



March 27, 2018

U.S. Department of Health and Human Services  
Office for Civil Rights  
Attention: Conscience NPRM, RIN 0945-ZA03  
Hubert H. Humphrey Building  
Room 509F  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**RE: Human Rights Campaign Public Comment in Response to the Proposed Regulation, Protecting Statutory Conscience Rights in Health Care RIN (0945-ZA03)**

To Whom It May Concern:

On behalf of the Human Rights Campaign's more than three million members and supporters nationwide, I write in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. As the nation's largest organization working on behalf of lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, we are deeply troubled by the likely impact of the proposed regulation on LGBTQ people—who already face significant barriers to accessing quality healthcare. The proposed regulation sets forth a problematic standard that prioritizes individual providers' beliefs ahead of patient health and well-being. As proposed, this regulation adopts an overly expansive interpretation of existing conscience protections that will undoubtedly empower healthcare providers to deny life-saving care to some of the most vulnerable patients.

**The Proposed Regulation is Overly Broad and Fails to Address the Impact on Vulnerable Health Minorities, Including LGBTQ People.**

*Discrimination against LGBTQ People is Real and Causes Irreparable Harm.*

LGBTQ patients face an increased risk of discrimination at the hands of healthcare providers. Numerous surveys, studies, and reports have documented the widespread extent of the discrimination faced by LGBT individuals and their families in the health care system. One

nationwide study found that 56 percent of lesbian, gay, and bisexual (LGB) respondents and 70 percent of transgender respondents reported experiencing discrimination by health care providers, including providers being physically rough or abusive, using harsh or abusive language, or refusing to touch them.<sup>1</sup> In the same study, 8 percent of LGB respondents and 27 percent of transgender respondents reported being refused necessary medical care outright.<sup>2</sup> Similarly, the 2015 National Transgender Discrimination Survey found that 33 percent of respondents had negative experiences when seeing a health care provider in the past year.<sup>3</sup> The survey also found that respondents were three times more likely to have to travel more than 50 miles for transgender-related care than for routine care.<sup>4</sup>

Beyond each of these numbers is an individual story – and too often a nightmare. The Human Rights Campaign gathered over 13,000 individual comments and stories in response to the Department’s request for public comment regarding the proposed regulation implementing Section 1557 of the Affordable Care Act. Thousands of our members shared personal, heartbreaking stories of discrimination and denial when seeking healthcare. Our members recounted incidents of hostility including homophobic statements, intrusive and unnecessary questioning, and unwarranted physical removal of a same-sex partner from a doctor’s visit. One of the most common stories of hostility and harassment reported by our members in their public comments included unwanted proselytizing by hospital or clinic staff. Unwanted proselytizing is a distinct form of bullying. It undermines patient care and can prevent individuals from seeking much needed care in the future.

Amongst the thousands of stories we received, many members shared stories of outright denial of care. For example, a nurse assigned to care for an elderly gay man in an assisted living facility refused to bath him or provide the necessary day-to-day care that he needed and deserved simply because he was gay. We have also received calls from individuals who have been denied access to treatment because they are in a same-sex couple. In one particular instance two nurses serving in the military and stationed in Missouri had been denied fertility treatment by every local clinic and by the military hospital because of their sexual orientation. The couple was forced to drive five hours round trip to a clinic in another city to receive treatment. This denial of care was not only a threat to their dignity, but required a costly and time-consuming alternative.

### *HHS has Consistently Found LGBTQ People to be Vulnerable to Discrimination*

For almost a decade HHS has consistently considered LGBTQ people to be a health disparity population for purposes of HHS-funded programs and services. Healthy People 2020 provides

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<sup>1</sup> Lambda Legal, *When Health Care Isn’t Caring: Lambda Legal’s Survey on Discrimination Against LGBT People*

<sup>2</sup> *Id.*

<sup>3</sup> S.E. James, C. Brown, & I. Wilson, *2015 U.S. Transgender Survey*, 97 (National Center for Transgender Equality 2017).

