

# EXHIBIT D

**UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF NEW YORK**

NATIONAL FAMILY PLANNING  
AND REPRODUCTIVE HEALTH  
ASSOCIATION; and PUBLIC  
HEALTH SOLUTIONS,

Plaintiffs,

v.

ALEX M. AZAR II, in his official  
capacity as Secretary of the U.S.  
Department of Health and Human  
Services; U.S. DEPARTMENT OF  
HEALTH AND HUMAN SERVICES;  
ROGER SEVERINO, in his official  
capacity as Director of the Office for  
Civil Rights of the U.S. Department of  
Health and Human Services; OFFICE  
FOR CIVIL RIGHTS of the U.S.  
Department of Health and Human  
Services,

Defendants.

CIVIL ACTION NO. 19-cv-05435

(rel:19-cv-04676-PAE; 19-cv-05433-PAE)

**DECLARATION OF CLARE M. COLEMAN**

I, Clare M. Coleman, declare and state the following:

1. I am the President and CEO of the National Family Planning & Reproductive Health Association (“NFPRHA”), a Plaintiff in this action. I submit this declaration in support of Plaintiffs’ motion for a preliminary injunction barring enforcement of the Department of Health and Human Services (“HHS”) regulation entitled: Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg.

23,170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88) (the “Health Care Refusal Rule” or the “Rule”). A preliminary injunction would preserve the *status quo* during the pendency of this case and allow NFPRHA’s members to continue to provide quality family planning and other critical health care services to low-income patients as they have for decades, and prevent the Health Care Refusal Rule from disrupting and undermining the provision of this critical health care.

2. I submit this declaration to provide information about NFPRHA’s membership, on whose behalf it sues, and the Title X program. I also set forth facts showing the irreparable harms that will ensue if the Health Care Refusal Rule is allowed to take effect. These harms will affect not only Plaintiffs—including their clinicians and their patients—but also the general public health across the country.

### **MY BACKGROUND AND EXPERTISE**

3. I have led NFPRHA for nearly ten years. Prior to assuming NFPRHA’s leadership, I was President and CEO of Planned Parenthood Mid-Hudson Valley, a Title X provider with, at that time, 11 health centers in a four-county area. At Planned Parenthood Mid-Hudson Valley, I directed a 110-person staff, the majority of whom were dedicated to providing clinical services, and I oversaw the organization’s \$9 million operating budget.

4. My work experience also includes significant time as a senior staff

person on Capitol Hill, with an emphasis on health care and appropriations-related efforts, and as a legislative representative for Planned Parenthood Federation of America.

5. As discussed below, from 2010 to 2014, the Centers for Disease Control and Prevention (“CDC”) and HHS’s Office of Population Affairs (“OPA”) (the HHS office responsible for Title X family planning) developed a joint publication on how to provide quality family planning services. That document, “Providing Quality Family Planning Services,” is now referred to in the field as “the QFP.”<sup>1</sup> In developing these new national clinical standards for family planning care, CDC and OPA worked with various panels of outside experts.

6. The Acting Director of OPA appointed me to serve as a member of the Expert Working Group that advised the CDC and OPA throughout their development of the QFP. The Expert Working Group advised on the structure and content of the QFP recommendations and helped make those recommendations as feasible and relevant to the needs of the field as possible.

7. Through my professional experience, my interactions with NFPRHA members and with OPA and other federal agencies, my related work with Congress, and my review of literature and historical material, I am well-versed in

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<sup>1</sup> Centers for Disease Control and Prevention & Office of Population Affairs, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* (Apr. 2014), <https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf> (hereinafter “QFP”).

the history of Title X, all aspects of Title X programs (including best practices for providing family planning services and ensuring compliance with federal funding restrictions), and the process of Title X grant-making, and am regarded as an expert in the field.

8. This declaration is based upon my personal knowledge, experience, and expertise.

### **NFPRHA AND ITS MEMBERSHIP**

9. NFPRHA is a national, non-profit membership association that advances and elevates the importance of family planning in the nation's health care system and promotes and supports the work of family planning providers and administrators, especially those in the safety net (i.e., those providing publicly funded care). The interests that NFPRHA seeks to vindicate in this suit are central to its mission. NFPRHA is the lead national advocacy organization for the Title X family planning program, and it works to maintain Title X as a critical part of the public health safety net. NFPRHA envisions a nation where all people can access high-quality, client-centered, affordable, and comprehensive family planning and sexual and reproductive health care from providers of their choice.

