AMERICAN ATHEISTS

March 6, 2023

Secretary Xavier Becerra
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: Comments from American Atheists Regarding Safeguarding the Rights of Conscience as Protected by Federal Statutes (Doc. No. 2022-28505, RIN 0945-AA18)

Dear Secretary Becerra:

American Atheists writes in support of the proposed rule entitled "Safeguarding the Rights of Conscience as Protected by Federal Statutes."[1] This Proposed Rule would rescind the harmful denial of care[2] rule adopted by the Trump Administration,[3] later stayed by multiple courts because of its many flaws and inconsistencies.[4] Religion should never be a justification to refuse necessary medical care, and we hope that this Proposed Rule will help restore a much-needed focus on patient health and well-being, rather than a disproportionate focus on the beliefs of hospitals and providers. We support adoption of the Proposed Rule and provide herein suggestions for various amendments to strengthen the final rule.

American Atheists is a national civil rights organization that works to achieve religious equality for all Americans by protecting what Thomas Jefferson called the "wall of separation" between government and religion created by the First Amendment. We strive to create an environment where atheism and atheists are accepted as members of our nation's communities and where casual bigotry against our community is seen as abhorrent and unacceptable. We promote understanding of atheists through education, outreach, and community-building and work to end the stigma associated with being an atheist in America. As advocates for the health, safety, and well-being of all Americans, American Atheists object to efforts to subordinate medical care to the religious beliefs of providers and institutions.

[1] Office for Civil Rights, U.S. Dept. of Health and Human Services, Safeguarding the Rights of Conscience as Protected by Federal Statutes, 88 Fed. Reg. 820 (Jan. 5, 2023), Docket No. HHS-OS- 2022-28505, RIN 0945-AA18, https://www.federalregister.gov/documents/2023/01/05/2022-28505/safeguarding-the-rights-of-conscience-as-protected-by-federal-statutes [hereinafter "Proposed Rule"].

[2] Because the framing regarding "rights of conscience" is inaccurate and misleading, we will instead refer to these rules and the act of refusing to provide health care services based on religious beliefs as "denial of care rules" and "denial of care," respectively.

[3] Office for Civil Rights, U.S. Dept. of Health and Human Services, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23170 (May 21, 2019), Document No. 2019-09667, RIN 0945-AA10, https://www.federalregister.gov/documents/2019/05/21/2019-09667/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority [hereinafter "Trump Rule" or "2019 Rule"].

[4] *See Washington* v. *Azar*, 426 F. Supp. 3d 704 (E.D. Wash. 2019), *appeal pending*, No. 20-35044 (9th Cir.); *City & Cnty. of San Francisco* v. *Azar*, 411 F. Supp. 3d 1001 (N.D. Cal. 2019), *appeal pending*, Nos. 20-15398 et al. (9th Cir.); *New York* v. *HHS*, 414 F. Supp. 3d 475 (S.D.N.Y. 2019), *appeal pending*, Nos. 19-4254 et al. (2d Cir.).

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The Trump Rule, which was enacted in 2019 and replaced the previous rule issued in 2011,[5] created sweeping changes that expanded the ability of hospitals and health care providers to refuse to provide any type of care based on their beliefs. This rule was unnecessary, as shown by the fact that there were less than a dozen complaints filed by providers in the span of years before the Trump Rule was proposed. It was quickly stayed by the courts because, among other reasons, it far exceeded the statutory authority of the Department. The Trump Rule not only addressed a problem that did not exist but did so at the expense of the safety and well-being of patients.

Too often, providers and hospitals deny essential care to individuals based on their religious beliefs, including contraception, sterilization, certain infertility treatments, abortion,[6] gender affirming care for trans patients,[7] reproductive health care for trafficking victims,[8] and end-of-life care.[9] Denial of care laws are used across the country to prevent patients from accessing the care they need.[10] In just a few specific examples: LGBTQ individuals have been denied appropriate mental health services and counseling,[11] a newborn was denied care because her parents were lesbians,[12] women suffering miscarriage have been

[5] Office for Civil Rights, U.S. Dept. of Health and Human Services, Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 76 Fed. Reg. 9968 (Feb 23, 2011), Docket No. HHS-OS- 2011-3993, RIN 0991-AB76, https://www.federalregister.gov/documents/2011/02/23/2011-3993/regulation-for-the-enforcement-of-federal-health-care-provider-conscience-protection-laws [hereinafter, "2011 Rule"].

