National
Family Planning
& Reproductive Health Association

March 27, 2018

US 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 SW
Washington, DC 20201

Attn: Protecting Statutory Conscience Rights in Health Care NPRM, RIN 0945-ZA03

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to provide comments on the US Department of Health and Human Services' (HHS) notice of proposed rulemaking (NPRM), "Protecting Statutory Conscience Rights in Health Care," RIN 0945-ZA03.

NFPRHA is a national membership organization representing the nation's publicly funded family planning providers, including nurse practitioners, nurses, administrators, and other key health care professionals. NFPRHA's members operate or fund a network of more than 3,500 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers and other private nonprofit organizations.

NFPRHA is deeply concerned that this NPRM ignores the needs of the patients and individuals served by HHS' programs and creates confusion about the rights and responsibilities of health care providers and entities. Because they receive Title X, Medicaid, and other HHS funds, NFPRHA members would have no choice but to comply with this rule: Failure to do so could lead to termination of current or pending HHS funds, as well as return of money previously paid to NFPRHA members for services they have provided. This means hundreds of millions of dollars in federal funding are at stake for NFPRHA members if they run afoul of the rule. Without federal support, many of our members would be forced to drastically scale back the services they provide to their patients or to close completely. Because NFPRHA members represent the vast majority of Title X clinical locations that serve people who cannot afford to pay for health care on their own, this would leave many low-income and uninsured or under-insured patients without access to family planning and other critical health care services.

Although this NPRM claims the authority to interpret numerous statutes of concern and interest, NFPRHA will limit its comments primarily to the unjustified and unauthorized expansion of the Church amendments (42 USC 300a-7), Coats-Snowe amendment (42 USC 238n), and Weldon amendment (e.g. Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. H, Tit. V, sec. 507(d)) (together, "Federal health care refusal statutes"). Because this NPRM encourages unprecedented discrimination against patients and opens the door to undermining the intent and integrity of key HHS programs, including the Title X family planning program, it should be withdrawn.

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Background on the 2008 Health Care Refusal Regulations

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 once, in late 2008.

In 2008, HHS promulgated an NPRM 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. (73 Fed. Reg. at 50, 278). 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.[1] Notably, HHS conceded, it received "no Comments indicating that there were any [federal] funding recipients not currently compliant with [the underlying statutes]" (73 Fed. Reg. at 78,095). HHS published a final rule on December 19, 2008, which did not materially differ from the NPRM and was immediately subject to legal challenge by multiple parties, including NFPRHA and seven state attorneys general.[2]

In 2011, HHS rescinded those aspects of the 2008 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." (76 Fed. Reg. at 9969). This rule remains in effect.

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[1] Comments to Provider Conscience Regulations, 73 Fed. Reg. 50274 (August 26, 2008) (to be codified at 45 CFR 88).

[2] *National Family Planning and Reproductive Health Association et al v. Leavitt*, No. 09-cv-00055 (Dist. Conn. Jan. 15, 2009) *State of Conn. et al. v. United States of America*, No. 09-cv-00054 (Dist. Conn. Jan. 15, 2009); *Planned Parenthood Federation of America v. Leavitt*, No. 09-cv-00057 (Dist. Conn. Jan. 15, 2009); *State of Conn. et al. v. United States of America*, No. 09-cv-00054 (Dist. Conn. Jan. 15, 2009).

According to the current NPRM, since 2008, "OCR [Office for Civil Rights] has received a total of forty-four complaints [related to Federal health care refusal laws], the large majority of which (thirty-four) were filed since the November 2016 election." (83 Fed. Reg. at 3886). To place that figure into context, OCR in total received approximately 30,166 complaints in fiscal year (FY) 2017.

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The NPRM overstates statutory authority and seeks to dramatically expand the reach of the underlying statutes.

