NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

April 9, 2009

Office of Public Health and Science
Department of Health and Human Services
Attention: Rescission Proposal Comments
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 716G
Washington, DC 20201

Re: Comments on Health and Human Services – Rescission of the Regulation Entitled "Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law"; Proposal, 74 Fed. Reg. 10,207, March 10, 2009, RIN 0991-AB49.

Dear Acting Secretary Johnson,

The following comments are submitted by the National Women's Law Center ("Center"), a nonpartisan, non-profit organization based in Washington, D.C. dedicated to improving the lives of women and girls. The Center submits the following comments in strong support of the proposed regulation, "Rescission Proposal," published on March 10, 2009 by the Department of Health and Human Services ("Department" or "HHS"). 74 Fed. Reg. 10,207 (Mar. 10, 2009). The Rescission Proposal proposes to fully rescind the regulation entitled "Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law" ("HHS Regulation").

The Center fully supports the Rescission Proposal because it is necessary to undo the confusion and potential for harm caused by the HHS Regulation in a host of areas. For example, the HHS Regulation allows providers and entities to ignore the health needs of patients and restrict access to a wide range of health care services, information, counseling, and referrals. It opens the door for insurance plans, hospitals, and other entities to deny women access to most forms of birth control. The HHS Regulation has a disproportionate impact on low-income women and other vulnerable communities. It creates serious confusion throughout the health care system by threatening and obfuscating existing legal requirements and health care program requirements. Any one of these failings warrants the proposed rescission of the HHS Regulation. Taken together, they demonstrate that the Rescission Proposal is imperative to restore trust to the provider-patient relationship, ensure that patients are not denied access to health care services or basic information about all of their health care options, and eliminate the confusion among providers, patients, and entities engendered by the HHS Regulation.

I. Background

On August 26, 2008, the Department proposed the HHS Regulation. 73 Fed. Reg. 50,274 (Aug. 26, 2008). It claimed that the regulation is needed to educate recipients of Department funds about their legal obligations under three statutes—often referred to as the Church Amendments,[1] the Coats Amendment,[2] and the Weldon Amendment.[3] These laws ensure that certain individuals and institutions are not discriminated against if they refuse to provide or participate in certain health services or research activities.

The Department's proposed regulation received an overwhelming response of more than 200,000 comments. A broad range of individuals and organizations opposed the proposed regulation, including the American Medical Association; more than 150 Members of Congress; a bipartisan group of 13 state attorneys general; 27 state medical societies; associations of state health officials; the American Hospital Association; the National Association of Community Health Centers; more than a dozen medical specialty societies, including the American College of Emergency Physicians, the American College of Surgeons, and the American College of Obstetricians and Gynecologists; Commissioners and the Legal Counsel of the Equal Employment Opportunity Commission; professional nurses associations, including the American Nurses Association; HIV/AIDS provider groups; religious organizations; and advocacy groups who work on lesbian, gay, bisexual and transgender rights, HIV/AIDS, women's rights, reproductive rights, and international issues. These commenters, including the Center, raised serious questions and concerns about the impact of the HHS Regulation.

Despite the overwhelming response in opposition to the proposed regulation, the Bush Administration published the final regulation on December 19, 2008. 73 Fed. Reg. 78,072 (Dec. 19, 2008). The HHS Regulation became effective on January 20, 2009. Contrary to its stated purpose, the HHS Regulation does not clarify health care providers' obligations and rights under the underlying statutes; rather, it serves only to confuse and to limit patient access to health care services and information.

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[1] 42 U.S.C. § 300a-7 (2008) (specifying that receipt of federal funds does not require an individual or institution to provide sterilization or abortion services and permitting individuals to refuse to perform or assist in the performance of a sterilization or abortion procedure, if doing so would be contrary to his or her religious beliefs or moral convictions).

[2] Public Health Service Act § 245, 42 U.S.C. § 238n (2008) (prohibiting the federal government and any state or local government receiving federal financial assistance from "discriminating" against any physician, residency training program, or participant in a health professionals training program on the ground that such person or entity refuses to receive or provide training in induced abortions, to perform such abortions, or to provide referrals for such training or such abortions).

[3] Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, § 508d, 121 Stat. 1844, 2209 (2007) (providing that no funds made available can go 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.").