10. In addition to its Title X advocacy, NFPRHA provides education, expert resources, and technical assistance to Title X grantees and sub-recipients, and concretely supports the work of those entities on an ongoing basis as they

implement Title X. In addition to its direct membership assistance, NFPRHA's meetings and conferences enable members to share expertise and experiences. If necessary, NFPRHA engages in litigation to ensure that Title X operates lawfully. Among other efforts, NFPRHA also advocates for and supports maintaining access to abortion services and works to advance health equity by eliminating barriers that contribute to disparities in health care access.

11. NFPRHA represents more than 850 health care organizations in all 50 states, the District of Columbia, and the U.S. territories, and also includes in its membership individual professionals with ties to family planning care. NFPRHA's organizational members include state, county, and local health departments; private non-profit family planning organizations (including Planned Parenthood affiliates and many others); family planning councils; hospital-based health practices; and federally qualified health centers ("FQHCs"). One of NFPRHA's members is Plaintiff Public Health Solutions.

12. NFPRHA currently has more than 65 Title X grantee members and almost 700 Title X sub-recipient members. NFPRHA member organizations operate or fund a network of more than 3,500 health centers (93% of Title X-funded service sites) that provide family planning services to nearly 3.7 million Title X patients (94% of patients served in Title X-funded sites) each year.

13. The majority of these patients live on income levels at or below the

poverty line and are uninsured or underinsured. In 2017, 90% of Title X users had family incomes that qualified them for either subsidized or no-charge services. Forty-two percent of Title X users were uninsured, which is more than triple the national rate for adults (13%).<sup>2</sup> If they were not able to obtain care at the health centers associated with NFPRHA members, many of these patients would have no other access to family planning services.

14. The services NFPRHA members provide include contraceptive education and counseling; a wide range of contraceptive services, including provision of birth control pills, emergency contraception, and intrauterine contraceptives (commonly called IUDs); breast and pelvic exams and cervical cancer screening; education on health promotion and disease prevention; pregnancy testing and non-directive pregnancy options counseling and referrals; screening for, and treatment of, sexually transmitted infections; and HIV testing and counseling. In addition to providing family planning services, some NFPRHA members also provide a range of other reproductive and primary health care services including prenatal care and abortion services.

15. In addition to Title X funding, many of NFPRHA's organizational members and their network of health centers accept Medicaid. Medicaid, Title

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<sup>2</sup> Office of Population Affairs, *Title X Family Planning Annual Report: 2017 National Summary* (Aug. 2018), <https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf> (hereinafter "2017 FPAR").

XIX of the Social Security Act, 42 U.S.C. § 1396, is a joint federal-state program that provides reimbursement to health care providers for the provision of health care services, including family planning services, to low-income individuals. In 2017, Medicaid paid for \$495 million worth of services provided by entities that receive Title X funding.

16. Additional federal funding sources administered by HHS help finance services provided by many NFPRHA members, including the Title V Maternal and Child Health Block Grant (a federal-state partnership to supplement health care for mothers, children and their families); Title XX Social Services Block Grant (grants to enable states to fund a range of social and health services); Temporary Assistance to Needy Families (grants to states to provide cash assistance, education and direct services, including family planning, for needy families); the Ryan White HIV/AIDS Program (the largest federally funded program for low-income, uninsured, and under-insured people living with HIV/AIDS); CDC's STD program funds (grants to all states and certain cities with high STD prevalence rates); State Children's Health Insurance Program (federal matching funds to states to expand health care coverage for uninsured children); and grants under Section 330 of the Public Health Services Act to provide primary health care services to underserved populations.

17. NFPRHA members also receive federal funding administered by



agencies other than HHS, which would nonetheless be at risk under the Rule. This includes, for example, the Special Supplemental Nutrition Program for Women, Infants, and Children (“WIC”), which is administered by the Department of Agriculture.

### **HISTORY AND STRUCTURE OF THE TITLE X PROGRAM**

18. Title X is the only dedicated source of federal funding for family planning services in this country. Title X became law as part of the “Family Planning Services and Population Research Act of 1970.” Pub. L. No. 91-572, 84 Stat. 1504 (1970).

19. Title X was enacted with overwhelming bipartisan support. In 1969, President Richard M. Nixon called on Congress to “establish as a national goal the provision of adequate family planning services ... to all those who want them but cannot afford them,” stressing that “no American woman should be denied access to family planning assistance because of her economic condition.” President Richard M. Nixon, Special Message to the Congress on Problems of Population Growth (July 18, 1969).

20. However, Congress also recognized that, in this area of individuals’ reproductive decision-making, there must be “explicit safeguards to insure that the acceptance of family planning services and information relating thereto must be on a purely voluntary basis by the individuals involved.” S. Rep. No. 91-1004, at 12

(1970). Thus, through Title X, Congress sought to provide low-income patients with biomedical contraceptives, with equal access to high-quality family planning medical care, and with the true freedom to make their own decisions about whether and when to have children. Those purposes remain the Title X program's central focus.