For decades, federal health care refusal statutes have given specified individuals and institutions certain rights to refuse to perform, assist in the performance, and/or refer for abortion and/or sterilization services. Despite the lack of a congressional mandate to do so, the NPRM seeks to dramatically expand the scope and reach of these laws, as well as grant overall responsibility for ensuring and enforcing compliance with those statutes to OCR, using identical language to many aspects of the now-rescinded 2008 regulation that faced widespread opposition at that time.[3]

The Church amendments were enacted by Congress in the 1970s in response to debates about whether the receipt of federal funds required recipients to provide abortion or sterilization services. These provisions make clear, among other things, that:

- The receipt of federal funding under the Public Health Service Act (PHSA) (42 U.S.C. § 201 et seq.) does not itself obligate any individual to perform or assist in the performance of sterilization or abortion procedures if those procedures are contrary to the individual's religious or moral beliefs (Church (b)(1)); and,
- Health care personnel employed by certain federally funded programs and facilities cannot be discriminated against in terms of employment, promotion, or the extension of staff or other privileges for performing or assisting in the performance of sterilization or abortion services, or refusing to perform or assist in the performance of such services based on their religious or moral beliefs (Church (c)(1)).

In 1996, Congress adopted the Coats amendment in response to a decision by the accrediting body for graduate medical education to require OB/GYN residency programs to provide or permit abortion training. The Coats amendment prohibits federal, state, and local governments from discriminating against "individual physicians, postgraduate physician training programs, or a participant in a program of training in the health profession" that refuse to provide or require training in abortions or individuals who refuse to be trained to provide abortions.

[3] Comment of the National Family Planning & Reproductive Health Association to Provider Conscience Regulations, Tracking Number 8072403d to 73 Fed. Reg. 50274 (proposed August 26, 2008) (comment dated September 25, 2008) (to be codified at 45 CFR 88).

Since 2004, Congress has attached the Weldon amendment to the annual appropriations measure that funds the Departments of Labor, Health and Human Services, and Education (Labor-HHS). That amendment prohibits federal agencies and programs and state and local governments that receive money under the Labor-HHS Appropriations Act from discriminating against individuals, health care facilities, insurance plans, and other entities because they refuse to provide, pay for, provide coverage of, or refer for abortion.

The Church, Coats-Snowe, and Weldon amendments were never intended to provide individual health care providers and/or entities with the myriad and expansive rights of refusal this NPRM seeks to achieve. Without statutory authorization, the NPRM expands the reach of the Church, Coats-Snowe, and Weldon beyond what was contemplated by Congress and is permitted by existing federal law, by expanding the categories of individuals and entities whose refusals to provide information and services are protected; expanding the types of services that individuals and entities are allowed to refuse to provide; and expanding the types of entities that are required to accept such refusals. For example:

- The NPRM attempts to extend the restriction of the Weldon amendment as to the entities to which it applies, funding beyond that appropriated by Labor-HHS appropriations, and the kinds of entities considered to be "health care entities" under Weldon. The statute of the Weldon amendment states:

  > "(1) None of the funds ***made available in this Act*** may be made available to ***a Federal agency or program, or to a State or local government***, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term ''***health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan***" [emphasis added].

  Yet § 88.3(c) of the NPRM adds new language that applies the Weldon amendment's prohibitions not only to federal agencies and programs and state and local governments that receive Labor-HHS funds, but also to "***[a]ny entity that receives funds through a program administered by the Secretary or under an appropriations act for the Department that contains the Weldon amendment***" [emphasis added].

  This language broadens Weldon's reach in two impermissible ways: 1) it applies the restrictions of the Weldon amendment beyond the statutory reach of federal agencies or programs, or state or local governments, to any entity receiving certain federal funds; and, 2) it extends the restrictions to entities that do not even receive funding via Labor-HHS appropriations, to apply to funding through any program administered by HHS.

These extensions of Weldon's reach are clearly contrary to both the plain language of the Weldon amendment and to congressional intent.