[6] Nat'l Women's Law Ctr., *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care* (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf. *See also* American Civil Liberties Union, *Health Care Denied* (May 2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[7] Nat'l Women's Law Ctr., *Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS* (May 2014), http://www.nwlc.org/sites/default/files/pdfs/lgbt_refusals_factsheet_05-09-14.pdf.

[8] *ACLU of Mass. v. Sebelius*, 821 F. Supp. 2d 474 (D. Mass. 2012), *vacated as moot sub nom., ACLU of Mass. v. U.S. Conference of Catholic Bishops*, 705 F.3d 44 (1st Cir. 2013).

[9] *See* Directive 24, U.S. Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services (5th ed. 2009), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf (denies respect for advance medical directives).

[10] *See, e.g.*, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, Nat'l Women's L. Ctr. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Catherine Weiss, et al., *Religious Refusals and Reproductive* Rights, Am. Civil Liberties Union (2002), https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report; Julia Kaye, et al., *Health Care Denied*, Am. Civil Liberties Union (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, Pub. Rights Private Conscience Project (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[11] *Ward v. Wilbanks*, 09-CV-11237, 2010 WL 3026428 (E.D. Mich. July 26, 2010), *rev'd and remanded sub nom. Ward v. Polite*, 667 F.3d 727 (6th Cir. 2012), *dismissed with prej*. by *Ward v. Wilbanks*, 09-CV-11237 (E.D. Mich. Dec. 12, 2012) (case settled).

[12] Abby Phillip, "Pediatrician refuses to treat baby with lesbian parents and there's nothing illegal about it," *The Washington Post* (Feb. 19, 2015), https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it/.

denied prescription medication,[13] and individuals have been denied HIV medication,[14] all because of someone else's religious beliefs.

We applaud the Department for taking steps to ensure that the overemphasis of denial of care provisions by the Trump Administration does not continue to undermine the provision of essential health services across the country.

1. **Rescission of the 2019 Rule is appropriate because it was unconstitutional, extra-statutory, exceedingly harmful, and, ultimately, vacated by several courts.**

While American Atheists opposes denial of care in all its forms, we recognize that the Department must implement regulations in alignment with Federal statutes. The 2011 Rule struck a good balance by meeting the narrow, statutorily defined denial of care provisions in Federal law while protecting the health care access and well-being of patients. Unfortunately, the Trump Administration upended this balanced framework in 2019. The Department is correct to rescind the majority of the Trump Rule, however, we would caution against retaining the misleading and inappropriate framing of the rule as well as its broad expansion of included statutes (see below).

Congress has passed several narrow statutory provisions allowing for limited circumstances in which health care providers may not be required to participate in specific health care procedures, such as abortion and sterilization.[15] The Trump Rule built those narrow exceptions into an ambiguous framework that "prohibits discrimination" against only those health care providers who refuse to engage in health care practices that offend specific religious viewpoints - those most often held by conservative Christians. However, actual instances of providers being required to engage in specific health care procedures to which they object are vanishingly rare. Not only is it inappropriate as a policy matter to place so much emphasis on a rare and easily handled issue at the expense of health care for everyone, it is unconstitutional for the Department to protect the religious beliefs certain providers without considering the impact on the health, safety, and well-being of third parties, such as patients.

The Establishment Clause of the First Amendment requires the Department to consider the impact any accommodation or exemption for religious health care providers would have on patients. Specifically, the Constitution bars the federal government from crafting "affirmative" accommodations within its programs if the accommodations would substantially harm any third parties.[16] The Constitution

[13] *Denied Care When Losing a Pregnancy: Pharmacies Refuse to Fill Needed Prescriptions*¸ Nat'l Women's Law Ctr. (Apr. 16, 2015), http://www.nwlc.org/our-blog/denied-care-when-losing-pregnancy-pharmacies-refuse-fill-needed-prescriptions.

