discrimination-and-mistreament-on-lgbtq-patients-and-families/.

106,000 people in the U.S. died from drug overdose in 2021.[10] The COVID-19 pandemic exacerbated the problems related to the overdose epidemic, with deaths significantly rising in the past two years. And while the opioid epidemic affects individuals from all walks of life, it is increasingly harming BIPOC communities.[11] The clear, evidence-based treatment standard for opioid use disorder (OUD) is treatment with the medications buprenorphine and methadone.[12] MOUD is so valuable to OUD treatment that the World Health Organization considers buprenorphine and methadone "Essential Medications."[13] However, drug use stigma stands in the way of saving lives.[14] After decades of treating SUDs as a matter for the carceral state rather than a public health imperative, the U.S.' prevailing cultural consciousness generally perceives drug use as a moral failing and drug users as less deserving of care. As a result, people with SUD can have a difficult-enough time finding appropriate care, such as local methadone clinics in rural areas.[15] By allowing providers to individually decide not to provide or recommend SUD treatments, the 2019 Final Rule would have stood in the way of evidence-based treatment standards, amplifying geographic inequities in access to MOUD and triggering countless deaths.

The 2019 Final Rule would have also exacerbated barriers to sexual and reproductive health care by preventing prospective health care employers from asking job applicants about which services they might refuse to provide. This could have forced entities from

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[10] Marianne R. Spencer, Arialdi M. Miniño, & Margaret Warner, *Drug Overdose Deaths in the United States, 2001-2021*, NAT'L CTR. FOR HEALTH STAT. (2022).
[11] Rina Ghose, Amir M. Forati, & John R. Mantsch, *Impact of the COVID-19 Pandemic on Opioid Overdose Deaths: A Spatiotemporal Analysis*, 99 J. URBAN HEALTH 316 (April 2022), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8856931.
[12] U.S. DEP'T HEALTH & HUM. SERV., PUB NO. (SMA)12-4214, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS (2012), *available at* https://store.samhsa.gov/shin/content/SMA12-4214/SMA12-4214.pdf; NATIONAL INSTITUTE ON DRUG ABUSE, EFFECTIVE TREATMENTS FOR OPIOID ADDICTION (Nov. 2016), *available at* https://nida.nih.gov/publications/effective-treatments-opioid-addiction.
[13] WORLD HEALTH ORGANIZATION, 19TH WHO MODEL LIST OF ESSENTIAL MEDICINES (April 2015), *available at* http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf.
[14] Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL'Y 49, 56 (2010); German Lopez, *There's a highly successful treatment for opioid addiction. But stigma is holding it back.*, VOX (Nov. 15, 2017), *available at* https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone.
[15] Christine Vestal, *In Opioid Epidemic, Prejudice Persists Against Methadone*, STATELINE (Nov. 11, 2016), *available at* https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/11/11/in-opioid-epidemic-prejudice-persists-against-methadone.

hospitals or obstetrics and gynecology practices to abortion or gender-affirming care clinics to hire and keep on staff a physician or other employee unwilling to do the very job they were hired to do. In addition, the 2019 Final Rule failed to clarify that health care entities still had to comply with the Emergency Medical Treatment and Labor Act (EMTALA), the federal law that protects people with emergency medical conditions. EMTALA's protections are critical for people seeking emergency reproductive health care, particularly during a miscarriage, which can threaten their future fertility and even their life.

II. By maintaining the 2019 Final Rule's expansion of health care refusals, the Proposed Rule will disproportionately harm populations that already struggle with inadequate access to care

The 2019 Final Rule dangerously threatened to heighten health inequities by targeting those most likely to grapple with refusals of care—those seeking sexual and reproductive health care, particularly abortion care and miscarriage management, and LGBTQI+ people—placing access to care even further out of reach. One of the ways in which it did so was by expanding OCR's enforcement authority from three federal health care refusal laws to twenty-five. By maintaining this aspect of the 2019 Final Rule, the 2023 Proposed Rule not only stands to inappropriately lock up already inadequate resources for the enforcement of Section 1557 of the Patient Protection and Affordable Care Act (ACA) and other nondiscrimination laws, but also embolden refusals of care.