- While the Church amendment prevents PHSA funds from being used to require individuals and institutions to, among other things, "assist in the performance" of abortions and sterilizations, and prevents employment discrimination against those who refuse to do so, § 88.2 of the NPRM provides an unprecedentedly and unjustifiably broad definition of the term "assist in the performance" that runs counter to congressional intent and common sense. The NPRM would define "assist in the performance" as participating "in ***any activity*** with an ***articulable connection*** to a procedure, health service or health service program, or research activity" [emphasis added]. In other words, HHS proposes to create refusal rights for anyone who can ***simply express a connection*** between something they do not want to do and an abortion or sterilization procedure (e.g., scheduling appointments, processing payments, or treating complications). Even the sole instance of previous rulemaking under the Church amendments in 2008, which was rescinded before it ever took effect, was not so broad.

- Likewise, the NPRM's definition of referral/refer seeks to dramatically expand the scope and reach of the Coats-Snowe and Weldon amendments and runs counter to congressional intent and common sense. Section 88.2 of the NPRM defines "referral/refer for" abortion to include:

  > "the provision of any information (including but not limited to name, address, phone number, email, website, instructions, or description) by any method (including but not limited to notices, books, disclaimers, or pamphlets, online or in print), pertaining to a health care service, activity, or procedure, including related to availability, location, training, information resources, private or public funding or financing, or directions that could provide any assistance in a person obtaining, assisting, training in, funding, financing, or performing a particular health care service, activity, or procedure, where the entity or health care entity making the referral sincerely understands that particular health care service, activity, or procedure to be a purpose or possible outcome of the referral."

  This definition would impair the ability of health care professionals to fulfill their legal and ethical duties of providing complete, accurate, and unbiased information to their patients. For example, as discussed further below, the NPRM could be read to permit employees of Title X-funded health centers and other federally funded entities to refuse to provide information and referrals to patients, without ever addressing patient needs and in clear violation of the fundamental tenets of informed consent.

As interpreted by the NPRM, the Church, Coats-Snowe, and Weldon amendments would be radically expanded to create far-reaching protections for individuals and entities that would refuse to provide patients not only with health care services, but also the most basic information about their medical options and that seek to obstruct the ability of certain patients to access any care at all. This is

impermissible and, as discussed below, would cause unprecedented harm to patients and undermine the integrity of key HHS programs.

This NPRM goes beyond HHS' statutory authority and should be withdrawn.

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The NPRM attempts to grant OCR oversight authority and enforcement discretion that is overly broad and vague; unduly punitive; and ripe for abuse.

While some of the investigative authority and enforcement powers of the current NPRM appear to comport with similar provisions in other areas subject to OCR oversight and enforcement authority, the NPRM 1) includes new, troubling provisions that are vague, overly broad, and overly punitive; and 2) as a whole, appear to impart in OCR authority and enforcement discretion that is ripe for abuse.

Indeed, while the NPRM claims to "borrow...from enforcement mechanisms already available to OCR to enforce similar civil rights laws," the NPRM contains troubling differences. For example, the NPRM states that investigations may be based on anything from 3rd party-complaints to news reports, and yet at the same time appears to give OCR the authority to withhold federal financial assistance and suspend award activities, based on "threatened violations" alone, without first allowing for the completion of an informal resolution process. (See 83 Fed. Reg. at 3891, 3930-31). By contrast, the Department of Justice (DOJ) regulations implementing Title VI of the Civil Rights Act of 1964 (prohibiting discrimination on the basis of race in federally funded programs) state that DOJ will not take such drastic steps to respond to actual or threatened violations unless noncompliance cannot first be corrected by informal means. (See 28 C.F.R. § 42.108(a)). When combined with other aspects of the NPRM, concern over the breadth and potential harm of such provisions is obvious and legitimate. For instance:

- Under § 88.6, the NPRM includes a 5-year reporting requirement that requires any recipient or sub-recipient subject to an OCR compliance review, investigation, or complaint related to the health care refusal rules to inform any current HHS "funding component" of the review/investigation/complaint, as well as to disclose that information in any application for new or renewed "Federal financial assistance or Departmental funding." Once again, this is distinct from the DOJ regulations enforcing Title VI, which only require disclosure of compliance reviews (not every investigation or complaint, regardless of whether it is unfounded) over the past two years. (28 C.F.R. § 42.406(3)). Yet the NPRM fails to explain the purpose of the vastly expanded reporting requirement and period. In light of the broad investigative authority and harsh penalties described above, this leaves affected entities with significant concern about how such information is intended to be used and whether it will unfairly prejudice consideration of applicants for federal funds or penalize currently funded entities in ways that could be extremely harmful.