21. Indeed, every year from 1996 to the present, in making appropriations for Title X, Congress has reiterated that it must fund only *voluntary* family planning projects. This echoes two sections of the original Title X enactment. 42 U.S.C. §§ 300, 300a-5. In addition, every year from 1996 to the present, Congress has mandated that within the Title X program, "all pregnancy counseling shall be nondirective." *See* HHS Appropriations Act, 2019, Pub. L. No. 115-245, 132 Stat. 2981, 3070-71 (2018).

22. Section 1001 of the statute provides for the funding of competitive grants to public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects, *see* 42 U.S.C. § 300, and those projects are Title X's means of service provision to individuals.

23. In every fiscal year from 2015 to 2019, Congress has appropriated \$286,479,000 annually for Title X purposes. Of that, HHS distributes approximately \$260 million annually in grants under Section 1001 to fund Title X family planning services.

24. HHS awards grants to fund Title X care in geographic service areas throughout the country and in the U.S. territories. Within each project funded by Title X, there are typically three levels: the grantee, sub-recipients, and individual service sites.

25. Title X coverage across the nation, whether urban, rural, or suburban, is wide. In 2010, the Guttmacher Institute reported that 72% of U.S. counties had at least one health center supported by Title X.<sup>3</sup>

26. In some states and territories, the state or territorial health department is the sole grantee operating the single Title X project for the state or territory; other states or territories have a non-profit organization as the sole grantee; and in other states or territories there may be multiple Title X grantees with multiple projects. Roughly half of Title X grantees are governmental entities and half are non-profit institutions. Some grantees handle only overall program direction, funding, administration, and oversight, while their sub-recipients provide all clinical care at their service sites. In other instances, the grantee itself operates direct service sites and may or may not also have sub-recipients who operate additional sites.

27. In 2017, Title X-funded health centers served 4,004,246 clients.

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<sup>3</sup> Special tabulations of data from Jennifer J. Frost, Mia R. Zolna & Lori Fohwirth, *Contraceptive Needs and Services, 2010*, Guttmacher Institute (July 2013), [https://www.guttmacher.org/sites/default/files/report\\_pdf/contraceptive-needs-2010.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-2010.pdf).

Women made up 88% of those served, men 12%. Title X programs serve patients without regard to age or marital status. In 2017, approximately 91% of program users were adults; 9% were 18 or 19 years of age, 47% were between 20 and 29, 36% were 30 or older. Title X programs serve a racially and ethnically diverse population, including a disproportionately high percentage of black and Latina clients. According to the 2017 FPAR, 54% of program users identified as white, 22% as black or African-American, 33% identified as Hispanic or Latinx, 4% as Asian, and 1% as either Native Hawaiian or Other Pacific Islander or American Indian or Alaska Native. 2017 FPAR at 10-12. 25. Fourteen percent of 2017 users reported having limited English proficiency. *Id.* at ES-2.

28. Consistent with Title X's purpose, providers in a Title X project must give priority in the provision of services to persons with limited incomes and in fact, Title X clients are overwhelmingly poor or low-income. In 2017, 90% of clients had incomes at or below 250% of the federal poverty level ("FPL"); 67% had incomes at or below poverty the poverty level and 23% had incomes between 101-250% of the FPL. *Id.* at 21. In 2017, the FPL for a single person was \$12,060 and \$24,600 for a family of four in the 48 contiguous states and District of Columbia.<sup>4</sup> As required by Title X regulation, clients with incomes below the federal poverty line do not pay anything for the services or supplies they receive

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<sup>4</sup> Office of the Secretary, U.S. Dep't of Health & Human Services, *Annual Update of the HHS Poverty Guidelines*, 82 Fed. Reg. 8831 (Jan. 31, 2017).

from a Title X provider. For clients with incomes not below the federal poverty line but not more than 250% of that level, Title X providers charge using a schedule of discounts to the reasonable cost of providing services or supplies.

### **TITLE X CLINICAL STANDARDS AND PROGRAM REQUIREMENTS**

29. Each Title X project supplements its federal funding with service reimbursement payments, such as from Medicaid or private insurance, patient-paid fees (from those with incomes between 101 and 250% of the FPL as well as from patients paying full fee for their care), and/or state, local or private sources. These sources, together with Title X funds, comprise the project's overall budget. But the Title X grants are the essential backbone of this national program. That is because the Title X grant requires the critical feature of free care for low-income patients, supports staff and infrastructure expenses that are not reimbursable under insurance, arises out of merit-based selection of grantees, and requires providers to comply with all of the Title X program's comprehensive requirements.

30. All care within any Title X project, even though the Title X grant is only a part of the project's budget, is bound by the federal law, regulations, and clinical and administrative standards of the Title X program.