II. The Rescission Proposal Will Protect Patient Access to Health Care Services and Information, Restoring Open Communication Between Patients and Providers

The Rescission Proposal is necessary to prevent the HHS Regulation from reducing access to information, health care services, and referrals in a range of areas. The HHS Regulation gives entities and individuals expansive rights to refuse to provide health care services and information, without regard to the impact on patients. The effect of the HHS Regulation is broad, limiting patient access in a range of areas, including contraceptive care, end-of-life care, infertility care, sexually transmitted infections, HIV/AIDS care, drug addiction, and mental health services, among others.

In giving such sweeping license to refuse without taking patients' needs into account, the HHS Regulation runs counter to its own goal. The Department's comments accompanying the HHS Regulation repeatedly emphasize the importance of "open communication" between patients and providers. The Department said, "Delivery of health care services is significantly improved when patients and health care providers have full, open, and honest conversations about the services they request and provide." 73 Fed. Reg. at 78,074. Similarly, the Department stated, "Patients are best served when their providers communicate clearly and early about any services they decline to provide or participate in." 73 Fed. Reg. at 78,081. Yet, the HHS Regulation instead allows absolute refusals to provide information, not even requiring providers to notify patients about services and information they refuse to provide. This discourages honest conversation and undermines the relationship between providers and patients, who rely upon their providers for complete and accurate information.

The Rescission Proposal will protect patient access to care and information by ensuring that patients' needs continue to be taken into account. This will restore trust to the provider-patient relationship and advance the open communication the Department appeared so eager to promote.

III. The Rescission Proposal is Especially Critical for Low-Income Women and Other Vulnerable Communities

The HHS Regulation Jeopardizes Access to Health Care Services for Women, Especially Low-Income Women

The HHS Regulation has a disproportionate impact on women's access to health care services and information, posing a serious threat to women's health. This is in part because women's reproductive health care services are the focus of the vast majority of refusals. For example, women living in communities where a Catholic and non-Catholic hospital merge have been left without access to abortion, contraception, sterilization, and infertility treatment services.[4] Women seeking treatment for miscarriages at Catholic

[4] For examples, see MergerWatch, Hospitals and Religious Restrictions, http://www.mergerwatch.org/hospital_mergers.html (last visited Apr. 6, 2009).

hospitals have been denied the standard of care and placed in life- and health-threatening situations.[5] Rape survivors seeking care at hospitals have been refused information about and access to emergency contraception, denying them the ability to prevent pregnancy.[6] Women seeking to fill legally valid prescriptions for birth control have been refused by pharmacists,[7] and pharmacies have refused to stock certain contraceptives altogether.[8] Women are denied coverage for their prescription contraceptives under their employer's prescription drug plan, even when the plan covers other prescription drugs.[9]

Women denied needed services are forced to bear the burden of additional costs, delays, and health risks incurred by going elsewhere. Some may be prohibited from going elsewhere, if their insurer imposes the restriction or prevents them from seeking care outside the plan.

The reduction of available health services and information permitted by the HHS Regulation adversely affects all women in need of reproductive care, but falls most heavily on low-income women. In particular, the HHS Regulation threatens the ability of low-income women to receive comprehensive information and referrals under the Title X family planning program, which provides contraceptive services and cancer screenings to 5 million low-income women annually. The Rescission Proposal will restore the long-standing protections that ensure that women served by the Title X program can get complete and accurate family planning services, as well as information about and referrals for all their pregnancy options, including prenatal care, adoption, and abortion.

The Rescission Proposal will not just protect low-income women's access to health care services and information, but will benefit all low-income individuals. Low-income individuals are more likely to rely on federal programs administered or funded by HHS for their health care services, so this restriction in access to information or services has a direct effect on them. Low-income individuals also already face a more limited pool of providers. In the case of Medicaid enrollees, inadequate reimbursement rates keep providers out of the program, while low-income individuals not on Medicaid are less likely to have private health care coverage. Adding the additional barrier of absolute refusals to provide information or services only compounds the lack of providers available to low-income individuals. Therefore, low-income individuals will benefit most from the Rescission Proposal.

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[5] Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774 (2008).
[6] *See, e.g.*, Sabrina Rubin Erdely, *Doctor's Beliefs Can Hinder Patient Care*, SELF, June 2007, *available at* http://www.msnbc.msn.com/id/19190916/.
[7] *See* Nat'l Women's Law Ctr., Pharmacy Refusals 101 (Mar. 31, 2009), *available at* http://www.nwlc.org/pdf/pharmacyrefusals101.109.pdf.
[8] *See* Rob Stein, '*Pro-Life' Drugstores Market Beliefs*, WASH. POST, June 16, 2008, at A1.
[9] *See, e.g.*, Amanda Millard, *Religious Leaders Explain Importance of Contraception in Wake of Belmont Abbey Stance*, GASTON GAZETTE (N.C.), Feb. 21, 2008.