[14] Complaint*, Simoes v. Trinitas Reg'l Med. Ctr*., No. UNNL-1868-12 (N.J. Super. Ct. Law Div. May 23, 2012).

[15] The Church Amendments, 42 U.S.C. § 300a-7 (2018); The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018).

[16] U.S. Const. amend. I; *Cutter v. Wilkinson*. 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).

commands that "an accommodation must be measured so that it does not override other significant interests;"[17] "impose unjustified burdens on other[s];"[18] or have a "detrimental effect on any third party."[19]

The Trump Rule unjustifiably expanded the limited religious exemptions created by Congress without considering that exemptions that enable entities receiving taxpayer funding to refuse to provide critical health care services would undoubtedly harm third parties, in violation of the Establishment Clause.[20]

This is especially troubling because the Trump Rule exceeded the Department's authority; conflicted with other federal and state laws, including Title VII[21] and EMTALA;[22] and conflicted with the Office for Civil Rights' (OCR) mission to address health disparities and discrimination that harms patients.[23] It is no surprise then that the rule was invalidated by three separate courts: the Eastern District of Washington state, the Northern District of California, and the Southern District of New York.[24] The Washington court stated that "the APA violations are numerous, fundamental, and far-reaching that the rulemaking exercise here was sufficiently shot through with glaring legal defects as to not justify a search for survivors."[25] In the Northern District of California the court "vacated [the rule] in its entirety based on the administrative record and not on any considerations specific to the plaintiffs."[26]

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[17] *Cutter v. Wilkinson*, 544 U.S. at 722.

[18] *Id.* at 726.

[19] *Id*. at 720, 722; *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. at 2781; *Estate of Thornton v. Caldor*, 472 U.S. at 710 ("unyielding weighting" of religious exercise "over all other interests…contravenes a fundamental principle" by having "a primary effect that impermissibly advances a particular religious practice."); *Texas Monthly, Inc. v. Bullock*, 480 U.S. 1, 18 n.8 (1989) (religious accommodations may not impose "substantial burdens on nonbeneficiaries").

[20] Respecting religious exercise may not "unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling." *See Burwell v. Hobby Lobby*, 134 S. Ct. at 2787. When considering whether the birth control coverage requirement was the least restrictive means in *Hobby Lobby*, the Court considered that the accommodation offered by the government ensured that affected employees "have precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing coverage." *See id.* at 2759. In other words, the effect of the accommodation on women would be "precisely zero." *Id.* at 2760.

[21] 42 U.S.C. § 2000e-2 (1964).

[22] 42 U.S.C. § 1295dd(a)-(c) (2003).

[23] OCR's Mission and Vision, Dep't of Health and Human Servs. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").

[24] *New York* v. *HHS*, 414 F. Supp. 3d 475 (S.D.N.Y. 2019).

[25] *Washington v. Azar*, 426 F. Supp. 3d 704 (E.D. Wash. 2019).

[26] *City & Cnty. of San Francisco* v. *Azar*, 411 F. Supp. 3d 1001 (N.D. Cal. 2019).

2. The Department should reject Trump Administration framing of "federal conscience and nondiscrimination laws" and exclude the statutes added to the enforcement scheme by the 2019 Rule.

The Department proposes to retain the additional statutory provisions added to the rule's enforcement scheme[27] by the 2019 Rule, which pertain to a wide range of programs, including Medicare and Medicaid, administration of the Affordable Care Act, and others.[28] The Trump Rule increased the number of provisions the Department is responsible for enforcing from three in 2011 to approximately 25 in 2019. It is inappropriate to retain these provisions because: 1) it combines unalike statutes into one category in ways that are misleading and harmful, and 2) it heightens enforcement of those statutes in a manner not contemplated by Congress.

The Trump Administration grouped together disparate health care opt-outs, secular exemptions, and various religious exemptions into one category.[29] This was done in order to create ambiguity and erect a framework extending the narrow exemptions created by Congress into a broad, extra-statutory protection for "conscience rights in health care" that allows health care institutions and providers to refuse to provide nearly any necessary medical care to which they object.[30] The Department nevertheless uses this misleading framing throughout the Proposed Rule to describe relevant exemptions under federal law. In order to reduce confusion for both providers and consumers, we recommend that the Department cease to use the obfuscatory "right of conscience" framework and to more accurately describe the scope of possible exemptions, including both religious and secular exemptions.