31. The central OPA office within HHS, which was created by the same legislation that established Title X, administers the overall program. As OPA's current Program Requirements for Title X summarize:

All Title X-funded projects are required to offer a broad range of acceptable and effective medically (U.S. Food and Drug Administration (FDA)) approved contraceptive methods and related services on a voluntary and confidential basis. Title X services include the delivery of related preventive health services, including patient education and counseling; cervical and breast cancer screening; sexually transmitted disease (STD) and human immunodeficiency virus (HIV) prevention education, testing, and referral; and pregnancy diagnosis and counseling.<sup>5</sup>

The Program Requirements also specify that Title X services are to comply with the national standards of clinical care set forth in the QFP, discussed further below.

32. When a patient comes to a Title X-funded health center, she or he sees and experiences it as a place to gain access to clinical care by medical professionals—just like any other health center or doctor’s office.

33. Likewise, the clinical care expected by patients and offered under the terms of Title X is the same type of care that is offered in a private-practice medical office, not second-class care. The confidential, trusting clinician-patient relationship, for example, is at least as important to Title X patients as it is to any other patient populations.

34. In fact, in my experience and based upon my knowledge of the field, Title X patients often have a heightened need to be able to trust, understand, and rely upon the medical professionals that provide them with this safety-net care.

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<sup>5</sup> Office of Population Affairs, *Program Requirements for Title X Funded Family Planning Projects*, at 5 (Apr. 2014), <https://www.hhs.gov/opa/sites/default/files/Title-X-2014-Program-Requirements.pdf>.

That is because Title X patients often have had a previous negative experience in attempting to navigate the health care system as low-income persons and have fewer personal connections to health care professionals that they can draw upon. They often have no or limited other options for care. Patients often face multiple challenges in receiving appropriate and complete clinical care, such as language barriers, cultural differences, a history of trauma or abuse, and/or other vulnerabilities. And Title X care touches on the most intimate and sensitive areas of life, again requiring a high degree of trust between patient and health care provider to allow the communication that is essential for quality clinical care and education.

35. For all these reasons, Title X patients especially need to be able to count on the professionalism, thoroughness, and sensitivity to patients' concerns from the medical providers they encounter within Title X health centers.

*The QFP Clinical Standards*

36. Because Title X aims to best advance equal and effective access to family planning methods and services, OPA has periodically adopted and revised clinical standards and other program guidance. These have governed grant applicants and grantees to help ensure that Title X programs are providing evidence-based clinical care consistent with current nationally recognized standards, and are consistently and effectively accomplishing Title X's purpose.

37. In 2014, the OPA and the Centers for Disease Control issued a joint publication on clinical standards for providing quality family planning services. The QFP describes national clinical guidance for any family planning provider, whether funded by Title X or not.

38. The QFP set new national clinical standards for family planning services, after a lengthy process involving dozens of technical experts and the Expert Working Group of which I was a part. It drew on the CDC's "long-standing history of developing evidence-based recommendations for clinical care" and the fact that "OPA's Title X Family Planning Program has served as the national leader in direct family planning service delivery" since 1970. QFP at 2.

39. The QFP's recommendations "outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services." *Id.* at 1. These recommendations, for example, are used by medical directors, including those who oversee Title X projects, "to write clinical protocols that describe how care should be provided." *Id.* at 3.

40. As described in the QFP, chief among the essential attributes of quality care (discussed immediately after safety and effectiveness) is a "[c]lient-centered" approach. *Id.* at 2. Client-centered care means starting from the client's



own reason for seeking family planning information or services. *Id.* at 2, 4. It is also essential that care “is respectful of, and responsive to, individual client preferences, needs, and values” and that individual “client values guide all clinical decisions.” *Id.* at 4. Thus, under the QFP standards, providers’ own preferences do not determine patient care. Instead, providers are trained and work hard to provide patients in a culturally sensitive and individualized way, with the information and assistance each patient needs to make informed decisions consistent with the patient’s own priorities and beliefs—not those of an individual provider.

41. Similarly, QFP appendices that address quality family planning counseling and best practices for providing information to clients stress the fundamental principle that “[e]stablishing and maintaining rapport with a client is vital to” family planning counseling. *Id.* at 45; *see id.* at 48.

42. Further, “[c]lients need information that is medically accurate, balanced, and nonjudgmental to make informed decisions,” and the provider “must present information in a manner that can be readily understood and retained by the client.” *Id.* at 46. The QFP discusses strategies for making information accessible and clear to clients, to help ensure that each one can understand the options and make informed choices.

43. The QFP specifically instructs, in a section entitled “Pregnancy

Testing and Counseling,” that pregnancy “test results should be presented to the client, followed by a discussion of options and appropriate referrals.” *Id.* at 14.