The HHS Regulation Has a Disproportionate Impact on Other Vulnerable Americans, Including Communities of Color, Individuals Living in Rural Communities, and the LGBT Population

The Rescission Proposal will particularly benefit communities of color, because more individuals of color rely on HHS-funded health care programs than their white counterparts. For example, people of color are disproportionately represented in Medicaid. Racial and ethnic minorities comprise about one-third of the total U.S. population but more than half of all Medicaid recipients.[10] Consequently, the restrictions in access to care created by the HHS Regulation have disproportionate effects on communities of color. Communities of color are also more likely to lack health insurance, receive lower-quality care, often have poorer access to care, and suffer from worse health outcomes. The HHS Regulation compounds these disparities, a result at odds with this Administration's commitment to eliminating racial and ethnic disparities in health care.

The Rescission Proposal is also critical to protecting access to care and information for individuals who live in rural areas. Women living in rural areas of the United States in particular already face unique barriers to accessing health care. They are more likely to be uninsured or underinsured (i.e. with health coverage that leaves them vulnerable to financial risk and/or unmet health needs).[11] Research demonstrates that rural residents are more likely than their urban counterparts to be self-employed or to work for small or low-revenue employers that do not offer job-based health insurance. Regardless of their insurance status, rural women have more trouble finding a health provider near their home. Rural residents are four times more likely to live in a medically underserved area, since health care facilities in rural parts of the country have more trouble attracting and retaining doctors, nurses, and other health providers.[12] Providers practicing certain specialties, such as those in the obstetrics/gynecology field, are particularly lacking in rural areas; this often presents a major barrier for rural women who need reproductive health services. Long travel distances and limited transportation options create additional obstacles to rural women's access to health care. If a woman needs a health service that is only offered by a very limited number of providers in the area, such as reproductive or mental health care, transportation is especially problematic. For instance, a woman and her family may need to travel for hours—sometimes by multiple modes of transportation—in order to reach a pharmacy that stocks contraceptives, an abortion provider, or a mental health provider that can treat depression. If that provider refuses because of the HHS Regulation, rural women may be left without an alternative source of care.

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[10] Families USA, "Reforming Medicaid": How State Waivers Will Hurt Racial and Ethnic Minorities (Nov. 2005).

[11] Rural Assistance Center, Women's Health Frequently Asked Questions, http://www.raconline.org/info_guides/public_health/womenshealthfaq.php#access (last revised May 19, 2008).

[12] *See* U.S. Dep't of Health & Human Serv., Facts about…Rural Physicians, http://www.shepscenter.unc.edu/rural/pubs/finding_brief/phy.html (last visited Apr. 2, 2009).

The Rescission Proposal is also needed to protect access to care and information for members of the lesbian, gay, bisexual, and transgender ("LGBT") population, particularly women. The LGBT population is more likely to face barriers in access to care and preventive services.[13] With an insufficient number of health care providers who can sufficiently treat this population—either due to outright discrimination, ignorance, or misinformation—it is often more difficult for women in the LGBT community to get comprehensive care, and they may actually be less willing to seek care if they cannot find a provider who can adequately meet their needs.[14] Women of color who identify as LGBT face multiple levels of discrimination related to racism, sexism, and homophobia.[15] The HHS Regulation only adds to these barriers.

IV. The Rescission Proposal is Necessary to Minimize the Potential for Harm Resulting from the Ambiguity and Confusion It Created

The HHS Regulation creates significant confusion about how it interacts with other laws and health care program requirements. The result is that nearly 572,000 health care providers and the millions of patients they serve are left facing ambiguity and confusion when trying to determine their rights and responsibilities. The Rescission Proposal is needed to minimize the potential for harm arising from such uncertainty.