Furthermore, because most of the provisions added to the enforcement scheme based on this false "right of conscience" framework have nothing to do with religion or conscience, we recommend that they be removed. For example, 42 U.S.C. § 18023 provides that "[n]o qualified health plan offered through an Exchange may discriminate against any individual health care provider…because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions."[31] This law applies to all health care providers who do not provide abortion, regardless of their reasons for doing so. The text of the law does not discuss religion or conscience and a decision by a health care provider to not offer abortion services is not inherently religious – such a decision may, for example, result from financial, legal, medical, or practical considerations rather than religious or conscience-based objections. As the Supreme Court has

[27] Proposed 45 CFR § 88.1 (defining "federal health care provider conscience protection statutes").

[28] Sections 1303, 1411, and 1553 of the ACA, 42 U.S.C. §§ 18023, 18081, and 18113; certain Medicare and Medicaid provisions, 42 U.S.C. §§ 1320a-1(h), 1320c-11, 1395i-5, 1395w-22(j)(3)(A)-(B), 1395x(e), 1395x(y)(1), 1395cc(f), 1396a(a), 1396a(w)(3), 1396u-2(b)(3)(A)-(B), 1397j-1(b), and 14406; Consolidated Appropriations Act, 2022, Pub. L. 115-245, div. H, section 209, div. K, title VII, section 7018; 22 U.S.C. § 7631(d); 22 U.S.C. § 2151b(f); 42 U.S.C. §§ 280g-1(d), 290bb-36(f), 1396f, 1396s(c)(2)(B)(ii); 5106i(a)); and 29 U.S.C. § 669(a)(5).

[29] 45 CFR §§ 88.1, 88.3.

[30] U.S. Dept. of Health and Human Services, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23170 (May 21, 2019), Doc. No. 2019-09667, RIN 0945-AA10, https://www.federalregister.gov/documents/2019/05/21/2019-09667/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority.

[31] 42 U.S.C. § 18023(b)(4).

repeatedly stated, the mere fact that a policy or action aligns with a particular tenet of a belief system does not mean the policy is based on that belief system.[32]

Similarly, 42 U.S.C. § 18113,[33] Pub. L. 105–12, § 6, Apr. 30, 1997, 111 Stat. 25. § 14406,[34] 42 U.S.C. § 1395cc(f)(1)(c),[35] 22 U.S.C. § 2151b(f)[36] are labeled as conscience laws through inclusion in 45 CFR Part 88, but they are not actually predicated on religion or conscience-based objections.

Other provisions referenced in CFR Part 88 apply to specific secular exemptions that have nothing to do with "conscience." For example, 42 U.S.C. § 18081 covers individuals seeking an exemption "as an Indian, or as an individual eligible for a hardship exemption."[37] 22 U.S.C. § 7631 prevents aid from being provided with a condition that the recipient "endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS."[38] 29 U.S.C. § 669 prevents that chapter from being "deemed to authorize or require medical examination."[39] These limitations are not predicated on religious beliefs or conscience, and they should not be miscategorized as protecting conscience rights through inclusion in the Proposed Rule.

In addition, by retaining the various provisions added by the Trump Rule in the category of "federal health care provider conscience protection statutes," the Department expands enforcement in ways that were not intended by Congress. The authorizing statutes cited by the Department vary widely in scope and applicability. In fact, many of the statutes cited by the Department for this purpose fail to provide any authorization to take or investigate complaints.[40] The Department relies on its housekeeping authority[41] to support the Proposed Rule, however, that authority allows the Department to set the terms and conditions of its own grants, not to impose conditions on grantees beyond the bounds of the grant.[42] Here, despite

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[32] *See McGowan v. Maryland*, 366 U.S. 420, 445 (1961); *Braunfeld v. Brown*, 366 U.S. 599, 606-07 (1961); *Harris v. McRae*, 448 U.S. 297 (1980); *Bowen v. Roy*, 476 U.S. 693, 712 (1986).

[33] 42 U.S.C. § 18113 (governments and health care providers "may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.").