Even before the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, women, people with disabilities, LGBTQI+ people, people living in rural communities, and BIPOC faced severe health inequities.[16] People who live at the intersection of multiple non-dominant identities are multiply burdened by discrimination and experience compounded inequities. Refusals of health care—including contraception, sterilization, assisted reproduction, abortions, and gender-affirming care—play a significant role. These refusals force people to delay or forego necessary care, which can threaten not only their health, but also their lives.

[16] Dobbs v. Jackson Women's Health Organization, 597 U.S. __ (2022).

Refusals harm women and families with low incomes, who are more likely to be uninsured, underinsured, and locked into health insurance plans that do not meet their needs.[17] Many cannot afford to pay out of pocket for services nor travel to another location if services are refused.[18] This is especially true for immigrant women, who may be locked out of health care programs like Medicaid, and women living in rural areas, who struggle with access to care amid dwindling health care resources.

Health care refusals disproportionately affect Black, Indigenous, and other women of color. According to a 2014 report, doctors often fail to inform Black women of the full range of reproductive health options regarding labor or delivery possibly due to stereotypes about Black women's sexuality and reproduction.[19] Young Black women noted that they were shamed by providers when seeking sexual health information and contraceptive care in part, due to their age, and in some instances, sexual orientation.[20] Atop these effects, refusals further limit options for culturally appropriate care. A 2018 report shows that women of color in many states disproportionately receive their care at Catholic hospitals, which follow religious directives that limit doctors' ability to provide the full range of care.[21]

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[17] In 2021, an estimated 19 percent of women were uninsured. Single mothers, women of color, and women with low incomes are more likely to be uninsured. *Women's Health Insurance Coverage*, KAISER FAMILY FOUND., (Dec. 21, 2022), *available at* https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/#:~:text=One%20in%20five%20(19%25),at%20or%20above%20200%25%20FPL. Immigrant women are also more likely to be uninsured. Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, CONTRACEPTION 8 (2018), *available at* http://www.contraceptionjournal.org/article/S0010-7824(18)30065-9/pdf. In 2022, more insured women than men reported experiencing problems with insurance coverage of needed health services or medications. Michelle Long et al., *Experiences with Health Care Access, Cost, and Coverage: Findings from the 2022 KFF Women's Health Survey*, KAISER FAMILY FOUND. (Dec. 20, 2022), https://www.kff.org/womens-health-policy/report/experiences-with-health-care-access-cost-and-coverage-findings-from-the-2022-kff-womens-health-survey/.

[18] *See* Tapales et al., *supra* note 15, at 8, 16.

[19] CTR. FOR REPROD. RIGHTS, NAT'L LATINA INST. FOR REPROD. HEALTH, & SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, REPRODUCTIVE INJUSTICE: RACIAL AND GENDER DISCRIMINATION IN U.S. HEALTH CARE 20-22 (2014), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf [hereinafter REPRODUCTIVE INJUSTICE]; IN OUR OWN VOICE: NAT'L BLACK WOMEN'S REPROD. JUSTICE AGENDA, THE STATE OF BLACK WOMEN & REPRODUCTIVE JUSTICE 32-33 (2017), *available at* http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

[20] REPRODUCTIVE INJUSTICE, *supra* note 19, at 16-17.

[21] Kira Shepherd, et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT (2018), *available at*

By maintaining the 2019 Final Rule's expansion of federal health care refusal laws, the Proposed Rule will give health care providers, such as Catholic hospitals, a license to opt out of evidence-based care that the medical community endorses. If implemented as it stands, more women, particularly women of color, LGBTQI+ women, and women with disabilities, will be put in situations where they will have to decide between receiving compromised care or seeking another provider to receive quality, comprehensive reproductive health services. For others who live in rural or otherwise underserved communities, there may be no alternative provider.

