



State of California
Office of the Attorney General

XAVIER BECERRA
ATTORNEY GENERAL

February 18, 2020

Via e-filing at www.regulations.gov

Secretary Alex Azar
U.S. Department of Health & Human Services
Hubert H. Humphrey Building, Room 514-G
200 Independence Avenue SW
Washington, DC 20201

RE: Comments on Proposed Rule, “Ensuring Equal Treatment of Faith-Based Organizations,”
85 Fed. Reg. 2974 (Jan. 17, 2020); RIN 0991-AC13

Dear Secretary Azar:

The undersigned State Attorneys General of California, Connecticut, Delaware, the District of Columbia, Hawai‘i, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Vermont, Virginia, Washington, and Wisconsin (the States) submit these comments in opposition to the proposed rule: “Ensuring Equal Treatment of Faith-Based Organizations,” (“Proposed Rule”). The Proposed Rule seeks to roll back critical patient protections established in 2016, which guaranteed transparency when patients received services from faith-based providers and ensured that those patients understood the parameters of their rights. *See* 81 Fed. Reg. 19,355 (April 4, 2016). The U.S. Department of Health & Human Services’s (HHS) Proposed Rule places providers over patients by eliminating requirements that faith-based health and social service providers receiving federal funds notify patients of their rights and protections. Further, these providers are no longer required to refer patients to alternative providers upon request by the patient. The Proposed Rule also redefines the term “indirect Federal financial assistance,” making it easier for faith-based organizations to promote religion using federal healthcare dollars. These changes will inflict harm on the States and their residents—particularly lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) individuals, women, especially women of color, and lower-income patients—who already disproportionately face discrimination in the healthcare setting and experience barriers to accessing care.

While the Proposed Rule maintains that patients cannot be discriminated against for not holding the same religious beliefs as a provider, or for seeking counseling and care that the provider may object to, removing notice and referral requirements disempowers patients,

needlessly erects barriers to healthcare, and limits access to complete, accurate, and impartial information.

We respectfully request you withdraw the Proposed Rule.

I. The Proposed Rule Will Harm the States' Residents, Particularly Women, LGBTQ, and Lower-Income Patients

The Proposed Rule fails to safeguard the rights of women, LGBTQ, and lower-income individuals, who already disproportionately face barriers to care, particularly when it comes to obtaining accurate information about their healthcare and referrals. The receipt of accurate and impartial information from providers is vital to a patient's health, and could make the difference between life and death.¹ And the ability to obtain a referral should the patient desire, or need, to seek care from a different provider is not only an ethical imperative, it is part of the duty of care providers owe to patients, even where providers have a conscience objection.² Patients must feel

¹ Prior HHS rulemaking has acknowledged this. *See* 84 Fed. Reg. 7783 (March 4, 2019) (“[O]pen communication in the doctor-patient relationship would foster better over-all care for patients.”); *see also* Wendy Chavkin et al., *Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences’ and Policy Responses*, 123 *Int’l J. Gynecol. & Obstet.*, S41, S46, S48 (2013) (refusal to provide abortion-related services and contraception led to increased maternal and infant morbidity and mortality); Shabab Ahmed Mirza et al., *Discrimination Prevents LGBTQ People From Accessing Health Care*, Center for American Progress (January 18, 2018), <https://www.americanprogress.org/issues/lgbtq-rights/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/>.

² *See, e.g.*, American Medical Association, *Code of Medical Ethics Opinions 1.1.7 and 1.2.3*, <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf> (“In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.” and “Physicians’ fiduciary obligation to promote patients’ best interests and welfare can include consulting other physicians for advice in the care of the patient or referring patients to other professionals to provide care.”); American College of Obstetricians and Gynecologists, *Code of Professional Ethics*, p. 3, <https://www.acog.org/About-ACOG/ACOG-Departments/Committees-and-Councils/Volunteer-Agreement/Code-of-Professional-Ethics-of-the-American-College-of-Obstetricians-and-Gynecologists?IsMobileSet=false> (“The obstetrician–gynecologist should consult, refer, or cooperate with other physicians, health care professionals, and institutions to the extent necessary to serve the best interests of their patients.”); American College of Obstetricians and Gynecologists, *Committee Opinion No. 385* (Nov. 2007, reaffirmed 2019), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine?IsMobileSet=false> (“Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.”); *see also* Kinsey Hasstedt, *Unbiased*

confident that their provider is offering all relevant information necessary for their wellbeing.³ Yet, the Proposed Rule would eliminate the requirement that faith-based organizations receiving HHS funding provide referrals. *See* 85 Fed. Reg. 2982 (proposing to delete 45 C.F.R. §§ 87.3(j)–(k)).