[34] (Cannot "require any provider or organization...to inform or counsel any individual regarding any right to obtain an item or service furnished for the purpose of causing, or the purpose of assisting in causing, the death of the individual, such as by assisted suicide, euthanasia, or mercy killing.")

[35] 42 U.S.C. § 1395cc(f)(1)(C) (cannot "condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.").

[36] ("None of the funds made available...may be used to pay for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions.")

[37] 42 U.S.C. § 18081(5)(A).

[38] 22 U.S.C. § 7631(d)(1)(A).

[39] 29 U.S.C. § 669(a)(5).

[40] *See, e.g.,* the Religious Freedom Restoration Act (42 U.S.C. § 2000bb *et seq.*).

[41] 5 U.S.C. § 301.

[42] *See Chrysler Corporation v. Brown,* 441 U.S. 281 (1979).

lack of specific provisions in these statutes, the Department claims broad enforcement authority for actions taken by grantees outside the funded programs.
Although the Department proposes to enforce these rules through OCR,[43] many of these provisions were not traditionally overseen by that office.[44] They do not share the well-developed body of legal guidance applicable to civil rights complaints, and it is unclear which, if any, of the traditional safeguards for civil rights complainants, such as anti-retaliation protection, are available to religious refusal complainants.

By amplifying enforcement, the Department compounds the potential harm cause by these denial of care provisions and distracts from its critical work to combat discrimination. As noted herein, denials of care have real consequences for those who cannot access the care they need because of a provider or hospital's religious beliefs. Compared to civil rights complaints, denial of care complaints are significantly less frequent, and they virtually never result in adverse medical outcomes. Patients who encounter denial of care, much like patients that face discrimination in health care, may be unable to find a suitable provider, they may suffer adverse health consequences or death due to the denial, and they are likely to face additional complicating factors such as poverty and marginalization based on their identity. Complainants seeking to deny care or that were prevented from denying care, on the other hand, are unlikely to face the medical complications or death that can result from denial of care. The Department should use its limited resources to enforce civil rights protections, not an expansive portfolio of denial of care provisions.

3. The Department should clarify the notice provisions in the Proposed Rule, creating separate recommended best practices to protect employees and patients.

The Proposed Rule provides for voluntary notice that entities "subject to the federal health care provider statutes" may post.[45] However, the proposed notice provision is ambiguous because it fails to elucidate the purpose of the notice, who is to be notified, or what they are to be notified about. The Proposed Rule states that "OCR considers the posting of a notice consistent with this part as a best practice" and refers to the model notice text in Appendix A. The proposed language provides numerous locations where notice should be posted,[46] but offers no insight about who the grantee should be trying to reach with this notice, nor the content of the notice. Turning to the model notice text, we note that it does little to clarify:

> [Name of entity] complies with applicable Federal health care provider conscience protection statutes, including [list applicable conscience statutes]. If you believe that [Name of entity] has violated any of these provisions, you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms

[43] Proposed 34 CFR § 88.2.

[44] Margot Sanger-Katz, Trump Administration Strengthens 'Conscience Rule' for Health Care Workers, https://www.nytimes.com/2019/05/02/upshot/conscience-rule-trump-religious-exemption-health-care.html.

[45] Proposed 45 CFR § 88.3.

[46] Proposed 45 CFR § 88.3(b).

> and more information about Federal conscience protection laws are available at https://www.hhs.gov/conscience.[47]

So, basically, if a person (there is no indication of who this applies to) reading this notice is aware of a violation of a law (there is no description of what these laws do or what a violation would be), they can report it to the Department. We believe the problem here is that the Department is trying to achieve two separate and conflicting goals at the same time:

1) Inform employees that they may bring complaints when required by employers to participate in procedures they object to in violation of the law; and
2) Inform the public that they may be subject to denial of care by providers or facilities.

And because of that mixed motive, neither goal is well-served by the proposed notice provision or model notice language.