The NPRM also includes very troubling language that appears to be little more than a pretext for defunding entire classes of providers, which it cannot do. § 88.7 states, "The Director may, in coordination with a relevant Department component, restrict funds for noncompliant entities in whole or in part, including by ***limiting funds to certain programs and particular covered entities, or by restricting a broader range of funds or broader categories of covered entities***" [emphasis added]. This delegation of authority is not only far beyond the scope of the underlying laws but seems designed to grant arbitrary authority that is ripe for abuse, with no mechanism of due process or oversight to prevent entire categories of providers or programs from being penalized without cause. To the extent § 88.7 seeks to create a back door to excluding certain family planning providers from the Title X and Medicaid programs—efforts that have been repeatedly rejected by the courts—it, again, exceeds the scope of the agency's authority and will do nothing more than harm the health and well-being of patients. Given the lack of evidence that the system currently in place cannot adequately handle complaints, as well as any sufficient justification for departing from the processes used to ensure compliance with other federal statutes, the NPRM should be withdrawn.

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The NPRM opens the door to undermining the intent and integrity of key HHS programs, including the Title X family planning program.

The NPRM ignores the reality that some individuals and entities object to the essential health services that are the foundation of longstanding, critical HHS programs like Title X. 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.

The Title X family planning program was created by Congress in 1970 "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services" (42 USC 300). Title X projects are designed to "consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children" (42 CFR 59).

In 2014, more than 20.2 million women in the United States were in need of publicly funded contraceptive services. Women in need of publicly funded family planning services is defined as follows: "1) they were sexually active (estimated as those who have ever had voluntary vaginal intercourse, 2) they were able to conceive (neither they nor their partner had been contraceptively sterilized, and they did not believe they were infecund for any other reason); 3) they were neither intentionally pregnant nor trying to become pregnant; and, 4) they have a family income below 250% of the federal poverty level. In addition, all women younger than 20 who need contraceptive services, regardless of their family income are assumed to need publicly funded care because of their heightened need—for reasons of confidentiality—to obtain care without depending on their family's resources or private insurance."[4] In

[4] Jennifer Frost et al, *Contraceptive Needs and Services, 2014 Update* (New York: Guttmacher Institute, 2016).

the face of this widespread need, publicly funded family planning and sexual health care provides a crucial safety net for women and families. The impact of these services cannot be underestimated. Without publicly funded family planning services, there would be 67% more unintended pregnancies (1.9 million more) annually than currently occur.[5]

Congress has specifically required that "all pregnancy counseling shall be non-directive" (Public Law 110-161, p. 327), and current regulations require that pregnant women receive "referral[s] upon request" for prenatal care and delivery, adoption, and/or pregnancy termination (42 CFR 59.5(a)(5)). Despite the incredible success of the Title X program and the critical services it provides, Title X has been chronically underfunded, with no new service dollars allocated in nearly a decade. It is a testament to the dedication of the existing Title X network to meeting the goals of the program that, despite limited resources, these providers still serve more than four million patients per year.[6]

However, in addition to the overly broad definitions of "referral" and "assist in the performance" discussed above, by proposing a definition of "discrimination" that jettisons the longstanding framework that balances individual conscience rights with the ability of health care entities to continue to provide essential services to their patients, the NPRM seems designed to allow entities that refuse to provide women with the basic information, options counseling, and referrals required by law to compete on the same footing for federal money with family planning providers who adhere to the law and provide full and accurate information and services to patients. The NPRM thus threatens to divert scarce family planning resources away from entities that provide comprehensive family planning services to organizations that refuse to provide basic family planning and sexual health care 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 under-insured, but would also be contrary to congressional intent and explicit statutory requirements of the Title X family planning program.