<sup>4</sup> *Id.* at 98.

that, “Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”<sup>5</sup> The Healthy People report provides science-based national objectives designed to improve the health of every American.<sup>6</sup> One of the five core missions detailed by the initiative is to identify critical research areas and data collection needs and opportunities.<sup>7</sup> Healthy People 2020 specifically provides that recognizing the impact of social determinants on health – which include factors like sexual orientation and gender identity – is essential to improving the health and well-being of the nation.<sup>8</sup>

The National Institutes of Health has also formally designated sexual and gender minorities as a health disparity population for purposes of NIH research.<sup>9</sup> The term "sexual and gender minorities" includes lesbian, gay, bisexual, transgender, and queer people.<sup>10</sup> This designation recognizes the devastating health disparities facing LGBTQ people across the nation and the need for a concerted federal research response. In announcing this designation NIH provided that, “mounting evidence indicates that SGM populations have less access to health care and higher burdens of certain diseases, such as depression, cancer, and HIV/AIDS.”<sup>11</sup>

The proposed rule is silent as to how hospitals should navigate the impact of the proposed “protections” on patient care, including the anticipated increase in discriminatory denials. The absence of any protections for vulnerable populations, including those who are LGBTQ, is a marked departure from longstanding HHS policies regarding patient care and access.

### *LGBTQ People will be Disparately Impacted by the Proposed Regulation’s Expansive Interpretation of Conscience Laws*

The regulation purports, among other things, to clarify current “religious refusal clauses” related to abortion and sterilization in three federal statutes. Each of these statutes refers to specific, limited circumstances in which health care providers or health care entities may not be required to participate in abortion and sterilization procedures. The regulation, however, creates ambiguity about these limited circumstances and encourages an overly broad interpretation that

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<sup>5</sup> Healthy People 2020, *Disparities*, <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities> (last visited Mar. 26, 2017).

<sup>6</sup> Healthy People 2020, *About Healthy People*, <https://www.healthypeople.gov/2020/About-Healthy-People> (last visited Mar. 26, 2017).

<sup>7</sup> *Id.*

<sup>8</sup> *Disparities*, <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities> (last visited Mar. 26, 2017).

<sup>9</sup> Eliseo J. Pérez-Stable, M.D., *Director’s Message: Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes*, National Institute on Minority Health and Health Disparities (Oct. 6, 2016) <https://www.nimhd.nih.gov/about/directors-corner/message.html>.

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

goes far beyond what longstanding legal tradition and public policy understanding have understood the statutes permit.

For example, section (d) of the Church Amendments refers to circumstances when a person may refuse to participate in any part of a health service program or research activity that “would be contrary to his religious beliefs or moral convictions.”<sup>12</sup> Even though longstanding legal interpretation has applied this section singularly to participation in abortion and sterilization procedures, the proposed rule does not make this limitation clear. This ambiguity can encourage an overly broad interpretation of the statute that empowers a provider to refuse to provide *any* health care service or information for a religious or moral reason—potentially including not just sterilization and abortion procedures, but also Pre-Exposure Prophylaxis (PrEP), infertility care, treatments related to gender dysphoria, and even HIV treatment. Some providers may try to claim even broader refusal abilities, as a recent analysis of complaints to HHS showed that transgender patients are most often discriminated against simply for being who they are rather than for the medical care they are seeking.<sup>13</sup>

Doctors may be misled into believing they may refuse to administer an HIV test or prescribe PrEP to a gay or bisexual man, or refuse screening for a urinary tract infection for a transgender man.<sup>14</sup> In fact, medical staff may interpret the regulation to indicate that they can not only refuse, but decline to tell the patient where he would be able to obtain these lifesaving services or even inform patients of their treatment options. This puts the health of the patient, and potentially that of others, at risk. The regulation could lead a physician to refuse to provide fertility treatments to a same-sex couple, or a pharmacist to refuse to fill a prescription for hormone replacement therapy for a transgender customer. In addition, by unlawfully redefining the statutory term “assisting in the performance” of a procedure, the rule could encourage health care workers to obstruct or delay access to a health care service even when they have only a tangential connection to delivering that service, such as scheduling a procedure or running lab tests to monitor side-effects of a medication. The extension and broadening of this clause will impair LGBTQ patients’ access to care services if interpreted—as the proposed rule improperly appears to do—to permit providers to choose patients based upon sexual orientation, gender identity, or family structure.