For example, the suggested posting locations include employee-focused locations such as employee handbooks, orientation materials, training, and worksite locations with other employee-focused notices. But they also include websites, worksite locations where notices to the public are posted, and student handbooks, which are more public-focused and better suited to the second goal. Similarly, while most of the Proposed Rule is focused on the ability of employees to opt out of providing specific health care services they object to, the notice provision provides that, "[w]here possible, and where the recipient does not have a conscience-based objection to doing so, the notice should include information about alternative providers that may offer patients services the recipient does not provide for reasons of conscience."[48]

We believe it is very important to encourage health care institutions and providers that deny care to make this fact transparent to patients, and we applaud the Department for encouraging grantees to do so. However, it is not possible to do so through the vague proposed notice provision and model language. Instead, we recommend that the Department adopt two voluntary notice provisions, one focused on employees and one on patients, in order to provide more clarity for everyone.

Patients potentially incur costs, suffer medical consequences, and lose time by going to providers that refuse to provide the services that they require. However, if facilities posted services that they refuse to provide publicly then it could prevent patients from wasting time and money seeking care at facilities that will not treat them, as well as the dignitary harm a patient may suffer when their care is denied because of the provider or facility's beliefs.

In many areas of the country various health care services are difficult or impossible to find because major health care providers that deny care based on religious beliefs are the sole community provider.[49] A recent study found that there are over 50 communities nationwide where health care is only available at Catholic

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[47] Proposed 45 CFR Part 88, Appendix A.

[48] Proposed 45 CFR § 88.3(d).

[49] Solomon, Uttley, HasBrouck, and Jung, *Bigger and Bigger: The growth of Catholic Health Systems*, 15, Community Catalyst, (2020), https://www.communitycatalyst.org/news/press-releases/new-report-finds-rapid-growth-of-catholic-health-systems.

hospitals, which routinely deny necessary health care to individuals based on religious restrictions.[50] In these areas, religion-based denial of care can force people to travel long distances to find the health care that they need. For example, in a recent high-profile case, a Minnesota woman was denied access to emergency contraceptives by all the pharmacies in her town.[51] She had to drive over a hundred miles through a snowstorm to get the health care she needed. A jury found that being publicly denied health care service caused the women $25,000 worth of emotional damages. If consumers can easily determine whether a provider has claimed exemption, they may be able to make health care choices that better allow them to access needed care.[52]

The Department should recommend, as a best practice, that notice to patients be posted on health care providers' websites and in patient-focused areas that identifies procedures the provider does not perform as well as alternative providers in the area that do perform those services. Moreover, the Department should do more to inform patients in various contexts that they may be denied care because of the religious beliefs of providers and facilities. Research shows that many people are not aware of denial of care, do not expect to be denied services, and are unaware when denial of care occurs.[53] More public education on this issue is critical.

A second voluntary notice provision should focus on informing employees at facilities of their rights under the Proposed Rule. For clarity, this notice should resemble the notice provided in the 2019 Rule, updated to reflect the Proposed Rule.

4. The Department should clarify enforcement provisions by defining relevant terms limiting scope of enforcement.

We appreciate the proposed changes the Department has made to the enforcement provisions, especially compared to the 2019 Rule, which included extreme enforcement provisions that were unlawful and coercive. However, additional clarification is needed in several places, including: 1) the investigative

[50] Hayley Penan & Amy Chen, *The Ethical & Religious Directives: What the 2018 Update Means for Catholic Hospital Mergers*, National Health Law Program (2019), https://healthlaw.org/resource/the-ethical-religious-directives-what-the-2018-update-means-for-catholic-hospital-mergers/.

[51] Samira Asma-Sadeque, "US jury finds in favor of pharmacist who denied woman morning-after pill," The *Guardian* (Aug. 6th, 2022), https://www.theguardian.com/us-news/2022/aug/06/morning-after-pill-contraception-judge-minnesota.

[52] We note that transparency alone does not solve the burden inflicted upon consumers by denial of care. As noted above, in at least 50 communities, there are no alternative providers of abortion and various types of reproductive care. Moreover, consumers may face limited choices because of their insurance coverage, costs, or for other reasons.