The Proposed Rule also dispenses with faith-based organizations’ notice obligations. Under the Proposed Rule, faith-based providers will no longer be required by federal law to notify patients of:

- The patient’s right to a referral, should he or she object to the religious character of the organization,
- The patient’s right to be free from discrimination based on his or her religious belief (or his or her refusal to hold a religious belief),
- The patient’s right to refuse to attend or participate in any explicitly religious activities,
- Faith-based organizations’ duty to separate in time and location any privately-funded, explicitly religious activities (e.g., worship, religious instruction, proselytization), and
- The patient’s right to report any violation of these protections to the HHS awarding entity.

See 85 Fed. Reg. 2982 (proposing to delete 45 C.F.R. §§ 87.3(i)(1)(i)–(v)). These notices are not mere “administrative burdens,” they are vital protections that safeguard the rights of patients, particularly women and LGBTQ patients, who have historically faced discrimination and inequity in the healthcare field.

A. The Proposed Rule Will Harm Women, Particularly Women of Color

Removing notice and referral requirements will adversely impact women seeking reproductive care, including abortion, especially given the recent uptick in federal funding

Information on and Referral for All Pregnancy Options Are Essential to Informed Consent in Reproductive Health Care, Guttmacher Institute (Jan. 2018), <https://www.guttmacher.org/gpr/2018/01/unbiased-information-and-referral-all-pregnancy-options-are-essential-informed-consent>.

³ Particularly in the family planning context, extensive research in the field of family planning counseling demonstrates that women want to be supported by family planning staff, but that they have the opportunity to make their own decision based upon information provided by their providers. *See* Edith Fox et al., *Client Preferences for Contraceptive Counseling: A Systematic Review*, 55 Am. J. Preventive Med. 691 (2018); Karen Pazol et al. *Impact of Contraceptive Education on Knowledge and Decision Making: An Updated Systematic Review*, 55 Am. J. Preventive Med. 703 (2018).

supporting religiously-affiliated family planning organizations.⁴ Indeed, religiously affiliated so-called “crisis pregnancy centers” (CPCs) are now the recipients of significant amounts of federal funding from HHS. For example, on March 29, 2019, HHS granted Obria and its network of crisis pregnancy centers \$5.1 million in Title X funds.⁵ But, while access to a wide range of contraceptive methods is crucial for women’s reproductive health,⁶ CPCs often limit family planning counseling and options.⁷ Although CPCs market themselves as full scope healthcare clinics, in reality, they typically only offer limited healthcare services such as ultrasounds, pregnancy tests, and testing for sexually transmitted infections (STIs), to the exclusion of

⁴ The Title X program funds healthcare providers throughout the country to support preventive care, including critical reproductive healthcare. On March 4, 2019, HHS published a final rule that restricts access to critical preventive healthcare and prohibits doctors from providing accurate information to patients and referrals for abortion, disrupts the provider-patient relationship, and disproportionately affects communities of color. *See* 84 Fed. Reg. 7714 (Mar. 4, 2019). Since HHS announced that the Title X rule is in effect, Title X recipient the State of Illinois and fifteen sub-recipients of Title X funding operating 149 clinic sites in California have withdrawn from the Title X program. *See Essential Access Health, Inc., et al. v. Azar, et al.*, No. 3:19-cv-01195-EMC, Dkt. No. 135 at ¶ 7 (N.D. Cal. Jan. 23, 2020) (listing agencies that have withdrawn from the Title X program); Office of the Governor, *State of Illinois Refuses to Implement the Trump Administration’s Title X Gag Rule*, (July 18, 2019), <https://www2.illinois.gov/Pages/news-item.aspx?ReleaseID=20325>. Two grantees and 54 sub-recipients, operating 186 clinic sites, in New York have also withdrawn from the Title X program. *Compare Oregon, et al. v. Azar, et al.*, No. 6:19-cv-00317-MC, Dkt. No. 46 at ¶ 4 (declaration on behalf of grantee Public Health Solutions listing number of sub-recipients and sites) & Dkt. No. 66 at ¶ 15 (declaration on behalf of grantee New York State Department of Health listing same) (D. Or. Mar. 21, 2019); *with* Title X Family Planning Directory (January 2020) *available at* <https://www.hhs.gov/opa/sites/default/files/Title-X-Family-Planning-Directory-January2020.pdf> (listing only two New York grantees: Beacon Christian Community Health Center and The Floating Hospital, Inc. with no sub-recipients or service sites).

⁵ Kenneth P. Vogel and Robert Pear, *Trump Administration Gives Family Planning Grant to Anti-Abortion Group*, N.Y. Times (Mar. 29, 2019), <https://www.nytimes.com/2019/03/29/us/politics/trump-grant-abortion.html>.