Refusals directly impact the ability of LGBTQI+ people to obtain culturally and clinically competent health care and reduce the availability of quality health care for LGBTQI+ individuals. LGBTQI+ individuals already experience significant health inequities, and denying medically necessary care based on sexual orientation, gender identity, or variation in sex characteristics (e.g., intersex status) exacerbates these inequities. LGBQ+ people are:

> more likely to delay care, less likely to have a usual source of care, . . . more likely to be concerned about medical bills, . . . lack [. . .] healthcare professionals adequately trained in providing culturally competent care, [and encounter] high cost-sharing and/or lack of coverage for certain services including hormone treatments and other gender-affirming care.[22]

Health care avoidance by LGBQ+ persons is based in the reality that LGBQ+ people face discrimination in a wide variety of services affecting access to health care, including reproductive services, adoption and foster care services, child care, homeless shelters, and transportation services – as well as physical and mental health care services.[23]

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https://lawrightsreligion.law.columbia.edu/bearingfaith#:~:text=%E2%80%9CBearing%20Faith%3A%20The%20Limits%20of,birth%20at%20a%20Catholic%20hospital; *see also* Tess Solomon et al., Community Catalyst, *Bigger and Bigger: The Growth of Catholic Health Systems* (Oct. 2020), *available at* https://www.communitycatalyst.org/resources/publications/document/2020-Cath-Hosp-Report-2020-31.pdf.

[22] Arielle Bosworth et al., Assistant Sec. for Planning & Evaluation, Ofc. of Health Policy, *Issue Brief: Health Insurance Coverage and Access to Care for LGBTQ+ Individuals* (June 2021), *available at* https://aspe.hhs.gov/sites/default/files/2021-07/lgbt-health-ib.pdf.

[23] HUM. RTS. WATCH, ALL WE WANT IS EQUALITY: RELIGIOUS EXEMPTIONS AND DISCRIMINATION AGAINST LGBT PEOPLE IN THE UNITED STATES, (Feb. 2018),

Horrific examples of health care discrimination against transgender people combined with the increased slate of outright political attacks on transgender individuals and their families have put trans and gender non-conforming individuals' lives at risk.[24] As many states move to ban transgender-specific health care that is safe and medically uncontroversial, governments have a direct role in eliminating options for quality, culturally- and clinically-appropriate health care for transgender individuals.[25] These bans and refusals only bolster a trend that already exists in staggering numbers: a 2022 survey found that nearly one in three transgender individuals experienced some form of health care refusal and about half of transgender or nonbinary individuals had a negative experience with a doctor or health care provider in the past year.[26] Sanctioning health care refusals is at odds with OCR's goal of increasing access to health care for all individuals. Instead, OCR must recognize, as several federal district courts have done, that refusals of health care on the basis that an individual is transgender is prohibited discrimination on the basis of sex.[27]

Health care refusals enable discrimination and further limit intersex individuals' access to quality health care. Lack of understanding of intersex experiences and discrimination against those with intersex traits may result in religious or religiously-affiliated providers and entities denying care or services to intersex individuals.[28] In fact, a 2022 survey found

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https://www.hrw.org/report/2018/02/19/all-we-want equality/religious-exemptions-and-discrimination-against-lgbt-people.

[24] *Attacks on Gender-Affirming and Transgender Health Care*, AM. COLL. OF PHYSICIANS (Nov. 11, 2022), *available at* https://www.acponline.org/advocacy/state-health-policy/attacks-on-gender-affirming-and-transgender-health-care.

[25] *See* E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. OF TRANSGENDER HEALTH S1 (2022), *available at* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.

[26] Caroline Medina & Lindsay Mahowald, *Discrimination and Barriers to Well-Being: The State of the LGBTQI+ Community in 2022*, CTR. FOR AM. PROGRESS (Jan. 12, 2023), *available at* https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/.