The HHS Regulation Creates Confusion Regarding Employment Practices

Title VII of the Civil Rights Act of 1964 prohibits health care employers from discriminating against any applicant or employee in hiring, promotion, termination, or any other term or condition of employment based on religious beliefs.[16] It requires employers to reasonably accommodate the sincerely-held religious beliefs, observances, and practices of its applicants and employees, when requested, unless the accommodation

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[13] Los Angeles Gay & Lesbian Ctr., Advancing Gay and Lesbian Health: A Report from the Gay and Lesbian Health Roundtable (Jan. 2000), *cited in* Gay & Lesbian Med. Ass'n, HEALTHY PEOPLE 2010 COMPANION DOCUMENT FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) HEALTH (Apr. 2001), http://www.gayhealth.com/binary-data/GH_TEXT_BLOCK/attachment/1911.pdf.

[14] Nat'l Women's Law Ctr. et al., MAKING THE GRADE ON WOMEN'S HEALTH: A NATIONAL AND STATE-BY-STATE REPORT CARD (2004), http://www.nwlc.org/pdf/HRC04Chapter_4_KeyHealthDisparities.pdf.

[15] B. Green, *Ethnic-Minority Lesbians and Gay Men: Mental Health and Treatment Issues*, 11 J. GAY & LESBIAN SOCIAL SERV. 93 (1994), *cited in* Nat'l Coalition for LGBT Health, LGBT Mental Health and Substance Abuse: Decreased Resources, Increased Risk (n.d.).

[16] 42 U.S.C. § 2000e-2(a) provides that it is unlawful employment practice for an employer:

> (1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions or privileges of employment, because of such individual's race, color, religion, sex, or national origin; or
>
> (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex, or national origin.

would impose an undue hardship on business operations.[17] This means that for more than four decades, Title VII has allowed employers to strike a careful balance between ensuring that patients are able to access vital health care services and information and protecting employees' religious beliefs and practices.

This balance is especially critical in the health care arena. As two Commissioners of the Equal Employment Opportunity Commission (EEOC), the federal agency charged with enforcing Title VII, wrote during the public comment period, "In the healthcare context, the balancing of interests that characterizes the Title VII analysis is particularly essential, because of the need to ensure the continuity of medical care for citizens without unnecessary and potentially life-threatening denials or delays."[18] Title VII case law illustrates that this balancing has successfully worked to protect both employee's religious beliefs and the needs of patients who seek access to health care services.[19] For this reason, the Legal Counsel of EEOC said in public comment to HHS, "The concern that motivated the proposed Provider Conscience Regulation with respect to employment – that health care employers deny certain religious accommodations and thereby infringe on the employee's ability to practice religion – is already addressed by Title VII and the law developed under it."[20]

By regulating in this area, the HHS Regulation creates significant ambiguity. EEOC's Legal Counsel and the two Commissioners raised serious concerns about the confusion the HHS Regulation would cause. For example, the Commissioners said the HHS Regulation would only serve to "throw [Title VII's] entire body of law into question, resulting in needless confusion and litigation in an attempt to redefine religious freedom rights for employees in the healthcare sector."[21] The HHS Regulation did not resolve these concerns. Instead, it further exacerbated them. For example, in its comments accompanying the HHS Regulation, the Department said that the protections contained in the underlying laws are broader than those afforded under Title VII and that accommodation must occur, 73 Fed. Reg. 78,083, 78,085, but simultaneously stated that

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[17] 42 U.S.C. § 2000e(j) provides that:

> The term "religion" includes all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably accommodate an employee's or prospective employee's religious observance or practice without undue hardship on the conduct of the employer's business.

[18] Letter from Stuart J. Ishimaru, Commissioner & Christine M. Griffin, Commissioner, U.S. Equal Employment Opportunity Commission, to Secretary Michael Leavitt, United States Department of Health and Human Services, Subject: Provider Conscience Regulation, Sept. 25, 2008, at 3.

[19] *See* Equal Employment Opportunity Comm'n, *Compliance Manual Section 12, Religious Discrimination*, Directives Transmittal 915.003 (July 22, 2008), *available at* http://www.eeoc.gov/policy/docs/religion.html.

[20] Letter from Reed L. Russell, Legal Counsel, U.S. Equal Employment Opportunity Commission, to Brenda Destro, Office of Public Health and Services, Department of Health and Human Services, Re: Provider Conscience Regulation, Sept. 24, 2008, at 3.

[21] Letter from Stuart J. Ishimaru, *supra* note 18, at 2. *See also* Letter from Reed L. Russell, *supra* note 20, at 4 (explaining that introducing another standard for some workplace discrimination and accommodation complaints would create confusion).