⁶ U.S. Centers for Disease Control and Prevention, *Providing Quality Family Planning Services*, 63:4 Morbidity & Mortality Wkly. Rep. (Apr. 25, 2014), <https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf> (“The report . . . emphasizes offering a full range of contraceptive methods for persons seeking to prevent pregnancy . . . in accordance with the recommendations for women issued by the Institute of Medicine and adopted by HHS.”).

⁷ Maggie Jo Buchanan et al., *The Anti-Choice Movement’s Continued Pursuit of Politicized Medicine*, Center for American Progress (Mar. 14, 2018) <https://www.americanprogress.org/issues/women/reports/2018/03/14/447885/anti-choice-movements-continued-pursuit-politicized-medicine/> (collecting examples of CPCs providing misleading information to pregnant women and refusing to provide certain reproductive health services).

providing contraception and abortion care.⁸ CPCs have been known to offer misleading information to patients in order to discourage them from obtaining abortions.⁹ In terms of referrals, most explicitly do not provide referrals for abortion, tend to avoid discussion of contraception, and dismiss the role of condoms in preventing STIs.¹⁰ CPCs have also been reported to target women of color because of the higher than average rates of abortion among their demographic. The reason for these higher rates further demonstrates why the Proposed Rule will disproportionately affect women in minority communities: Abortion rates are directly tied to unintended pregnancy rates, which are high among women of color due to the barriers they face in accessing high quality contraceptive services and the difficulties of using their chosen method of birth control consistently, and effectively, over long periods of time.¹¹

This surge in federal funding for CPCs, combined with the Proposed Rule's removal of crucial notice and referral requirements, would exacerbate the deceptive practices by CPCs to the detriment of women seeking reproductive counseling. In the context of women's health decisions, and in particular with respect to a woman's decision about whether to carry to full term or terminate a pregnancy, obtaining complete and honest healthcare information is critical *and* time-sensitive. In healthcare, information can "save lives," *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011), permit "alleviation of physical pain," *Va. State Bd. Of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 763-64 (1976), and enable people to act in "their own best interest," *Sorell*, 564 U.S. at 578 (quoting *Va. State Bd. of Pharmacy*, 425 U.S. at 770). Such medical information allows women to take control of their most "intimate and personal choices . . . central to personal dignity and autonomy." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992) (plurality op.).

Removing the referral requirement will create an additional barrier to the provider-patient relationship, as women will not be able to either obtain the care they need or make an informed decision about their healthcare condition and options. For example, timely access to emergency contraception is crucial to survivors of sexual assault, such that many states have made it a

⁸ Amy G. Bryant et al., *Why Crisis Pregnancy Centers Are Legal but Unethical*, AMA Journal of Ethics (May 2018), <https://journalofethics.ama-assn.org/article/why-crisis-pregnancy-centers-are-legal-unethical/2018-03>; Joanne D. Rosen, *The Public Health Risks of Crisis Pregnancy Centers*, Guttmacher Institute (September 10, 2012), <https://www.guttmacher.org/journals/psrh/2012/09/public-health-risks-crisis-pregnancy-centers>.

⁹ United States House of Representatives Committee on Government Reform—Minority Staff Special Investigations Division, *False and Misleading Health Information Provided by Federally Funded Pregnancy Resource Centers* (2006), <https://web.archive.org/web/20170320194302/http://www.chsourcebook.com/articles/waxman2.pdf>.

¹⁰ Bryant, *supra* note 8.

¹¹ National Women's Law Center, *Crisis Pregnancy Centers are Targeting Women of Color, Endangering Their Health*, Fact Sheets (March 6, 2013), <https://nwlc.org/resources/crisis-pregnancy-centers-are-targeting-women-color-endangering-their-health/>.

requirement by law.¹² Yet, the Proposed Rule seeks to permit faith-based organizations who do not provide contraception to abstain from providing such a referral, adding delays that could result in negative health consequences or unintended pregnancy.

B. The Proposed Rule Will Harm LGBTQ Patients

In the healthcare setting, it is well documented that LGBTQ individuals face discrimination.¹³ LGBTQ individuals report experiencing barriers to receiving medical services, including disrespectful attitudes, discriminatory treatment, inflexible or prejudicial policies, and even outright refusals of essential care, leading to poorer health outcomes and often serious or even catastrophic consequences.¹⁴ Transgender people in particular report hostile and/or disparate treatment from providers.¹⁵ More broadly, LGBTQ individuals experience worse physical health compared to their heterosexual and non-transgender counterparts,¹⁶ have higher

¹² See Cal. Penal Code § 13823.11(e) (requiring health care providers give female survivors of sexual assault the option of postcoital contraception); Cal. Health & Safety Code § 1281 (requiring hospitals to adopt protocol for immediate referral of survivors of sexual assault to a local hospital that can comply with provisions of Cal. Penal Code § 13823.11); N.Y. Pub. Health Law § 2805-p (McKinney 2008) (requiring hospitals providing emergency treatment to provide emergency contraception to rape survivors upon request); see also generally National Women’s Law Center, *Providing Emergency Contraception to Sexual Assault Survivors: Elements of a Successful State EC in the ER Law*, Fact Sheet (June 2013), https://nwlc.org/wp-content/uploads/2015/08/providing_ec_to_sexual_assault_survivors_factsheet_6-28-13.pdf.