[27] *See* Hammons v. Univ. of Md. Med. Ctr., __F. Supp. 3d __, 2023 WL 121741 (D. Md. Jan. 6, 2023) (also discussing Fain v. Crouch __F. Supp. 3d__, 2022 WL 3051015 (S.D.W.V. Aug. 2, 2022) and Kadel v. Folwell, __F. Supp. 3d__, 2022 WL 3226731 (M.D.N.C. Aug. 10, 2022).

[28] *See* Jeniece Lusk & Jodien Johnson, *Bibles and Bathrooms: Intersex Variation Awareness Among College-Aged American Christians*, 12 SAGE OPEN (2022), *available at* https://doi.org/10.1177/21582440221095011; *see, e.g.,* Stephanie Budway, *Religion and Intersex: Perspectives from Science, Law, Culture, and Theology* (2023); Susannah Cornwall, *Bodily rights and gifts: intersex, Abrahamic religions and human rights*. 23 CULTURE, HEALTH, & SEXUALITY 533

that more than half of intersex respondents experienced a refusal of care in their lifetime due to the religious affiliation of the provider, hospital, or health care entity.[29] These tangible—not just hypothetical—experiences of discrimination, including refusals, also cause intersex individuals to avoid seeking health care.[30] Permitting refusals based on intersex traits therefore exacerbates lack of access and poor quality of care for an already deeply underserved group.

People with disabilities disproportionately experience harm from health care refusals. For example, many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously affiliated providers. Given the intimacy of residential and personal care services, a denial based on someone's personal moral objection can potentially affect every facet of life for a person with disabilities–including visitation rights, autonomy, and access to the community. Historically, people with disabilities who rely on these services have faced discrimination, exclusion, and a loss of autonomy due to provider refusals. Further, individuals with HIV, a recognized disability under the American Disabilities Act, have repeatedly encountered providers who deny services, necessary medications, and other treatments citing religious and moral objections. Providers may deny people with reproductive health conditions such as endometriosis or polycystic ovarian syndrome access to oral contraceptives that provide relief from chronic pain and other severe symptoms. Due to limited provider networks in some areas and the important role that case managers and personal care attendants play in coordinating care, it may be more difficult for people with disabilities and older adults to find alternate providers who can help them in the instance of a refusal.

Finally, health care refusals disproportionately harm people who live in rural communities. Most rural communities in the U.S. lack sufficient health care services: the Health Resources and Services Administration (HRSA) classifies nearly 80 percent of rural areas as medically underserved.[31] Rural communities lack not just primary care options, but

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(2021), *available at* https://www.tandfonline.com/doi/abs/10.1080/13691058.2020.1743882?journalCode=tchs20.

[29] *See* Medina & Mahowald, *supra* note 26.

[30] *Id.*; *see* Caroline Medina & Lindsay Mahowald, *Key Issues Facing People with Intersex Traits*, CTR. FOR AM. PROGRESS (Oct. 26, 2021), *available at* https://www.americanprogress.org/article/key-issues-facing-people-intersex-traits/.

[31] Eli Saslow, *'Out here, it's just me:' In the medical desert of rural America, one doctor for 11,000 square miles'* WASH. POST (Sept. 28, 2019), *available at*

options for nearly every type of health care service as compared to non-rural areas.[32] Even when there are health care facilities currently available, lack of staff and resources continues to force more facilities to close: HRSA has designated 77 percent of rural areas as health professional shortage areas.[33] Rural hospitals and facilities seeking to preserve access to care for their communities more and more often find themselves entering into relationships with religiously affiliated organizations to stay open.[34] As the few, tenuous options for rural health care are consolidated into these organizations, rural communities risk losing access to some care to avoid losing access to all care. By permitting refusals, this proposed rule will facilitate further loss of access to care in rural communities.

III. OCR should clarify enforcement mechanisms to ensure they are not unduly coercive

We appreciate OCR's critical proposed changes to the 2019 Final Rule's extreme enforcement mechanisms.[35] However, additional clarification would ensure the enforcement mechanisms are not unduly coercive. OCR should clarify the terms "relevant funding" and "appropriate action" when describing the measures OCR can take against an entity that violates applicable health care refusal laws.[36] It should clarify for entities that must comply with the next final rule the potential limits HHS can put on its funding. OCR should articulate a limiting principle for determining "relevant funding" and make clear that it can never include all funding that the entity receives from HHS. Similarly, OCR should make clear "appropriate action" is limited to enforcement tools encompassed in existing regulations.

