



NYCLU

NEW YORK CIVIL LIBERTIES UNION

125 Broad Street, 19th Fl.
New York, NY 10004
212.607.3300
212.607.3318
www.nyclu.org

Galen Leigh Sherwin
Director, Reproductive Rights Project

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United States Department of Health and Human Services
Office of Public Health and Science
Attn: Brenda Destro
Hubert Humphrey Bldg.
200 Independence Ave. SW
Washington, DC 20201

Re: Provider Conscience Regulations

Ms. Destro,

I am writing on behalf of the New York Civil Liberties Union to submit comments on the proposed rule published at 73 Fed. Reg. 50274 (the “proposed rule” or “proposed regulation”), and to urge your withdrawal of the proposed regulation.

The proposed regulation, which purports to interpret three federal provisions, the Weldon, Church and Coats Amendments,¹ would expand the ability of health care providers, insurers and health care institutions to refuse to provide health care services, as well as information and referrals, to patients. The proposed regulation prohibits agencies and entities receiving funding from the Department of Health and Human Services from “discriminating” against individuals who object to the provision of abortion and sterilization, as well as other health care services. It also expands the universe of health care entities that may refuse to provide abortion training, counseling and services, and hinges federal funding on certification of compliance.

The New York Civil Liberties Union is one of the nation’s foremost defenders of civil liberties and civil rights. Founded in 1951 as the New York affiliate of the American Civil Liberties Union, we are a not-for-profit, nonpartisan organization with seven chapters and regional offices and nearly 50,000 members across the state of New York. Our mission is to defend and promote the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution,

¹ Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, § 508(d), 121 Stat. 1844, 2209; 42 U.S.C. § 300a-7; Public Health Service Act § 245, 42 U.S.C. § 238n.

including freedom of speech and religion, and the right to privacy, equality and due process of law for all New Yorkers.

The NYCLU has a long history of vigorously defending religious liberty. We are equally vigilant in our attempts to safeguard reproductive rights. We are therefore uniquely positioned to address the issues raised when religious belief affects decision-making about reproductive health care. The NYCLU strongly advocates solutions that balance the protection of public health, patient autonomy, and gender equality with the protection of individual religious belief and institutional religious worship. To achieve this balance, we believe it is often possible to accommodate an *individual* health care professional’s religiously-based refusal to provide a particular health service so long as the professional takes steps to ensure that the patient can receive that service elsewhere. However, because institutions – such as hospitals, insurance companies and pharmacies – serve patients and customers of all faiths and backgrounds, an institution’s wholesale refusal to provide services poses a much greater risk of harm to those who do not share in those religious beliefs and should not be allowed to trump all other important societal interests.

As explained in greater detail below, the proposed rule does not appear to strike the appropriate balance between reproductive freedom and religious liberty, and could therefore seriously undermine women’s ability to obtain essential reproductive health services – as well as patients’ ability to obtain health care services more broadly. The Department of Health and Human Services (the “Department”), which is “the United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves,”² has the express responsibility to further, not hinder, the public health. Accordingly, we urge the Department to withdraw the proposed rule.

1. The Regulation Threatens to Disturb the Balance Between Religious Objections and Patients’ Health Care Needs.

The proposed regulation threatens to upset the careful balance between the religious freedom of health care providers and patients’ ability to access health care services—a balance that has been carefully struck in both New York State and federal law.

Since the founding of our Nation, freedom of religion has been one of our most highly prized liberties, and protections for that freedom are enshrined in both the United States and New York State Constitutions. Congress, as well as the state legislatures, have enacted numerous laws to add force to those protections. Both Title VII of the 1964 Civil Rights Act and the New York State Human Rights Law currently protect against discrimination on the basis of religion and in employment.³ However, in codifying and applying these laws, courts and legislatures have been careful to ensure that in protecting

² See United States Department of Health and Human Services, HHS: What We Do, <http://www.hhs.gov/about/whatwedo.html/> (last visited Sept. 25, 2008).

³ 42 U.S.C. § 2000e *et seq.* (2008); N.Y. EXEC. LAW § 296 (McKinney 2008).

religious liberty, other fundamental rights and freedoms are not unduly burdened. The proposed regulation fails to take the same precautions.

The primary problem is the failure to define “discrimination” or to explain how the regulation interacts with existing laws protecting employees from discrimination on the basis of religion. For example, Title VII prohibits religious discrimination in employment and requires employers to attempt to accommodate employees’ religious beliefs.⁴ However, it also requires a careful evaluation of whether the accommodation proposed is reasonable, and whether granting such an accommodation would cause “undue hardship” to the employer.⁵ This careful balancing, which is conducted on a case by case basis,⁶ recognizes that employers should not be forced to sacrifice competing obligations in order to accommodate the religious beliefs of an employee.

