March 27, 2018

U.S. Department of Health & Human Services, Office for Civil Rights
Attn: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: Comments on HHS-OCR-2018-0002, Notice of Proposed Rulemaking, “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority”

If adopted, the proposed rule (HHS-OCR-2018-0002)\(^1\) will cause significant harmful effects for both patients and providers. To help mitigate these harms, the undersigned individuals urge the Office for Civil Rights (OCR) to make the following changes: reject some of the extremely broad definitions suggested in this proposed rulemaking; clarify how the proposed rule interacts with other federal anti-discrimination laws; and look to successful state models when restructuring the proposed rule. The undersigned individuals have worked on various aspects of health care reform as members of academic institutions and advocacy organizations.

As written, the proposed rule poses significant risks for both patients and health care employers. Specifically, the proposed rule threatens to:

- **Decrease patient access to evidence-based care and deprive patients of the information they need to make informed decisions.** Under the proposed rule’s extremely broad definitions, not only can providers refuse to provide any care that has an *articulable* (as opposed to reasonable) connection to a procedure or service that they find objectionable; but they can also refuse to refer patients to other providers who might be willing to provide such care, or to even inform patients that such care is necessary in the first place.

- **Substantially increase the cost of care by hospitals and other health care providers**—with those costs ultimately borne by consumers and taxpayers. The proposed rule raises possible conflicts with existing federal anti-discrimination laws, like Title VII. Yet, under the proposed rule, employers’ obligations to grant accommodations that may constitute an undue burden—which employers are currently exempted from granting under Title VII—remain unclear. This uncertainty may extend beyond the traditional health care field, as the proposed rule suggests a more expansive view of the entities it covers.

Several state regulations protecting conscience objections by health care providers have recognized the risks posed by these adverse consequences. As such, they have adopted a different approach to strike the appropriate balance between respecting conscience objections,

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ensuring patient access to evidence-based care, and promoting clarity for health care employers. HHS and OCR should look to those successful state models in revising the proposed rule.

I. The proposed rule makes it more difficult for patients to access evidence-based care by allowing health care workers to refuse to provide services or referrals that may be only tangentially related to a valid objection.

A. The proposed rule threatens access to evidence-based, medically necessary care.

The proposed rule makes it more difficult for patients to access medically necessary—and constitutionally protected—care. Under the proposed rule’s new definitions for “assist in the performance of” and “referral” or “refer to,” health care professionals can obstruct access to care by withholding information about health care options or by refusing to provide a referral to a provider who will perform a requested or necessary procedure. These refusals may also be inconsistent with physicians’ common law duties of informed consent.

First, under the proposed rule, “assist in the performance” has been newly defined to include “participat[ing] in any program or activity with an articulable connection to a procedure, health service, health program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity.” \(^2\) That the connection need only be articulable means that the relationship between the activity and the disputed procedure or service can be infinitely tangential, yet still captured by the rule.

Second, the new definition for “referral” or “refer for” allows providers to refrain from making any referrals they morally object to, regardless of how pertinent or relevant the referral is. The terms “include[\]

the provision of any information . . . by any method . . . 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.” \(^3\)

Sanctioning refusals to refer because a procedure might be a “possible outcome” risks patients foregoing medically necessary care because such care might, at some future date, lead to care that the provider finds objectionable.

Finally, the proposed rule may also encourage refusals that are inconsistent with physicians’ common law duties of informed consent. Patient autonomy to make decisions is the “fundamental principle underlying medical decisionmaking,” and the informed consent doctrine “is designed to protect patients by ensuring that they have the material information with which to make an informed choice.” \(^4\) Part of a physician’s duty to provide material information to patients

\(^2\) Id. at 3923.

\(^3\) Id. at 3924.

includes a duty to disclose all of a patient’s therapy options and the risks associated with each option. Failure to disclose all of a patient’s options—as the new definitions for “assist in the performance of” and “referral” or “refer to” allow—violates their right to make informed decisions about consequential medical treatment options.

Patients often have limited financial resources and time to make visits to multiple facilities in search of a provider who will give them the care they need. A study published in the New England Journal of Medicine provides empirical support for the proposition that patient access to care likely already suffers from religious refusals. The 2007 study authors concluded that already more than 14 percent of Americans “may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable,” and 29 percent of Americans may be served by physicians who will not refer patients to other providers for such treatments. These statistics may worsen with the overly broad protections in the proposed rule.

B. OCR should tailor the proposed rule to apply only to actions concretely connected to sincere objections.

The proposed rule increases barriers to care because it is not appropriately tailored to apply only to actions concretely connected to sincere objections. To more appropriately tailor the rule, OCR should narrow the definitions for “assist in the performance” and for “referral” or “refer for” suggested in this proposed rulemaking.

First, OCR should revert back to the previous definition of “assist in the performance of.” Before the proposed rulemaking, “assist in the performance” included participating in programs or activities that have a reasonable connection to a procedure, health service, etc. The proposed rule’s new emphasis on an “articulable” rather than “reasonable” connection means that providers can refuse to assist in almost any procedure or service in certain fields (e.g. obstetrics). Reverting back to the previous definition would ensure that conscientious objections do not impede access to evidence-based, medically necessary, and constitutionally protected care.