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https://www.washingtonpost.com/national/out-here-its-just-me/2019/09/28/fa1df9b6-deef-11e9-be96-6adb81821e90_story.html.

[32] *186 Rural Hospital Closures since January 2005*, UNC: THE CECIL G. SHEPS CTR. FOR HEALTH SERVS. RES., *available at* https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
(last visited Feb. 17, 2023); *Rural Healthcare Workforce*, RHIHUB, *available at* https://www.ruralhealthinfo.org/topics/health-care-workforce#workforce (last visited Feb. 17, 2023).

[33] Andy Miller, *Rural Communities Left Hurting Without a Hospital, Ambulance or Doctor Nearby*, KAISER HEALTH NEWS (Dec. 23, 2021), *available at* https://khn.org/news/article/rural-communities-left-hurting-without-a-hospital-ambulance-or-doctors-nearby/.

[34] Harris Meyer, *Hospital Merger in Washington State Stokes Fears About Catholic Limits on Care*, KAISER HEALTH NEWS (Aug. 3, 2020), *available at* https://khn.org/news/hospital-merger-in-washington-state-stokes-fears-about-catholic-limits-on-care/.

[35] 2023 Proposed Rule, 88 Fed. Reg. 829–830.

[36] *Id*.

IV. OCR should require additional, adequate notice of refusals of care

We appreciate OCR's decision to modify the language in the voluntary notice. The language of the notice in the 2019 Final Rule was one-sided, only requiring information regarding the right to refuse care. It did not inform patients of potential refusals of care and their right to receive full information about all of their options for care. While OCR suggests removing the objectionable language in the Proposed Rule and has streamlined the notice,[37] it should further amend the language in § 88.3 so that a patient clearly understands the ways their care may be affected by providers or institutions who refuse to provide care they need.

Section 1554 of the ACA prohibits OCR from promulgating regulations that "create[ ] any unreasonable barriers to the ability of individuals to obtain appropriate medical care."[38] Further, the law prohibits OCR from "restrict[ing] the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions" and "violat[ing] the principles of informed consent and the ethical standards of health care professionals."[39] Yet, this is exactly what health care refusals do. Although different federal statutes govern the scope of permitted refusals, OCR must ensure it does not go further than each statute in contravention of ACA § 1554.

When considering health care refusals, OCR must ensure that individuals receive the care they need, including appropriate notice of which care will not be provided. To do otherwise violates principles of informed consent and the ability of providers to disclose all relevant information about the patient's health care. As the rule is written, if a provider refuses to furnish a service, the onus will be on the patient to question whether their hospital, medical doctor, or health care professional has religious, moral, or other beliefs that would lead them to deny services. If an insurer refuses to cover a service, the individual must determine, in some cases having already received the service or committed to the insurance plan, how to cover the cost. Further, when services are denied, the individual currently has no guarantee to receive an explanation for the basis for refusal. This is likely

[37] *Id*.
[38] 42 U.S.C. § 18114 (2010).
[39] *Id*.

to occur, as the Proposed Rule does not have any provisions that stipulate that individuals must be given notice that they may be refused certain health care services on the basis of religious or moral beliefs.

As we recommended in our comments on the proposed Nondiscrimination in Health Care Programs and Activities rule, we recommend that HHS include in the notice requirement that any entity receiving or claiming a religious exemption include the existence and scope of such exemption in its required notices.[40] It would be misleading and inaccurate to require entities to tell participants and beneficiaries (and the public generally) that the entity does not discriminate if the entity does in fact discriminate in certain circumstances and has been granted permission to do so.