HHS "fully expect[s] health care entities to take the necessary steps to protect conscience rights while meeting the needs of their patients." 73 Fed. Reg. 78,084. The Rescission Proposal is therefore necessary to eliminate the confusion caused by the HHS Regulation and restore the careful balance long achieved by Title VII.

The HHS Regulation Creates Confusion that Threatens Access to Emergency Care

The HHS Regulation also creates confusion as to how it interacts with state and federal laws that protect patients in emergency situations. Concerns voiced during public comment focused in particular on the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or, if medically warranted, to transfer the person to another facility.[22] The HHS Regulation does nothing to clarify whether EMTALA requirements would be upheld in the face of the HHS Regulation. In its comments accompanying the final regulation, the Department acknowledged these concerns but simply stated that it does "not anticipate any actual conflict between EMTALA and this regulation." 73 Fed. Reg. 78,088. The lack of clarity on access to emergency care could place patients in grave danger and expose them to serious harm, including life-threatening delays in care. The Rescission Proposal therefore would help minimize the potential for harm created by the HHS Regulation for patients seeking emergency care.

The HHS Regulation Creates Confusion About Access to Contraception

The HHS Regulation does not clear up confusion about whether "abortion" can include contraception for purposes of the underlying laws. A leaked draft of the proposed regulation contained a medically inaccurate definition of abortion that would have included many commonly-used forms of contraception,[23] causing an outcry from the public and requests for clarity on this question. The HHS Regulation in both proposed and final form did nothing to clarify this. The Department declined in the final regulation to provide a definition of abortion, 73 Fed. Reg. 78,077, and merely states that there is "no evidence" that access to contraception will be restricted. 73 Fed. Reg. 78,081. This confusion gives an open invitation to insurance plans, hospitals, and other entities to deny women access to contraception. As described below, it also further complicates the question of whether states can enforce their own laws that protect access to contraception.

[22] *See* 42 U.S.C. § 1395dd(a)-(c).

[23] The leaked draft defined abortion as being "any of the various procedures—including the prescription, dispensing and administration of any drug or the performance of any procedure or any other action—that results in the termination of the life of a human being in utero between conception and natural birth, whether before or after implantation."

The HHS Regulation Creates Confusion About Enforcement of State Laws

The HHS Regulation creates ambiguity about interference with state laws and policies that protect and expand access to contraception. State attorneys general and governors expressed concerns about what the HHS Regulation means for their ability to enforce those state laws and policies.[24] The Regulation provided no clarity on this topic, saying that some state laws, if enforced, "might violate these federally protected rights" but that the Department "is not aware of any particular instance where a State has done so in an inappropriate fashion." 73 Fed. Reg. 78,088. This imprecise response, coupled with the confusion about whether "abortion" includes contraception, leaves state officials unclear about whether they can enforce their own laws protecting access to contraception. For example, twenty-four states have laws or policies requiring insurance policies offered in those states to include coverage for contraception in otherwise comprehensive prescription drug plans.[25] Fifteen states and the District of Columbia have laws requiring hospital emergency rooms to provide information about or access to emergency contraception to sexual assault survivors.[26] Fourteen states have laws or policies that

[24] *See, e.g.,* Letter from Terry Goddard, Attorney General Arizona et al., to Brenda Destro, Office of Public Health and Science, Department of Health and Human Services, Sept. 24, 2008; Letter from Chester J. Culver, Governor, State of Iowa, to The Honorable Michael O. Leavitt, Secretary, US Department of Health and Human Services, Sept. 25, 2008; Letter from Jim Doyle, Governor, State of Wisconsin, to Secretary Michael O. Leavitt, US Department of Health and Human Services, Sept. 23, 2008.