[53] *See* Stulberg DB, Guiahi M, Hebert LE, Freedman LR, Women's Expectation of Receiving Reproductive Health Care at Catholic and Non-Catholic Hospitals, *Perspectives on Sexual and Reproductive Health*, 2019;51(3):135-142; Schwandt HM, Sparkle B, Post-Kinney M, Ambiguities in Washington State hospital policies, irrespective of Catholic affiliation, regarding abortion and contraception service provision, *Reproductive Health*, 2018;15(1); Liu Y, Hebert LE, Hasselbacher LA, Stulberg DB, "Am I Going to Be in Trouble for What I'm Doing?": Providing Contraceptive Care in Religious Health Care Systems, *Perspectives on Sexual and Reproductive Health*, 2019;51(4):193-199; Wong ZJ, Thompson L, Boulware A, et al., What you don't know can hurt you: Patient and provider perspectives on postpartum contraceptive care in Illinois Catholic Hospitals, *Contraception*, published online November 2021:S0010782421004376.

process and the role the state agencies play in it, and 2) the definition of the terms "relevant funding" and "appropriate action." The Department should go beyond removing the unlawful enforcement provisions of the 2019 Rule by clarifying the remaining enforcement provisions. Lastly, we recommend that the Department use different forms to collect information on violations of the Proposed Rule than those used to collect civil rights complaints.

§ 88.2(a) delegates to OCR the authority to conduct investigations as part of OCR's enforcement of the relevant statutes. However, the Proposed Rule indicates that OCR might "seek assistance of any State agency." We seek additional information on the role State agencies may play in the process. Many State health departments have a record of hostility to those seeking reproductive health care and gender-affirming care. OCR should clarify which State agencies may provide assistance, whether these agencies will make recommendations regarding resolution of the investigation, and when OCR will engage in independent fact finding. OCR must also implement protections for the information gathered in the investigative process.

Another part of the enforcement provision that needs clarification is the use of the definitions for "relevant funding" and "appropriate action." In proposed § 88.2(c) the Department uses these terms to refer to potential consequences for violations of the rule. OCR should clarify a limiting principle for what constitutes "relevant funding" to ensure it is not coercive or in violation of the Spending Clause. Moreover, the Department should be clear that relevant funding can never include all of an entity's HHS funds. Similarly, OCR should clarify that appropriate action is limited to action taken pursuant to existing HHS regulations, such as the Department's Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS awards (UAR), and does not include any other enforcement tools.

Finally, because of the significant differences between denial of care forms, we recommend that OCR use separate forms to collect complaints for violations of the Proposed Rules and civil rights complaints. Currently, both types of complaints are collected through the same form,[54] which may create confusion for potential complainants, investigators, and others.

Denial of care complaints are legally distinct from civil rights complaints, therefore they will likely require different data and information to effectuate intake. For example, because of the narrow scope of the Church Amendments and other authorizing statutes, it is especially important that religious refusal complaints identify the HHS-associated funding source.[55] Similarly, because many of these authorizing statutes pertain only to religious refusals based on a few specific issues (such as abortion or sterilization), a form for taking these complaints should clearly allow complainants to select the type of care they are refusing to provide. Additionally, because of the constitutional requirement to consider burden on third parties and beneficiaries due to religious exemptions, the complainant should be asked to provide any known information about the individual(s) to whom they refused to provide care (while, of course, maintaining patient confidentiality) so that the Department can investigate as necessary.

[54] Dept. of Health and Human Services, Office for Civil Rights, Complaint Forms for Civil Rights and Conscience; Health Information Privacy and Security Complaints, OMB Control No. 0945-0002. ICR Ref. No. 202209-0945-001.

[55] Moreover, because religious refusal complainants are generally medical providers in the employ of the relevant entity, they are better positioned to identify such funding sources than civil rights complainants.

Using the same form for complainants who have been discriminated against or refused care and for those who would refuse care to others can only lead to confusion and reduce the likelihood that affected individuals will file complaints.

5. Denial of care has a disproportionate negative impact on vulnerable communities, including religious minorities such as atheists and nonreligious people.