The New York State Human Rights and Civil Rights laws similarly afford protection against religious discrimination by employers, including on the grounds that a health care provider refuses to provide abortion.⁷ However, the New York courts have also applied a balancing test, and have stopped short of requiring employers to offer accommodations that would impede their mission or interfere with their ability to conduct business.⁸

In the health care context, this has meant that employers whose mission is providing health care to the public have not been required to accommodate the religious beliefs of their employees if the accommodation sought would impede their ability to serve patients promptly and respectfully.⁹ By contrast, the regulation, on its face, does not involve the same inquiry—or indeed, any inquiry—into the impact of accommodation

⁴ 42 U.S.C. § 2000e(j) (2008).

⁵ *Id.*

⁶ *Philbrook v. Ansonia Bd. of Educ.*, 757 F.2d 476, 484-7 (2d Cir. 1985); *Tooley v. Martin Marietta Corp.*, 648 F.2d 1239, 1243 (9th Cir. 1981).

⁷ See N.Y. EXEC. LAW § 296; N.Y. CIV. RIGHTS LAW § 79-I (McKinney 2008); *Larson v. Albany Med. Ctr.*, 252 A.D.2d 936 (N.Y. App. Div., 3d Dep’t 1998).

⁸ See *Eastern Greyhound Lines v. New York State Div. of Human Rights*, 27 N.Y.2d 279, 284 (1970) (holding uniformly applied policy requiring all employees to be clean-shaven was not an unlawful discriminatory practice as applied to a Muslim employee whose religion required him to have a beard); *Harmon v. General Electric Co.*, 72 A.D.2d 903, 904 (N.Y. App. Div., 3d Dep’t 1979) (finding termination of employee who refused to continue working in employer’s machinery apparatus operation based on pacifist views, which are part of his Catholic faith, was not an unlawful discriminatory practice). While the NYCLU may not agree with the outcome in each of these cases, we cite them merely to illustrate that the courts have adopted a balancing test that appears to be completely absent from the proposed regulation’s terms.

⁹ See *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 228 (3d Cir. 2000) (finding hospital’s offer to move nurse who objected to performance of abortions from labor and delivery to infant ICU constituted reasonable accommodation of religious beliefs); *Noesen v. Med. Staffing Network, Inc.*, 232 Fed. Appx. 581, 584, 2007 WL 1302118, at *3 (7th Cir. 2007) (finding that pharmacy was not required to offer accommodation to pharmacist who objected to provision of birth control removing him from all contact with patients because such accommodation would pose undue hardship on employer); *Grant v. Fairview Hosp. and Healthcare Servs.*, 2004 WL 326694, at *5 (D. Minn. 2004) (holding hospital had offered reasonable accommodation to ultrasound technician who disapproved of abortion by taking steps to avoid him coming into contact with patients contemplating abortion, but that it was not required to permit him to provide pastoral counseling to all pregnant patients receiving ultrasounds).

on the employer’s ability to fulfill its mission or provide service to the public. Instead, it contains what appears to be a blanket prohibition on religious “discrimination.”

Without any guidance as to how this prohibition interacts with current legal understandings of the rights and obligations of employers with respect to employees’ religious objections, employers across the health care system may feel constrained to accommodate employees’ religious objections at any cost. This could place family planning and STI clinics, hospitals, or pharmacies in the impossible position of feeling unable to fire, discipline, or refuse to hire employees who assert that their religious views prevent them from performing critical job functions—for example, a counselor at an STI clinic who refuses to counsel patients on condom use, or a receptionist in a family planning clinic who refuses to provide referrals for abortion. Given the amount of federal funds that are potentially at risk, providers may feel their hands are tied.

In other words, under the regulation, the religious objection of the individual provider appears to trump both the needs of the patient and the mission of the health care agency. Although it is important to protect individuals’ religious liberty, this should not come at the expense of patients’ health care needs or the ability of health care agencies to serve the public.

2. The Regulation Threatens to Sacrifice Patients’ Rights to Information

The regulation explicitly permits federally funded health care providers—both individuals and institutions—to withhold basic information and counseling from their patients. This flies in the face of legal and ethical principles of informed consent, which require health care providers to inform patients about all treatment options.