[25] They are: Arizona, Arkansas, California, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, Vermont, Washington, and West Virginia. ARIZ. REV. STAT. ANN. § 20-826 (West 2006); ARK. CODE ANN. § 23-79-1103(a) (2005); CAL. INS. CODE § 10123.196 (West 2006); CONN. GEN. STAT. ANN. § 38a-503e (West 2006); DEL. CODE ANN. tit. 18 § 3559 (2000); GA. CODE ANN. § 33-24-59.6 (West 2006); HAW. REV. STAT. ANN. § 431:10A-116.6; § 431:10A-116.7; § 432:1-604.5 (West 2006); 215 ILL. COMP. STAT. ANN. 5/356z.4 (West 2005); IOWA CODE ANN. § 514C.19 (West 2006); ME. REV. STAT. ANN. tit. 24 § 2332-J; 24-A M.R.S.A. § 2756; 24-A M.R.S.A. § 2847-G; 24-A M.R.S.A. § 4247 (West 2006); MD. CODE ANN., INS. § 15-826 (West 2006); MASS. GEN. LAWS ANN. 175 § 47W; 176A § 8W; 176B § 4W; 176G § 4O (West 2006); MO. ANN. STAT. § 376.1199 (West 2006); NEV. REV. STAT. ANN. § 689A.0415 (West 2006); N.H. REV. STAT. ANN. § 415:18-i; § 420-A:17-c; § 420-B:8-gg (West 2006); N.J. STAT. ANN. § 17:48-6ee(1) (2006); N.M. STAT. ANN. § 59A-22-42; § 59A-46-44 (West 2006); N.Y. INS. § 3221(1)(16) (West 2006); N.C. GEN. STAT. ANN. § 58-3-178; § 58-50-155 (West 2006); OR. REV. STAT. § 743A.066 (2008); R.I. GEN. LAWS § 27-18-57; § 27-19-48; § 27-20-43; § 27-41-59 (West 2006); VT. STAT. ANN. tit. 8 § 4099c (West 2006); WASH. ADMIN. CODE § 284-43-822 (West 2006); W. VA. CODE ANN. § 33-16E-4(a)-(b) (West 2006). *See also* Nat'l Women's Law Ctr., Contraceptive Equity Laws in Your State: Know Your Rights—Use Your Rights, *available at* http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf.

[26] The states are Arkansas, California, Colorado, Connecticut, D.C., Illinois, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Oregon, South Carolina, Utah, Washington, and Wisconsin. ARK. CODE ANN. § 20-13-1403 (West 2008); CAL. PENAL CODE § 13823.11 (West 2008); COLO. REV. STAT. ANN. § 25-3-110 (West 2008);CONN. GEN. STAT. § 19a-112e (2008); Emergency Care for Sexual Assault Victims Act of 2008, Leg. B. 323, Council Pd. 17 (D.C. 2009); 410 ILL. COMP. STAT. § 70/2.2 (2008); ILL. ADMIN. CODE tit. 77, §§ 545.20, .35, .60, .95 (2008); MASS. GEN. LAWS ANN. ch. 41, § 97B (West 2008); MASS. GEN. LAWS ANN. ch. 111, § 70E (West 2008); MINN. STAT. §145.4712 (2008);N.J. STAT. ANN. §§ 26:2H-12.6b to -12.6g (West 2008); N.J. STAT. ANN. §52:4B-44 (West 2008); N.M. STAT. ANN. §§ 24-10D-1 to -5 (West 2008); N.Y. PUB. HEALTH LAW § 2805-p (McKinney 2008); OR. REV. STAT. § 435.254 (2008); S.C. CODE ANN. § 16-3-1350 (2008); H.B. 132, 58th Leg, 2009 Gen. Sess. (Utah 2009); WASH. REV. CODE §§ 70.41.020, .350, .360 (2008); WIS. STAT. § 50.375 (2008).

prohibit or limit refusals to provide access to medication in the pharmacy.[27] The Rescission Proposal would eliminate the confusion created by the HHS Regulation that impedes enforcement of these laws.

V. Rulemaking is Not Needed in this Area and Any Non-Regulatory Means Should be Commensurate with the "Problem"

Regulation in this area was, and is, not needed. The underlying statutes have been on the books and in effect for many years, without any recognized need for clarification. These existing laws, as well as Title VII and related state laws, already adequately and appropriately protect employees' religious beliefs. As the two Commissioners of the EEOC made clear in their comments opposing the proposed regulation, regulation is "unnecessary to protect the religious freedom and freedom of conscience of healthcare workers, because Title VII already serves that purpose."[28]

Just as there is no demonstrated need for regulation, there is also no evidence that the public and recipients of Department funds require education about the underlying laws. However, should the Department believe there is evidence to suggest that education is necessary, those goals should be accomplished through non-regulatory means. A non-regulatory option for educating the public was identified by the Department itself. In the original proposed rule, the Department asked for comment on placing notices about the underlying statutes in applications for training, residency, and education programs that receive Department funds. *See* 73 Fed. Reg. 50,297. The Department could undertake similar educational efforts with respect to educating Department grantees. For example, the Department could develop a letter to send to its grantees, reminding them of the underlying laws. Such efforts would pose only a minimal burden to the Department and