The NPRM likewise creates confusion about whether Title X grantees may ensure that the subrecipients they contract with to provide Title X services actually provide the services the program was designed and funded by Congress to deliver. To the extent that the rule seeks to immunize subrecipients who refuse to provide essential services and complete information about all of a woman's pregnancy options, it undermines the very foundation of the Title X program and the health of the patients who rely on it.

In addition to potential issues with the selection of grantees and subrecipients, the proposed definition of "discrimination" also poses significant employment issues for all Title X-funded health centers. As discussed further below, the language in the NPRM could put Title X-funded health centers in the

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[5] Jennifer Frost et al, *Publicly Funded Contraceptive Services at U.S. Clinics, 2015* (New York: Guttmacher Institute, April 2017).

[6] Christina Fowler, *Family Planning Annual Report: 2016 national summary* (Research Triangle Park, NC: RTI International, 2017).

position of being forced to hire people who intend to refuse to perform essential elements of a position. For example, the rule provides no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the individual refuses to provide non-directive options counseling. Furthermore, the NPRM does not provide guidance on whether it is impermissible "discrimination" for a Title X-funded state or local health department to transfer such a counselor or clinician out of the health department's family planning project to a unit where pregnancy counseling is not done.

The NPRM would undermine the integrity of key HHS programs, including the Title X family planning program, and should be withdrawn.

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The NPRM fails to sufficiently address patient needs or achieve the careful balance struck by existing civil rights laws and encourages unprecedented discrimination against patients that will likely impede their access to care and harm their health.

The stated mission of HHS is "to enhance and protect the health and well-being of all Americans." Yet, the NPRM elevates the religious and moral objections of health care providers over the health care needs of the patients who HHS is obligated to protect. The NPRM allows individuals to refuse to provide health care services or information about available health care services to which they object on religious or moral grounds, with virtually no mention of the needs of the patient who is turned away. Patients should not be forced to bear the brunt of the objector's religious or moral beliefs, particularly to the detriment of their own health. In fact, legal and ethical principles of informed consent require health care providers to tell their patients about all of their treatment options, including those the provider does not offer or favor, so long as they are supported by respectable medical opinion. As such, health care professionals must endeavor to give their patients complete and accurate information about the services available to them.

Furthermore, the NPRM fails to address serious questions as to whether its purpose is to upset the careful balance struck in current federal law between respecting employee's religious and moral beliefs and employers' ability to provide their patients with health care services. Title VII of the Civil Rights Act of 1964 provides a balance between employers' need to accommodate their employees' religious beliefs and practices (including their refusal to participate in specific health care services to which they have religious objection) with the needs of the people the employer must serve. Under Title VII, employers have a duty to reasonably accommodate an employee or applicant's religious beliefs, unless doing so places an "undue hardship" on the employer. This law provides protection for individual belief while still protecting patient access to health care services. The NPRM provides no guidance about how, if at all, health care employers are permitted to consider patients' needs when faced with an employee's refusal to provide services.

The NPRM ignores the needs of patients and fails to consider whether an employer can accommodate such a refusal without undue hardship. In so doing, the NPRM invites health care professionals to violate their legal and ethical duties of providing complete, accurate, and unbiased information necessary to obtain informed consent. The failure of health care professionals to provide such information threatens patients' autonomy and their ability to make informed health care decisions.

Title VII is an appropriate standard that protects the needs of patients and strikes an appropriate balance. The NPRM should be withdrawn.

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NFPRHA appreciates the opportunity to comment on the NPRM, "Protecting Statutory Conscience Rights in Health Care." If you require additional information about the issues raised in these comments, please contact Robin Summers at rsummers@nfprha.org or 202-552-0150.

Sincerely,

Clare Coleman
President & CEO