For example, New York State Public Health Law requires physicians to obtain informed consent before provision of any procedure, and defines informed consent as including advice as to the foreseeable risks and benefits of a proposed treatment, as well as any alternatives.¹⁰ Ethical rules make clear that this includes those procedures to which the provider objects or those which he or she does not provide.¹¹ The proposed rule seems designed to do away with these essential safeguards by permitting individuals to refuse to provide such counseling and information. Under the scenarios posed by the proposed regulation, patients may never be able to access the refused health care – or even know about their right or option to do so.

Moreover, it is difficult to square the proposed regulation with the requirements of the Title X program, which has successfully provided contraceptive services to millions of Americans for almost forty years.¹² Federally funded health care providers in the Title X program are required to provide patients with counseling about *all* of their options, including abortion.¹³ Statistics compiled by the Guttmacher Institute confirm

¹⁰ See N.Y. PUB. HEALTH LAW § 2805(d) (McKinney 2008).

¹¹ See, e.g., American College of Obstetricians and Gynecologists Committee on Ethics, *The Limits of Conscientious Refusal in Reproductive Medicine*, Committee Opinion No. 385 (November 2007).

¹² See Public Health Service Act of 1970 §1001, 42 U.S.C. 300 (2008); Rachel Benson Gold, *Equipping Title X for the Future*, 11 GUTTMACHER POL’Y REV. 19, 19 (2008).

¹³ See 42 C.F.R. § 59.5(a)(5) (2008).

that without the contraceptive services provided at publicly funded clinics, there would be 46 percent more unintended pregnancies annually in the United States.¹⁴ Yet, depending on the Department’s interpretation of the proposed regulation, Title X providers could be forced to hire employees who refuse to provide contraceptive information, counseling and services; and organizations that are unwilling to provide women with complete and accurate information and services could be able to claim scarce federal family planning dollars. Thus, the proposed rule threatens to undermine important public health goals and leave patients without options in the face of a health care provider’s refusal to offer care.

3. The Regulation Could Jeopardize States’ Ability to Enforce a Range of Laws Protecting Patients’ Access to Health Care

New York also has many protections in place to ensure medical care for patients in need, such as professional misconduct laws prohibiting abandonment of a patient in need of care,¹⁵ and state laws requiring emergency treatment for patients at hospital emergency rooms.¹⁶ The proposed rule casts doubt on the State’s continued authority to enforce such provisions.

The proposed regulation appears to extend conscience protections to entities not currently covered by existing state or federal law. It explicitly applies to a broad range of institutions not previously understood to be covered by the Church, Coats and Weldon Amendments, such as insurance plans, pharmacies and hospitals. The Church, Coats and Weldon Amendments were designed to protect an individual right of conscience. They were never intended to allow *institutional* health care entities to refuse to provide such services. To the extent the existing refusal statutes extend protections to institutions, these protections are plainly limited to abortion and in some instances, sterilization. Any attempt to create a broad right to refuse health care services that runs to *institutions* would thus exceed the Department’s authority under the promulgating statutes.

It could also disturb current New York State law. New York State Civil Rights Law provides broad conscience protections for individuals who are unwilling to provide abortion due to their religious views.¹⁷ However, health care providers are still responsible for ensuring that patients receive adequate care, and can be held responsible for professional misconduct and potentially even medical malpractice should they fail to

¹⁴ See Guttmacher Institute, *Facts on Publicly Funded Contraceptive Services in the United States*, http://www.guttmacher.org/pubs/fb_contraceptive_serv.html#11.

¹⁵ N.Y. COMP. CODES R. & REGS. tit. 8, § 29.2 (2008) (including abandoning patient in need of care in definition of professional misconduct for medical professionals).

¹⁶ See New York State Emergency Medical Services Reform Act (EMSRA), N.Y. PUB. HEALTH LAW § 2805-b; see also Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd.

¹⁷ See N.Y. CIV. RIGHTS LAW § 79-i. (“When the performing of an abortion on a human being or assisting thereat is contrary to the conscience or religious beliefs of any person, he may refuse to perform or assist in such abortion by filing a prior written refusal setting forth the reasons therefor with the appropriate and responsible hospital, person, firm, corporation or association, and no such hospital, person, firm, corporation or association shall discriminate against the person so refusing to act.”)

make alternative arrangements to ensure the care of the patient.¹⁸ Moreover, the conscience protections that exist in New York, like those in federal law, are afforded to *individuals*, rather than institutions.¹⁹ Although hospitals may refuse to provide elective abortion procedures²⁰ (as they may *any* elective procedure), they are still subject to state and federal laws requiring provision of necessary medical care, including abortion, to patients in emergency circumstances.²¹ Thus, New York law strikes a careful balance between respecting the religious beliefs of individual health care providers and ensuring that patients’ health care needs are ultimately met. The proposed regulation should not be interpreted in such a manner to disturb the longstanding equilibrium between these important interests.