“Options counseling should be provided in accordance with the recommendations from professional medical associations, such as ACOG [(the American College of Obstetricians and Gynecologists)] and AAP [(the American Academy of Pediatrics)].” *Id.* at 14. It states that “[r]eferral to appropriate providers of follow-up care should be made at the request of the client” and not delayed. *Id.*

44. Similarly, at the National Clinical Training Center for Family Planning, funded by OPA to support Title X-funded providers, one of the 14 designated “core competencies” for family planning care is the ability to “[p]rovide pregnancy testing and counseling and appropriate referrals (to prenatal care, adoption services, and abortion), as needed.”<sup>6</sup> The core competency emphasizes that this counseling should be nondirective and include medically accurate discussion about options.

45. The QFP also endorses an approach to contraceptive counseling that emphasizes sharing with patients information about effectiveness of contraceptive choices. It “support[s] offering a full range of Food and Drug Administration (FDA)-approved contraceptive methods,” as long as each is safe for the particular

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<sup>6</sup> National Clinical Training Center for Family Planning, *Core Competencies for Contraceptive and Other Related Family Planning Services in the Context of Zika*, <http://nctcfp.org/Competencies/Core%20Competencies%20in%20English.pdf>

patient, “as well as counseling that highlights the effectiveness of contraceptive methods” so that “clients can make a selection based on their individual needs and preferences.” QFP at 2, 8. For clients “who have completed childbearing or do not plan to have children,” the QFP instructs that “permanent sterilization (female or male) is an option that may be discussed. Women and men should be counseled that these procedures are not intended to be reversible and that other highly effective, reversible methods of contraception (e.g., implants or IUDs) might be an alternative if they are unsure about future childbearing.” *Id.* at 9.

46. The QFP standard is to provide equitable, evidence-based care consistent with current professional knowledge, so that family planning does not vary in quality because of the personal characteristics of clients or the personal preferences of providers. *Id.* at 4.

### **PRIOR FEDERAL HEALTH CARE REFUSAL REGULATION AND LITIGATION**

47. In the decades-long history of the federal health care refusal statutes, none of which delegate rulemaking authority to HHS, regulations purporting to clarify and interpret these laws have been promulgated only one other time, in late 2008.

48. At that time, HHS promulgated a notice of proposed rulemaking purporting to interpret and enforce the federal health care refusal statutes claiming “concern . . . that there is a lack of knowledge on the part of States, local

governments, and the health care industry” of the refusal rights contained within these statutes. Proposed Rule, Ensuring that Department of Health and Human Services Funds Do Not Support Coercive of Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 50,274, 50,278 (Aug. 26, 2008)) (hereinafter “2008 NPRM”). Despite allowing only a 30-day comment period, HHS received more than 200,000 comments in response to the proposed rule—the vast majority of which opposed the rule as unnecessary, unauthorized, and overbroad. Notably, HHS conceded in the final rule published December 19, 2008, it received “no Comments indicating that there were any [federal] funding recipients not currently compliant with [the underlying statutes].” Ensuring that Department of Health and Human Services Funds Do Not Support Coercive of Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072, 78,095 (Dec. 19, 2008) (hereinafter “2008 Refusal Rule”).

49. The 2008 Refusal Rule would have permitted institutions and individuals employed at federally funded health care entities to refuse to provide a variety of basic health care services, including information, counseling and referrals, while completely ignoring the needs and rights of patients. *Id.* at 78,074. The 2008 Refusal Rule was scheduled to become effective on January 20, 2009—Inauguration Day.

50. On January 15, 2009, NFPRHA filed suit in the U.S. District Court for

the District of Connecticut seeking to enjoin the rule from taking effect (*National Family Planning & Reproductive Health Association, Inc. v. Leavitt*, No. 09-cv-55). The case was consolidated in the same court with similar challenges brought by then-Connecticut Attorney General Richard Blumenthal (on behalf of himself and the Attorneys General of California, Illinois, Massachusetts, New Jersey, New York, Oregon and Rhode Island) and the Planned Parenthood Federation of America and Planned Parenthood of Connecticut.

51. A new notice of proposed rulemaking proposing to rescind the 2008 Refusal Rule was published in the Federal Register on March 10, 2009, with a 30-day comment period. Proposed Rescission of the Regulation Entitled “Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law,” 74 Fed. Reg. 10,207 (Mar. 10, 2009) (hereinafter “2009 NPRM”). Because rescission had been proposed, the federal lawsuit was put on hold.