Second, OCR should narrow the scope of “referral” or “refer to” to include only referrals to the service that is religiously objectionable; in the case of these referrals, OCR should also clarify that the patients should still be fully informed of their conditions and legal treatment options. The proposed definition suggests, for example, that providers can refuse all referrals to OB/GYN services because they object to certain birth control methods, which such a provider might at some future date provide, even though the direct referrals are not for this service. At that level of removal, it is unreasonable to think that the objecting provider is actually involved in the prescription for contraceptives. Yet that provider’s individual and highly personal beliefs could

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prevent patients from obtaining the care they need—without necessarily knowing that they need the care or that they are being prevented from obtaining it.

Not only are the proposed rule’s new definitions for “assist in the performance of” and “referral” or “refer to” untenably broad, but they also threaten to impact patient access to needed medical care. OCR should narrow these definitions to help mitigate this outcome.

II. The proposed rule raises possible conflicts with existing federal anti-discrimination laws, leaving employers’ obligations to grant accommodations unclear.

A. OCR should make clear that Title VII’s undue hardship standard for religious accommodations still governs.

OCR should clarify how its proposed rule interacts with federal laws that prevent discrimination. Specifically, OCR should revise the rule to make clear that Title VII’s undue hardship standard for religious accommodation governs duties of health care employers to accommodate objecting staff. Under Title VII, when employers cannot “reasonably accommodate” the religious practice in question without undue hardship, they are relieved of their duty to accommodate religious employees.9 In Trans World Airlines, Inc. v. Hardison, the Court held that reasonable accommodations do not include those that require the entity “bear more than a de minimis cost.”10 In that case, Hardison’s religious beliefs prevented him from working on Saturdays. As part of a collective bargaining agreement, the TWA had instituted a seniority system by which employees could swap shifts based on seniority, but Hardison did not have sufficient seniority to swap out every Saturday. The Court found that accommodating this request would impose more than a de minimis burden on the employer, and that, therefore, the religious exemption to Title VII did not apply.

The undue hardship test is well understood and allows for flexible accommodation. There may be many religions in the workplace, and this standard ensures employees of various religions are accommodated—without imposing burdens on co-workers who hold different religious and moral beliefs. Since Hardison, courts have readily required that religious accommodations be granted when they cause no third-party effects,11 but they have also found that the exception to Title VII applies when the religious accommodation would impair the business’s function.12

B. Without such clarification, the new rule may result in onerous and unclear obligations for employers.

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11 See, e.g., Protos v. Volkswagen of America, 797 F.2d 129, 135 (3d Cir. 1986) (finding that there was no undue burden because, unlike in Hardison, 432 U.S., the company “regularly maintained, along with employees assigned to specific posts on the assembly line, a crew of roving absentee relief operators (ARO) to be deployed as substitutes for absent employees”).
By contrast, the new standard for religious accommodation seems absolute and would create onerous and unclear obligations for employers. There is no provision in the proposed rule that allows employers to refuse any accommodations. And, as discussed supra Part I, under the new definition for “assist in the performance of,” employees would only have to show some articulable connection to an objectionable service in order to secure an accommodation. Some employers may even read the proposed rule as a rejection of the Title VII undue burden standard. This may cause employers to err on the side of accommodation, even when such an accommodation would be unreasonable and detrimental to patients and other employees.

If the new regulation encourages more individuals—possibly not just providers, but also pharmacists, etc.—to claim a religious objection, providing an accommodation may prove difficult or costly. These services would likely still have to be provided in order to comply with other federal anti-discrimination laws, like Title II of the Civil Rights Act, Title VI of the same act, and Section 1557 of the Affordable Care Act. Under all of these laws, individuals seeking medical services in hospitals may not be discriminatorily denied such services. In that case, it is not inconceivable that employers would have to pay individuals more to perform certain procedures or to complete basic tasks (e.g. refilling contraception prescriptions or providing or managing emergency miscarriage treatment). This might also be a problem if the hospital uses a seniority system, like that at issue in Hardison.

The Emergency Medical Treatment and Labor Act of 1985 (EMTALA) may prove yet another hurdle for employers given the proposed rule. EMTALA requires that any hospital that receives Medicare funding and operates an emergency department must 1) “provide an appropriate medical screening examination to determine whether or not an emergency medical condition exists,” and 2) “provide any necessary stabilizing treatment or an appropriate transfer,” for anyone who 3) “comes to the emergency department.” But, under the proposed rule, certain objections by emergency department practitioners may conflict with EMTALA requirements. One place where this might present a problem is in miscarriage management. Under EMTALA, hospitals have a duty to provide medically appropriate care to individuals presenting with a miscarriage. However, the new rule would allow providers and staff—perhaps the only providers and staff on call in the emergency room—to not only refuse to provide such treatment, but also to refuse a referral to appropriate care. This means that hospitals would likely need to have individuals who are willing to perform these functions on call at all times. Again, this is likely to result in more than a de minimis cost to at least some employers, as it may require them to pay more for these services.