4. The Regulation Could Jeopardize States’ Ability to Enforce Laws Promoting Access to Contraception and Other Health Care Services.

Although the Weldon, Coats and Church Amendments focus principally on abortion, the breadth and vagueness of the proposed regulation leaves open the possibility that a wide range of health care services could be impacted. The proposed regulation could encourage refusals to provide not only abortion care, but also contraception. Indeed, an earlier draft of the regulation explicitly conflated abortion and contraception, and targeted contraceptive equity laws and others like them across the country as a “problem” that needed to be addressed. Although this troubling language has been removed, the proposed regulation offers no assurance that these laws will not be jeopardized.

Moreover, to the extent that the proposed rule creates a new right for institutions to refuse to provide health care services more broadly, including contraception, it could also undermine important state laws that have greatly expanded access to contraception in our state. For example, ours was one of the first states to enact a “contraceptive equity”

¹⁸ See, e.g., New York State Department of Education, New York State Board of Pharmacy, *Policy Guideline Concerning Matters of Conscience* (November 18, 2005), available at <http://www.op.nysed.gov/pharmconscienceguideline.htm> (setting forth professional obligation of pharmacists with religious, moral or ethical objections to “take appropriate steps to avoid the possibility of abandoning or neglecting a patient” and to make adequate arrangements “to ensure that their patients obtain properly ordered and therapeutically appropriate medications in a timely manner”); see also *Abraham v. Bd. of Regents of State of N.Y.*, 216 A.D.2d 812 (N.Y. App. Div., 3d Dep’t 1995) (disciplining nurse for refusing to respond to emergency situations involving patients on three occasions); *Husher v. Comm’r of Educ. of State of N.Y.*, 188 A.D.2d 739, (N.Y. App. Div., 3d Dep’t 1992) (disciplining nurse for leaving hospital during nursing shortage without arranging for coverage).

¹⁹ See N.Y. CIV. RIGHTS LAW § 79-i.

²⁰ See N.Y. COMP. CODES R. & REGS. tit. 10, § 405.9(b)(10) (“No hospital shall be required to admit any patient for the purpose of performing an induced termination of pregnancy, nor shall any hospital be liable for its failure or refusal to participate in any such act, provided that the hospital shall inform the patient of its decision not to participate in such an act or acts. The hospital in such event shall inform the patient of appropriate resources for services or information.”).

²¹ See New York State Emergency Medical Services Reform Act (EMSRA), N.Y. PUB. HEALTH LAW § 2805-b; see also Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd.

law, the Women’s Health and Wellness Act (WHWA),²² which requires employers who offer prescription drug coverage to cover prescription contraceptives. The WHWA was “designed to advance both women’s health and the equal treatment of men and women.”²³ Before the passage of contraceptive equity laws in states across the country, only half of the nation’s employer-based prescription drug plans covered any prescription contraceptives, and only one-third covered oral contraceptives.²⁴ Moreover, women paid 68% more than what men paid for out-of-pocket health care expenses overall.²⁵ The WHWA was intended to decrease this disparity by improving access to contraception, thus decreasing rates of unplanned pregnancy, abortion, and associated health risks, and to further women’s ability to participate equally in the economy, the workplace, and society as a whole.

In 2006, the WHWA was upheld by the New York State Court of Appeals, New York’s highest court, against legal challenge by religiously-affiliated hospitals and charity organizations that claimed that the law violated their religious beliefs.²⁶ The Court of Appeals held that the State has a “substantial interest in fostering equality between the sexes, and in providing women with better health care . . . [and an] absence of contraceptive coverage for many women was seriously interfering with both of these important goals.”²⁷ Moreover, the Court of Appeals held that the WHWA did not unreasonably interfere with the plaintiffs’ exercise of their religion and it was therefore constitutionally sound.²⁸ To the extent that this regulation permits institutions broad refusal rights with respect to contraception, as well as abortion, this regulation invites that issue to be litigated all over again.