52. In 2011, HHS rescinded those aspects of the 2008 Refusal Rule that were “unclear and potentially overbroad in scope,” but maintained those parts of the rule establishing an enforcement process for the federal health care refusal statutes and began an “initiative designed to increase the awareness of health care providers about the protections provided by the health care provider conscience statutes, and the resources available to providers who believe their rights have been

violated.” Regulation for the Enforcement of Federal Health Care Provider Conscience Protections, 76 Fed. Reg. 9968, 9969 (Feb. 23, 2011) (hereinafter “2011 Rule”). This rule remains in effect.

**THE 2019 HEALTH CARE REFUSAL RULE CONFLICTS WITH  
TITLE X’S COMMITMENT TO CLIENT-CENTERED CARE AND  
WILL HARM TITLE X PATIENTS**

**The Health Care Refusal Rule Will Authorize Employees With  
Religious or Moral Objections to Categorically Refuse to Provide  
Required Title X Services Despite the Harm It Would Cause to Patients  
or the Employer**

53. As I understand it, the Health Care Refusal Rule includes expansive definitions that dramatically expand the scope, meaning, and impact of the underlying statutory refusal provisions, permitting numerous individuals—in Title X-funded settings and despite Title X requirements or client needs and wishes—to refuse to perform or take any “action that has a specific, reasonable, and articulable connection to furthering a procedure or a part of a health service program” administered by HHS (like Title X).

54. The Rule’s expansive definitions of “assist in the performance” and “referral” and “refer for” would permit employees of Title X-funded health centers and other federally funded entities to refuse to provide certain reproductive health information and referrals, despite patient needs and in clear violation of the fundamental tenets of informed consent, ethics, and the Title X program requirements, including those found in the regulations, the statute, and the QFP.

55. As I understand it, the Rule also makes dramatic changes to the existing statutory understanding of “discriminate” or “discrimination,” requiring an absolute accommodation by employers of their employees’ religious and/or moral objections to performing or assisting in the performance of sterilization or abortion (including counseling and referral) and rejecting the longstanding balancing approach of Title VII of the Civil Rights Act that provided employers with the ability to manage religious accommodations for employees in a manner that balances the religious beliefs of the employee with the business operation needs of the employer.

56. The Rule also prohibits employers from asking job applicants whether they have any such objections to performing these aspects of the job. In fact, HHS explicitly refused to address in the Rule whether an employer under the Rule would be allowed to disqualify a person with religious or moral objections to covered practices even if such covered practices made up the primary or substantial majority of the duties of the position. However, HHS also stated in the Rule’s preamble that it is “not an acceptable practice under Federal conscience and anti-discrimination laws for covered entities to deem persons with religious or moral objections to covered practices, such as abortion, to be disqualified for certain job positions on that basis.” 84 Fed. Reg. at 23,191. As such, the rule puts Title X-funded health centers in the position of being forced to hire people who

intend to refuse to perform essential elements of a position.

57. Thus, “discrimination” under the Rule would seem to prohibit a Title X-funded entity from even asking a person applying for a job as a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests whether the individual would refuse to provide non-directive options counseling, let alone not hire the applicant because of such objections. And, once hired, the Title X-funded entity would be required to accommodate that objection without regard to the burden placed on the employer or the impact on patients.

58. Indeed, the Rule provides no meaningful guidance on how an employer is supposed to ensure patients continue to receive care in the face of an employee’s objection to performing a core job function and still comply with the Rule. For example, the Rule states that “the voluntary acceptance of an effective accommodation of protected conduct, religious beliefs, or moral convictions, will not, by itself, constitute discrimination.” The rule further states that “staffing arrangements,” such as “non-retaliatory staff rotations,” *can* be “acceptable accommodations in certain circumstances.” *Id.* But these vague platitudes provide cold comfort to the employer trying to determine how to balance patient health and safety and comply with Title X’s requirements and ensure that patients are receiving the care to which they are entitled by law, on a limited budget, without



risking the loss of critical federal funding.

59. This difficulty will be especially acute in Title X-funded settings without many employees, located in sparsely populated or rural areas, and in the 649 counties where a Title X-funded health center is the only publicly funded family planning provider.<sup>7</sup> For example, one Title X grantee in a rural state has only three nurse practitioners for its more than 10 health centers; these clinicians travel from health center to health center, meaning that only one would be at any one service site only a few days per month. If one (or more) of those clinicians objected to providing certain services, it would make it incredibly difficult for the health center or grantee to ensure that its patients continue to receive that care.

60. Title X-funded family planning organizations typically have deep expertise in the care they provide, and are trusted in their communities to provide high-quality, confidential, voluntary care to their clients. However, to the extent the Rule forces Title X providers to hire and employ individuals who actively withhold information and services from clients, the Rule will harm the providers' reputations and the provider-patient relationship of trust.

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<sup>7</sup> Jennifer J. Frost et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*, Guttmacher Institute, (Apr. 2017), <https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015>.