We are particularly concerned that the proposed rule will be used to refuse medically necessary care to transgender patients. We are concerned that the rule’s sweeping terms and HHS’s troubling discussions of a case involving a transgender patient will encourage the mistaken belief that treatments that have an incidental impact on fertility, such as some procedures used to treat

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<sup>12</sup> 42 U.S. Code § 300a–7(d).

<sup>13</sup> Sharita Gruberg and Frank J. Bewkes, *The ACA’s LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (Mar. 7, 2018) <https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/>.

<sup>14</sup> *Id.*

gender dysphoria, are sterilization procedures. Treatments for serious medical conditions may have the incidental effect of causing or contributing to infertility: for example, a hysterectomy to treat gender dysphoria, chemotherapy to treat cancer, and a wide range of medications can have the incidental effect of temporarily or permanently causing infertility. The primary purpose of such procedures, however, is not to sterilize, but to treat an unrelated medical condition. If religious or moral exemptions related to sterilization are misinterpreted to include treatments that have simply an incidental effect on fertility—as the vague and sweeping language of this rule encourages—it can lead to refusals that go even further beyond what federal law allows and unlawfully encourages individuals and institutions to refuse a dangerously broad range of medically needed treatments.

### **The Regulation Lacks Safeguards to Protect Patients from Harmful Refusals of Care.**

The proposed regulation is dangerously silent in regards to the needs of patients and the impact that expanding religious refusals can have on their health. The proposed regulation includes no limitations to its sweeping exemptions that would protect patients' rights under the law and ensure that they receive medically warranted treatment. Any extension of religious accommodation should always be accompanied by equally extensive protections for patients to ensure that their medical needs remain paramount, and that they are able to receive both accurate information and quality health services.

The expanded religious exemptions in the proposed regulations also conflict with many patient protections in federal laws like the Affordable Care Act and the Emergency Medical Treatment and Active Labor Act. While protections under these laws are subject to religious exemptions provided under federal statute, they are not subject to exemptions whose scope goes beyond federal law—including many of the exemptions expanded in this rule. Additionally, the proposed regulation's approach to religious exemptions—which appears to allow for no limitations even when those exemptions unjustifiably harm patients or employers—conflict with the well-established standard under other federal laws, like Title VII of the Civil Rights Act.

### **The Proposed Regulation Will Undermine Hospital and Provider Autonomy as Centers of Care and as Private Employers.**

Over the past decade, many hospitals and health systems have followed the recommendations of major accrediting bodies including the Joint Commission and have taken significant steps to ensure that LGBTQ patients receive consistent, quality, culturally competent care. Hospitals and health systems have trained staff, developed nondiscrimination patient and personnel policies, and have made other structural changes to ensure that facilities are welcoming. However, the proposed regulation could cause these hospitals and organizations to feel restricted in their ability to create inclusive and welcoming environments for both their staff, as well as their patients. The proposed regulation may empower staff to deny to provide services beyond the scope of existing law. Many hospitals facing the threat of a costly federal complaint and

investigation process may acquiesce to even unnecessary denials in order to avoid an investigation regardless of the merit of the complaint.

The proposed regulation also interferes with hospital and health systems' personnel decisions. Title VII requires employers to reasonably accommodate the sincerely-held religious beliefs, observances, and practices of its applicants and employees, when requested, unless the accommodation would impose an undue hardship on business operations.<sup>15</sup> This is defined as more than a de minimis cost. The proposed regulation fails to mention Title VII and the balancing of employee rights and provider hardships. The Equal Employment Opportunity Commission (EEOC) addressed this problematic intersection in its public comment in response to the 2008 regulation that had the substantively identical legal problem, noting that "Introducing another standard under the Provider Conscience Regulation for some workplace discrimination and accommodation complaints would disrupt this judicially-approved balance and raise challenging questions about the proper scope of workplace accommodation for religious, moral or ethical beliefs."<sup>16</sup> In this public comment the EEOC concluded that, "Title VII should continue to provide the legal standards for deciding all workplace religious accommodation complaints. HHS's mandate to protect the conscience rights of health care professionals could be met through coordination between EEOC and HHS's Office for Civil Rights, which have had a process for coordinating religious discrimination complaints under Title VII for over 25 years."<sup>17</sup>