New York was also one of the first states to require hospital emergency rooms to offer emergency contraception (“EC”) to sexual assault survivors. The New York Legislature found that “the victimization of women through rape is compounded by the possibility that the rape survivor may suffer an unwanted pregnancy by the rapist . . . [and] access to emergency contraception and timely counseling are simple, basic measures that can prevent this additional victimization.”²⁹ The Legislature therefore found it “essential that all hospitals that provide emergency medical treatment provide emergency contraception as a treatment option to any woman who seeks treatment” for sexual assault.³⁰

Under the proposed regulations, hospitals could fail to counsel or provide a woman with any information at all about the medical option to prevent pregnancy with

²² 2002 N.Y. Laws Ch. 554.

²³ *Catholic Charities of Diocese of Albany v. Serio*, 7 N.Y.3d 510, 518 (2006).

²⁴ Adam Sonfield, Rachel Benson Gold, Jennifer J. Frost & Jacqueline E. Darroch, *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates*, 2002, 36 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 72, 72-73 (2004).

²⁵ *Catholic Charities*, 7 N.Y. 3d at 519.

²⁶ *Id.* at 527.

²⁷ *Id.* at 528.

²⁸ *Id.*

²⁹ 2003 N.Y. Laws Ch. 625.

³⁰ *Id.*

emergency contraception—an option they may not be aware of. Even assuming she is aware of that option, a woman who has been raped should not be forced to go to a different health care provider to prevent pregnancy. In addition to the emotional burden imposed by such a delay, the risk that a victim will become pregnant increases the longer a woman is forced to wait to take EC. Unfortunately, in some instances, a rape victim that is refused EC by her hospital or health care facility may be unable to obtain EC at all. The Department should not promulgate regulations that undermine the enforcement of laws established to ensure comprehensive care to rape survivors.

By raising the question of whether enforcement of these laws against an institution that refuses to comply on religious grounds would be considered prohibited “discrimination,” the proposed regulation threatens to undermine important steps New York has taken in protecting women’s reproductive freedom. Undermining New York’s ability to enforce these laws would severely compromise the state’s ability to further the health and equality of all of its women.

5. Confusing and Undefined Terms Will Result in Diminished Access to Care

The proposed rule, which purports to educate the public and health care providers about existing federal conscience protections, will cause more confusion than it will provide clarification. The provisions contain numerous different obligations, each of which applies to different types of entity and institution. The failure to define key terms, including the term “discrimination,” makes it difficult, if not impossible, for covered entities to understand what is necessary for compliance. This uncertainty, coupled with the enormous amount of federal funding that is tied to compliance, makes it likely that entities subject to the regulation will adopt the broadest possible interpretation in order to reduce the risk of violation—thus significantly diminishing patients’ access to care.

* * * *

Since 1965, when the U.S. Supreme Court first protected a woman’s access to contraception, maternal and infant mortality rates have declined. In fact, the Centers for Disease Control and Prevention has declared family planning one of the ten most significant public health achievements of the 20th century.³¹ The reasons are simple: without contraception, women have more unplanned pregnancies and are less likely to obtain adequate and timely prenatal care. Access to contraception is also essential to women’s equality and autonomy, allowing women to make educational, employment and life choices that benefit themselves and their families.

However, if the proposed rule is extended to cover contraception it would undermine these important goals, and could lead to potentially disastrous public health consequences. Because the regulation impacts publicly-funded clinics, it targets the most

³¹ Centers for Disease Control and Prevention, *Ten Great Public Health Achievements – United States 1900 – 1999*, 48(12) MMWR 241-43 (1999), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm>.

vulnerable Americans—low income women, young women, and immigrant women. Without the contraceptive services provided at such clinics, there would be 46 percent more unintended pregnancies (1.4 million more) annually in the United States.³² Providing an end run around state laws that protect access to contraception would further compound this problem. Unintended pregnancy leads to higher rates of abortion, infant mortality, low birth weight, and maternal health complications during pregnancy. The cost of denying women access to critical services and information is too high, in terms of the impact on both individual women’s lives and society at large.

The proposed regulation also implicates a host of other health care services, including end-of-life care, HIV/AIDS counseling and treatment, reproductive technology and fertility treatments, and post-sexual assault care. This concern is heightened for individuals who already are subject to discrimination in the delivery of health care, such as unmarried couples, single individuals, people living with HIV/AIDS, and LGBT individuals.

At a time when the nation is in a health care crisis and Americans are struggling with soaring health care costs, the government should focus on increasing access to these critical prevention programs, not undermining it. We therefore request that the proposed regulation be withdrawn.

Sincerely,



Galen Sherwin,
Director, NYCLU Reproductive Rights Project

³² See Guttmacher Institute, *Facts on Publicly Funded Contraceptive Services in the United States*, *supra* note 14.