**The Health Care Refusal Rule Will Also Harm Title X Patients By Allowing into the Title X Network Employees and Entities That Refuse to Provide Required and Critical Title X Health Care Services**

61. In many respects, the Health Care Refusal Rule is an attempt by HHS to achieve by a back door what courts have already blocked: remaking Title X's network of providers in order to replace high-quality, trusted providers with new participants who object to core Title X care and use their religious beliefs to limit patients' access to complete and accurate reproductive health information, displacing the primacy of a patient's own beliefs or needs.

62. In the arena of health care, and particularly family planning and sexual health, HHS-funded programs cannot achieve their fundamental, statutory objectives if grantees, providers, and contractors have a categorical right to refuse to provide essential services, such as non-directive pregnancy options counseling.

63. As I understand it, for state and local health departments (NFPRHA represents 80% of health department Title X grantees) the Rule's definitional expansion of discrimination would also put health department grantees and sub-recipients in the untenable position of being forced to subcontract with entities without knowing (or even being able to ask) whether an entity objects to providing essential aspects of the Title X project.

64. As such, the Health Care Refusal Rule seems designed to allow entities that refuse to provide people seeking Title X health care with the basic

information, options counseling, and referrals required by law to compete on the same footing for federal money with family planning providers that adhere to the law and provide full and accurate information and services to patients. The Rule thus threatens to divert scarce family planning resources away from entities that provide comprehensive family planning services to organizations that refuse to provide these services. Diverting funds away from providers offering the full range of family planning and sexual health services would not only seriously undermine public health, especially for the low-income, uninsured, and underinsured, but would also be contrary to congressional intent and explicit statutory requirements of the Title X family planning program.

65. The Health Care Refusal Rule is HHS's third attempt to drastically change the Title X network in the last two years and reshape it contrary to the program's intent.

66. Traditionally, Title X grant competitions are run each year, and over a three-year period, all the grants are newly competed and awarded. The 2018 Funding Opportunity Announcement ("FOA"), which was unprecedented in that all jurisdictions were competed in a single year, drastically altered the criteria for evaluating grant applications. In particular, these changes deemphasized and devalued the provision of core Title X services—including nondirective pregnancy options counseling and abortion referrals—so that providers with objections to

performing those core services could still compete in the program. Fortunately, even with the relaxed criteria, HHS did not receive sufficient, adequate applications from those opposed to abortion counseling and referrals to fundamentally alter the network in the way it intended.

67. However, when that attempt to remake the network through the grant-making process failed, on June 1, 2018, HHS published a notice of proposed rulemaking for the Title X family planning program (“2018 Title X NPRM”). The 2018 Title X NPRM not only reintroduced the majority of a Reagan-era Title X rule known as the “domestic gag” rule, but it expanded those provisions and introduced numerous new and harmful requirements and restrictions.

68. The final rule was published on March 4, 2019. *See* Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019) (hereinafter “2019 Title X Rule”). Among other provisions, the 2019 Title X Rule violated various federal laws by restricting the ability of *all* Title X providers to provide abortion referrals and allowing providers to exclude the option of abortion from pregnancy counseling, even when the patient specifically seeks information about abortion.

69. NFPRHA filed a challenge, along with three co-plaintiffs and in conjunction with a related case filed by the Attorney General of Washington, to the 2019 Title X Rule, seeking to enjoin and set aside the unlawful rulemaking before

the rule's effective date of May 3, 2019. On April 25, the U.S. District Court for the Eastern District of Washington issued a preliminary injunction enjoining HHS from implementing or enforcing any part of the 2019 Title X Rule. *See Washington v. Azar*, 376 F. Supp. 3d 1119 (E.D. Wash. 2019).

70. In effect, the Health Care Refusal Rule is an attempt to accomplish via the back door—the dismantling of these core elements of the Title X program—what HHS has been unable to and prevented from directly accomplishing by other means.

**The Refusal Rule's Compliance and Enforcement Mechanisms Are Ripe For Abuse, Will Create Significant Compliance Burdens, and Will Jeopardize The Future of the Title X Program**

71. In addition to the harms I describe above, I am very concerned that the Rule's new compliance and enforcement mechanisms will threaten the critical funding our members rely on to provide essential health care services.

72. For example, the Rule would allow the Office for Civil Rights to investigate any Title X-funded entity whenever any information—even a third-party complaint or a news report—"indicates a threatened, potential, or actual failure to comply with Federal conscience and anti-discrimination laws" or the Rule.

73. The Rule also requires covered entities to at all times maintain records "evidencing compliance" and explicitly states that covered entities must provide

the Department virtually unlimited access to its books, records, accounts, facilities, and information upon request, and without regard for privacy or confidentiality concerns.