We very much appreciate the Department's commitment to using data to inform its civil rights work. In response to the Department's request for comments about how the 2019 Rule affected or would affect access to health care services, we direct your attention to the following research conducted by American Atheists through the U.S. Secular Survey.[56] The U.S. Secular Survey was an online survey of nearly 34,000 nonreligious people living in the U.S. conducted in late 2019. This research shows the alarmingly common discrimination faced by nonreligious people in the context of heath care and highlights the harmful impacts of this discrimination. In addition to the main report, American Atheists published subpopulation reports focusing on nonreligious women, Black nonreligious people, nonreligious youth, and nonreligious LGBTQ people.[57]

Nonreligious people routinely face discrimination in health care because of their beliefs. The U.S. Secular Survey showed that 14.6% of nonreligious participants that sought reproductive care within the past three years had negative experiences because of their nonreligious beliefs. Similarly, 17.7% had negative experiences in mental health services, 15.2% in substance abuse services, and 10.7% in other health services, all because of their nonreligious beliefs. Nonreligious women experienced significantly more discrimination than other participants in areas such as mental health services (21.6% vs. 14.7%), reproductive care (18.9% vs. 9.5%), and other health services (13.4% vs. 8.6%).[58]

For each area, nonreligious people experienced a significantly higher level of discrimination in very religious communities. For reproductive care, 21% of nonreligious participants in very religious communities reported negative experiences. Similarly, in very religious communities, 26.5% reported negative experiences in mental health services, 18.4% in substance abuse services, and 17.4% in other health services, because of their nonreligious beliefs.

Moreover, this discrimination was linked to increased negative psychological outcomes for nonreligious people. Nonreligious participants who had negative experiences in reproductive care were 39.7% more likely to screen positive for depression than other survey participants. Those who had negative experiences in mental health services, substance abuse services, or other health services were 94.4%, 71.4%, or 53.3% more likely, respectively, to screen positive for depression.

[56] Frazer, S., El-Shafei, A., Gill, A.M., *Reality Check: Being Nonreligious in America,* American Atheists (2020), www.secularsurvey.org.

[57] Available at www.secularsurvey.org.

[58] Frazer, S., El-Shafei, A., Gill, A.M., *Nonreligious Women in America: A Brief from the U.S. Secular Survey*, American Atheists and Secular Woman (2022), www.secularsurvey.org.

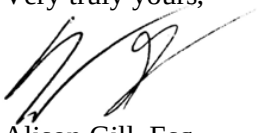
Our research also showed that nonreligious LGBTQ people face elevated levels of discrimination compared to their heterosexual/cisgender peers.[59] In the U.S. Secular Survey, 23.4% of nonreligious LGBTQ participants experienced discrimination or negative experiences in mental health services, 20.8% in reproductive care, 20.1% in substance abuse services, and 14.1% in other health care services. In very religious communities, these numbers are even higher, with 28.1% of nonreligious LGBTQ participants experiencing discrimination in reproductive health care services. This heightened rate of intersectional discrimination negatively impacts the psychological well-being of nonreligious LGBTQ people. Nonreligious LGBTQ people who encountered discrimination in mental health services were 68% more likely to screen positive for depression, and those encountered discrimination in substance abuse services were 73% more likely to screen positive for depression.

Given the harm caused by denial of care on atheist and nonreligious communities and many others, we urge to Department to develop measures for survey instruments such as the National Survey on Drug Use and Health (NSDUH), the Behavioral Risk Factor Surveillance System (BRFSS), and the National Health Information Survey (NHIS) suitable for collecting data about denial of necessary care based on religious beliefs and the impact thereof. This information is critical to understanding the full context of health care discrimination in the US, and the collection of such data will allow the Department to better fulfill its mission and improve health outcomes for marginalized Americans.

Conclusion

American Atheists supports adoption of the Proposed Rule, but we encourage the Department to consider various suggested amendments to exclude statutory provisions not traditionally enforced by OCR, expand voluntary notice to include notice to consumers, and clarify enforcement procedures. If you should have any questions regarding American Atheists' support to the Proposed Rule or our suggested amendment, please contact me at agill@atheists.org.

Very truly yours,



Alison Gill, Esq.
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American Atheists

[59] Frazer, S., El-Shafei, A., Goldberg, S., A., Gill, A.M., *Nonreligious Lesbian, Gay, Bisexual, Transgender, and Queer People in America: A Brief from the U.S. Secular Survey*, American Atheists (2022), www.secularsurvey.org.