RECOMMENDATION: Amend Proposed Rule § 88.3 to mandate the posting of a notice of federal conscience and nondiscrimination laws rather than considering it a best practice. Moreover, amend paragraph (d) as follows:

> (d) Content of the notice text. ***A recipient must post a notice to disclose any services that it does not provide on the basis of a conscience-based objection. They must provide this notice in the manner described in paragraphs (b) and (c) of this section.*** A recipient or the Department should consider using the model text provided in Appendix A for the notice, but may tailor its notice to address its particular circumstances and to more specifically address the conscience laws covered by this rule that apply to it.

OCR should also amend the text of Proposed Rule Appendix A to Part 88 to include model text for recipients to disclose any service(s) that they do not provide on the basis of an objection under a federal health care refusal law.

[40] We request that OCR consider aspects of NHeLP's comments on the 2022 proposed rule on Nondiscrimination in Health Programs and Activities in conjunction with these comments. Nat'l Health Law Prog., *Comments on Proposed Rule on Nondiscrimination in Health Programs and Activities*, 171–172 (Oct. 27, 2022), *available at* https://healthlaw.org/resource/nhelp-comments-on-section-1557-proposed-rule/.

V. OCR must publish information on complaints, investigations, determinations, and settlements conducted under this provision

Currently, health care entities and recipients of federal funds, those claiming exemptions, and those seeking clarity on enforcement of federal health care refusal statutes lack guidance on specific behavior and circumstances that constitute violations. While we agree that determinations must be made on a case-by-case basis, we recommend that OCR adopt a practice of publicizing its enforcement activities, including complaints received, investigations underway, determinations, and settlements. We recommend that OCR publish annual tallies of the number of complaints received and investigations conducted under each health care refusal statute, the number of investigations initiated, the number of complaints resolved, and the number of complaints closed without resolution.[41] For any determination letter issued or settlement announced, OCR should provide information on 1) relevant provisions of law; 2) a legal analysis of the determination; 3) exemptions requested, if any; and 4) compliance correction plans, if any.

Published precedent (even if redacted to eliminate individual's personally identifiable health information) is essential for educating health care entities on what conduct is and is not acceptable under health care refusal laws. Understanding the rationale for OCR's opinions is helpful to entities in ensuring that they are compliant and helpful for consumers to understand what conduct is acceptable. Without such precedent, entities are left only with limited guidance, such as Frequently Asked Questions (FAQs), which, while helpful, are often not sufficiently specific to help entities tailor their behavior in accordance with the law. We strongly recommend that OCR adopt this practice as part of its enforcement activities under this regulation without delay.

Conclusion

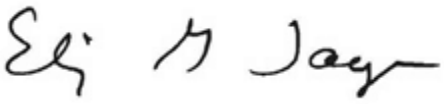
The National Health Law Program thanks OCR for its decision to largely rescind the 2019 Final Rule and return to the 2011 Rule framework. With that said, we urge OCR to fully rescind the 2019 Final Rule and amend certain aspects of the 2023 Proposed Rule, which

[41] Per our comments on the Proposed Rule on Section 1557, we also ask that OCR publish annual tallies of the number of complaints received and investigations conducted under Section 1557, disaggregated by the bases for the complaints (*i.e.*, race, color, national origin, sex, disability, age, or any combination thereof), the number of investigations initiated, and the number of complaints closed without resolution.

maintain inappropriate expansions of health care refusals to the detriment of underserved populations' health and wellbeing. We are also concerned that by failing to require adequate notice, the Proposed Rule would interfere in the patient-provider relationship by undermining informed consent.

Thank you for your attention to our comments. If you have any questions, please reach out to Madeline T. Morcelle, Staff Attorney, at morcelle@healthlaw.org, Charly S. Gilfoil, Staff Attorney, at gilfoil@healthlaw.org, Cat Duffy, Policy Analyst, at duffy@healthlaw.org, or Héctor Hernández-Delgado, Staff Attorney, at hernandez-delgado@healthlaw.org.

Sincerely,



Elizabeth G. Taylor
Executive Director