### **Conditions for Federal Healthcare Funding Must be Grounded in Promoting Health Outcomes**

"Enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services."<sup>18</sup> This is the mission statement that HHS asserts drives its programs, policies, and in turn this regulation. Conditions of receipt of funding for participation in HHS programs are routinely patient centered. The Conditions of Participation (CoPs) that guide the Medicare and Medicaid programs directly address patient care including infection control, nurse-bed ratios, and staffing requirements. Grant programs operated through HHS condition funding on beneficiary well-being and service delivery. For example, organizations receiving funding to serve runaway and homeless youth must certify that they are appropriately training staff to best meet the needs of youth. Domestic violence shelters receiving HHS grants must take steps to keep their delivery of services confidential to protect survivors. Patients and

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<sup>15</sup> Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e.

<sup>16</sup> Letter in response to request for public comment from Reed L. Russell, Legal Counsel, EEOC, to Brenda Destro, Department of Health and Human Services (Sept. 24, 2008) [https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii\\_religious\\_hhsprovider\\_reg.html](https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html).

<sup>17</sup> *Id.*

<sup>18</sup> Department of Health and Human Services, *Mission Statement*, <https://www.hhs.gov/about/strategic-plan/introduction/index.html> (last visited Mar. 26, 2017).

beneficiaries are at the center of these conditions. Holding organizations and hospitals accountable for delivering quality, accessible services and care is essential.

The proposed regulation offers no quantifiable description of a direct patient benefit. In fact, of the 216 page proposed rule, HHS dedicates a mere three paragraphs to what it describes as “ancillary” benefits to patients.<sup>19</sup> Webster’s Dictionary defines “ancillary” as “subordinate,” or “placed in or occupying a lower class, rank, or position: inferior.”<sup>20</sup> We believe this description to be troublingly accurate. One of these inferior patient benefits includes the ability to seek health care providers who share a patient’s deepest held beliefs—asserting that this will strengthen the doctor-patient relationship. The proposed regulation provides that “open communication in the doctor-patient relationship will foster better over-all care for patients. . . . Facilitating open communication between providers and their patients also helps to eliminate barriers to care, particularly for minorities.”<sup>21</sup> We could not agree more. However, as proposed the regulation does nothing to improve communication between patients and doctors, and will in fact dramatically undermine the relationship for any patient wary of discrimination. While the insertion of a physician’s personal religious belief within the healthcare relationship might be welcome by some, it will come at a devastating cost to a myriad of vulnerable and traditionally underserved communities.

Studies already show that fear of discrimination causes LGBTQ people to delay or wholly avoid necessary care – even in an emergency. The proposed regulation requires that entire facilities be put on notice that a range of health care workers can deny care based on their own moral or religious beliefs. As a result, the proposed regulation also puts many patients on notice that if they are honest and open about critical clinical factors including their medical history, behavior, and even marital status and family structure that they can be turned away from care. For communities with long histories of discrimination, like the LGBTQ community, the proposed regulation’s so-called “protections” will do nothing to promote open doctor-patient relationships. Instead, they provide a concrete, federally sanctioned requirement that may necessitate that they hide their own identities to get critical care.

The proposed regulation boldly asserts that it will “generate benefits by securing a public good— a society free from discrimination, which permits more personal freedom and removes unfairness.”<sup>22</sup> The Human Rights Campaign and our members work every day to create such a society. This is why we must oppose this regulation in its entirety.

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<sup>19</sup> Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. 18, 3916 (proposed Jan. 26, 2018).

<sup>20</sup> *Ancillary*, Merriam-Webster.com. Accessed March 26, 2018. <https://www.merriam-webster.com/dictionary/ancillary>.

<sup>21</sup> Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3917.

<sup>22</sup> *Id.* at 3916.