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[27] The states are Alabama, California, Delaware, Illinois, Maine, Massachusetts, Nevada, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Texas, and Washington. *Plan B – Options in Alabama*, ALABAMA STATE BOARD OF PHARMACY NEWS (Ala. State Bd. of Pharmacy, Birmingham, Ala.), Feb. 2007, at 1; CAL. BUS. & PROF. CODE §§ 733 (2008); *Considering Moral and Ethical Objections*, DELAWARE STATE BOARD OF PHARMACY NEWS (Del. State Bd. of Pharmacy, Dover, Del.), Mar. 2006, at 4; DEL. CODE REGS. 24 2500 § 3.1.2.4 (Weil 2008); ILL. ADMIN. CODE tit. 68, § 1330.91 (2009); 02-392 ME. CODE R. ch. 19 § 11 (Weil 2009) (citing ME. REV. STAT. ANN. tit. 32 § 13795(2) (2008)); Letter from President James T. DeVita, The Commonwealth of Massachusetts Board of Registration in Pharmacy, to Dianne Luby, President/CEO, Planned Parenthood League of Massachusetts, Inc. (May 6, 2004) (on file with the National Women's Law Center); NEV. ADMIN. CODE § 639.753 (2008); N.J. STAT. ANN. § 45:14-67.1 (West 2009); Letter from Lawrence H. Mokhiber, Executive Secretary, New York State Board of Pharmacy, to Supervising Pharmacists, Re: Policy Guideline Concerning Matters of Conscience (Nov. 18, 2005), *available at* http://www.op.nysed.gov/pharmconscienceguideline.htm; *Item 2061- Conscience Concerns in Pharmacist Decisions*, NORTH CAROLINA BOARD OF PHARMACY NEWSLETTER (N.C. Bd. of Pharmacy, Chapel Hill, N.C.), January 2005, at 1, *available at* http://www.ncbop.org/Newsletters/Jan2005.pdf; Oregon Board of Pharmacy, Position Statement: Considering Moral and Ethical Objections (June 7, 2006), *available at* http://www.oregon.gov/Pharmacy/M_and_E_Objections_6-06.pdf; 49 PA. CODE § 27.103 (2009) (statement of policy); Texas State Board of Pharmacy, Plan B, http://www.tsbp.state.tx.us/planb.htm; WASH. ADMIN. CODE § 246-869-010 (2008), enjoined as to emergency contraception in Stormans, Inc. v. Selecky, 526 F.3d 406 (9th Cir. 2008).

[28] Letter from Stuart J. Ishimaru, *supra* note 18, at 2.

would not burden or confuse the health care providers who receive Department funds in the way the current HHS Regulation does.

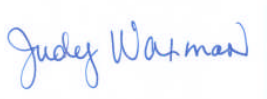
However, the Center strongly believes that any outreach and education the Department takes in this area should be commensurate with the problem the Department is seeking to address. In this case, there is no problem; the Regulation was merely a solution in search of one. The Department itself acknowledged as much in the comments accompanying the HHS Regulation when it said, "there is insufficient data to estimate the number of funding recipients not currently compliant with [the underlying laws]. We received no Comments indicating that there were any funding recipients not currently compliant." 73 Fed. Reg. at 78,094-95. In other words, the Department's decision to finalize the HHS Regulation appears not to be based on evidence that the HHS Regulation is needed to ensure compliance with and enforcement of the underlying laws.

On the other hand, numerous commenters pointed out the problem that does exist within the patient-provider relationship: refusals to provide health care information, counseling, referrals, and services. Commenters offered examples of situations under the HHS Regulation in which patients could be denied access to critical health care services or information because of the personal beliefs of a health care provider or entity without regard for patient need, situations that would result in diminished and delayed access to care, with the concomitant risks and threats to health and life. At this time of economic crisis, with more and more Americans losing their health care coverage and finding themselves needing to rely on these government programs, the Department should focus on getting complete health care information and services to individuals—not taking information and services away.

Conclusion

The Rescission Proposal is necessary to protect the health care needs of women, their families, and vulnerable communities and to minimize the potential for harm caused by the ambiguity and confusion created by the HHS Regulation. Full rescission of the HHS Regulation will serve to move the Department closer to its goal of fostering open communication between patient and provider and expanding and protecting health care access for all Americans. For these reasons, the Center urges adoption of the Rescission Proposal, leading to a full rescission of the HHS Regulation.

Sincerely,



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