Moreover, the proposed rule also limits how employers can plan around employees who wish to continue to practice in areas where they will require frequent religious accommodations (for example, OB/GYNs who have a religious objection to contraception). Under the proposed rule, it is considered discrimination “[t]o withhold, reduce, exclude, terminate, restrict, or

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14 Id. § 2000d.
15 Id. § 18116 (providing that “an individual shall not . . . be excluded from participation in, be denied the benefits of, be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance” on the basis of race, color, national origin, sex, age, or disability).
otherwise make unavailable or deny any benefit or privilege.” Therefore, entities may also be in contravention of the proposed rule if they accommodate employees by placing them in a non-preferred position. This furthers the likelihood that, in some situations, entities may have to double-staff certain departments, certainly at more than a de minimis cost and certainly with an effect on their business interests.

Under the proposed rule, these costs may also extend beyond traditional health care employers. As currently defined, the term “entity” extends far beyond the institutions within the purview of HHS reasonably covered by religious accommodation laws. Whereas before, “health care entity” and “entity” meant one and the same, “entity” now extends to “include any State, political subdivision of any State, instrumentality of any State or political subdivision thereof, and any public agency, public institution, public organization, or other public entity in any State or political subdivision of any State.” The proposed rule, then, extends covered entities far beyond the scope of traditional health care employers to include public institutions, public organizations, or any other public entity.

Finally, because the sanctions for violating the proposed rule are so severe, entities might feel coerced to comply with the rule at the expense of other federal anti-discrimination laws. This is particularly true, given that even non-aggrieved third parties can bring a complaint against the entity. If the Secretary refuses to clarify that the Title VII undue burden standard still applies, OCR should—at the very least—consider reducing penalties for first time offenders and delineating more specifically what types of “entities” it intends the rule to cover.

III. OCR should look to states that have achieved a balance between religious accommodations and access to care and narrow the proposed definitions accordingly.

OCR should look to existing state models for navigating the complex balance between protecting conscience and ensuring access to care. The majority of states protect provider conscience while protecting access to care in places of public accommodation. Of the forty-five states that protect provider conscience, only four protect providers who refuse to refer patients for medical procedures. Refusals to refer can have a profound negative impact on patient care, potentially obstructing access to constitutionally protected abortion services or discriminating against protected populations under state anti-discrimination law.

Many states have addressed the serious threat to health posed by refusals to provide care or to refer patients to other providers by coupling conscience protections with obligations to

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19 Id. at 3893. See also Katie Keith, Trump Administration Prioritizes Religious and Moral Exemptions for Health Care Workers, Health Affairs (Jan. 20, 2018), https://www.healthaffairs.org/do/10.1377/ hblog20180120.787956/full/.
21 Id. at 3931.
22 Id. at 3930 (noting that complaints can also be brought by non-aggrieved third parties “on behalf of others, or on behalf of an entity”).
direct patients to providers who will adhere to the patient’s chosen treatment plan. In California, a “health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience.”

However, upon refusing to provide the requested health service, the provider has a duty to “promptly inform the patient” and “immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.” California’s law protects providers from performing procedures against their conscience while ensuring patients can access the care they need.

Illinois law similarly provides strong protections for provider conscience, including refusals to refer, but simultaneously protects patient access to care. Illinois’ Health Care Right of Conscience Act, the broadest state conscience protection for refusals to refer, provides that physicians and other health care personnel have “no duty to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience.” However, facilities are obligated to “adopt written access to care and information protocols that are designed to ensure that conscience-based objections do not cause impairment of patients’ health,” and patients must be fully informed “of their condition, prognosis, legal treatment options . . . consistent with current standards of medical practice.” If requested, the facility must transfer or refer the patient to another facility or provide the patient with information necessary to contact another facility that provides the requested service.

OCR should adopt provisions similar to those in Illinois to ensure that protecting provider conscience does not jeopardize patient access to care. Health care facilities should be required to establish protocols to ensure patients can access necessary care. The provider objecting to the care need not personally refer patients, but as in Illinois, patients must at a minimum be given written information about providers willing to provide the requested service. Additionally, providers should be required to inform patients of all legal treatment options as part of their duty to patients to obtain informed consent. If OCR fails to proactively protect patients through its rulemaking process, OCR should, at a minimum, provide assurances that health care facilities can put these procedures in place without violating the proposed rule or putting their federal funding at risk. OCR needs to provide tools to ensure that health care providers who accommodate provider refusals do not sacrifice patient access to care.

CONCLUSION

In conclusion, we request OCR to make the following changes to the proposed rule:

- Ensure that the proposed rule does not impact access to evidence-based care by more appropriately tailoring the rule to the limited sphere of health providers and actions concretely connected to sincere religious objections.

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25 Id. § 4736.
27 Id. § 70/6.1(1).
28 Id. § 70/6.1(3).
• Clarify the relationship between the proposed rule and existing federal law, including clarifying that the Title VII undue burden standard still governs employers’ treatment of religious objections.
• Look to existing state models, like Illinois, for navigating the complex balance between protecting conscience and ensuring access to care.

Thank you for your consideration of our comments.

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