74. If HHS determines that an entity—or one of its sub-recipients—is out of compliance with the Rule, HHS can withhold, deny, suspend, terminate, or clawback billions of dollars in federal funds, including non-HHS appropriated or administered funds. HHS can even terminate federal funding during the pendency of good-faith voluntary compliance efforts.

75. Moreover, given the Rule’s permitting broad investigations based on potentially biased, agenda-driven complaints and the significant penalties under the Rule—including the requirement to report violations for a three-year period in any future grant applications—entities that receive HHS funds (including NFPRHA members) face significant concern about how collected information is intended to be used and whether it and/or any violations will unfairly prejudice consideration of applicants for federal funds or penalize currently funded entities in ways that could be extremely harmful.

76. Any loss of Title X funds would have a direct impact on NFPRHA members’ functions: cuts in health centers’ hours; staff layoffs; and, in some cases, health center closures. This would mean fewer patients would receive much-needed contraceptive and preventive services, as NFPRHA members are often low-

income patients' only option.

77. Indeed, six in ten Title X patients reported that the Title X-funded health center constituted their only source of health care over the past year.<sup>8</sup> Fourteen percent of all women and 25% of all poor women who obtained contraceptive services did so at a Title X-funded health center.<sup>9</sup> Ten percent of women who received a Pap test or pelvic exam, 18% of women who received testing, treatment, or counseling for a sexually transmitted infection (STI), and 14% of women tested for HIV during that time period received that care at a Title X-funded health center.<sup>10</sup>

78. Thus, loss of Title X-funded care—whether through reduced hours, staff layoffs, or closures—or directly through the provider refusals permitted by the Health Care Refusal Rule—will cause NFPRHA members' patients to suffer not only diminished access to family planning care, but also a range of other preventative care. The Health Care Refusal Rule would force NFPRHA members' patients to lose access to standard, ethical pregnancy counseling and referrals for abortion care, and would leave NFPRHA's members with few, if any, options to “use alternate staff or methods to provide or further any objected-to conduct”

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<sup>8</sup> Megan L. Kavanaugh, Mia R. Zolna & Kristen Burke, *Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016*, 50 Perspectives on Sexual & Reproductive Health 101 (Sept. 2018) <https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x>.

<sup>9</sup> *Id.*

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

without risking it being considered “adverse treatment” against the objecting employee or sub-recipient.

79. If HHS succeeds in bringing religious objectors into the Title X network, patients will also encounter more sites with other limitations, including only one or a few contraception options and no information about a broader range of methods, further undermining the program. All of these impacts will expose patients to greater health risks and more unintended pregnancies. The Health Care Refusal Rule will harm the central purpose of Title X and sacrifice low-income patients’ care to these new mandates.

80. Given the consequences are so severe, the cost-burdens associated with complying with the Rule—including obtaining legal advice to assess and advise on compliance, including the Rule’s interaction with existing state and federal legal obligations; reviewing and potentially revising job descriptions, hiring practices, and employee recruitment materials; revising policies and procedures, manuals, and handbooks; re-training staff with supervisory responsibilities on hiring and accommodation requests; and, of course, the cost of providing accommodations under the Rule and providing, if possible, alternate means for patients to receive the objected-to care—are significant.

81. Yet HHS grossly underestimates what compliance will entail. For example, the Rule estimates that covered entities will spend: (1) two hours on



average familiarizing themselves with the rule and its requirements, which represents the “one-time opportunity cost of staff time (a lawyer) to review the rule”; and (2) “an average of 4 hours [per year for the first five years] reviewing the assurance and certification language and the Federal conscience protection and associated anti-discrimination laws and the rule,” which is “a function of a lawyer spending 3 hours reviewing the assurance and certification and an executive spending one hour to review and sign.” 84 Fed. Reg. at 23,240-41.

82. Based on my knowledge and expertise of how seriously our members take their legal and ethical obligations, and based on my own review of the Rule (which runs over 100 pages) and the underlying laws, I believe this estimate totally misjudges the costs simply attempting to come into compliance with the Rule will impose on our members. For example, when the QFP standards were put in place in 2014, it took many grantees a year or more to update all policies and protocols, revise materials and have those materials reviewed by outreach and education committees (a process required under Title X guidelines), and sufficiently train staff at all service sites on the new clinical standards.

\* \* \*

83. In conclusion, based on my knowledge and experience, it is my firm belief that if this Rule takes effect it will have a devastating impact on our members, the patients they serve, and the Title X program as a whole.

I declare under penalty of perjury that the foregoing is true and correct. This declaration was executed on June 13, 2019, in Washington, D.C.

A handwritten signature in blue ink, appearing to read "Clare M. Coleman", with a long horizontal flourish extending to the right.

Clare M. Coleman