¹³ See Human Rights Watch, “All We Want Is Equality”: Religious Exemptions & Discrimination Against LGBT People in the United States 20-26 (2018), https://www.hrw.org/sites/default/files/report_pdf/lgbt0218_web_1.pdf (providing numerous examples); see also American Medical Association, *Advocating for the LGBTQ Community*, <https://www.ama-assn.org/delivering-care/population-care/advocating-lgbtq-community> (last visited Feb. 7, 2020) (collecting issue briefs on discrimination against LGBTQ patients); Patrick M. O’Connell, American Academy of Pediatrics, *Policy offers recommendations for care of LGBTQ youth* (July 2013), <https://www.aappublications.org/content/aapnews/34/7/22.1.full.pdf>.

¹⁴ Lambda Legal, *When Health Care Isn’t Caring: Lambda Legal’s Survey on Discrimination Against LGBT People and People Living with HIV* at 5–7 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf; see also Jennifer Kates, et al., Kaiser Family Found., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S.* (May 3, 2018), <https://www.kff.org/report-section/health-and-access-to-care-and-coverage-lgbt-individuals-in-the-us-health-challenges/>.

¹⁵ Nat’l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* at 97 (2016), <http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf>; see also Kates, *supra* note 14.

¹⁶ Kates, *supra* note 14, at 5.

rates of chronic conditions,¹⁷ and are at higher risk for certain mental health and behavioral health conditions, including depression, anxiety, and substance misuse.¹⁸ LGBTQ youth, in particular, report a greater incidence of mental health issues and suicidal behaviors, suffer bullying and victimization to a greater extent than heterosexual youth, and have difficulty addressing concerns related to their sexual identity with their medical providers.¹⁹

The Proposed Rule will only exacerbate these health disparities. Excusing faith-based organizations from notifying patients of their rights and providing referrals will particularly disadvantage LGBTQ patients who may seek services from faith-based organizations for mental health services²⁰, addiction counseling²¹, or screening for STIs, including HIV. The Proposed Rule has the potential to undermine the U.S. Centers for Disease Control and Prevention's (CDC) national strategy for ending the HIV epidemic in the United States. Early diagnosis and treatment are "key strategies" in the CDC's national HIV strategy.²² As such, removing the notice and referral requirements not only needlessly create barriers to LGBTQ patients obtaining diagnosis and treatment, it fuels a potential public health risk.

LGBTQ patients already tend to avoid seeking care out of fear of discrimination.²³ Any deterrent, including refusal to provide a referral, would further discourage LGBTQ patients from

¹⁷ *Id.*

¹⁸ *Id.* at 8.

¹⁹ Hudaisa Hafeez et al., *Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review*, Cureus (April 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5478215/>.

²⁰ "Research suggests that sexual minorities (e.g., people who identify as lesbian, gay, or bisexual) are at greater risk for substance use and mental health issues compared with the sexual majority population that identifies as being heterosexual." Grace Medley et al., *SAMHSA, Sexual Orientation and Estimates of Adult Substance Use and Mental Health: Results from the 2015 National Survey on Drug Use and Health*, NSDUH Data Review (October 2016), [https://www.samhsa.gov/data/sites/default/files/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015.pdf](https://www.samhsa.gov/data/sites/default/files/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015.pdf).

²¹ National Institute on Drug Abuse, *Substance Use and SUDs in LGBTQ Populations* (September 5, 2017), <https://www.drugabuse.gov/related-topics/substance-use-suds-in-lgbtq-populations> ("Surveys thus far have found that sexual minorities have higher rates of substance misuse and substance use disorders (SUDs) than people who identify as heterosexual.").

²² See HIV.gov, *What is 'Ending the HIV Epidemic: A Plan for America'?* (December 3, 2019), <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>; see also State of California Office of the Attorney General, *Response to Request for Information (RFI): Developing an STD Federal Action Plan* (June 3, 2019), <https://oag.ca.gov/system/files/attachments/press-docs/6-3-2019-ltr-secretary-alex-azar-response-request-action-std-plan.pdf>.

²³ See, e.g., Mirza, *supra* note 1 ("The 2015 U.S. Transgender Survey found that nearly 1 in 4 transgender people (23 percent) had avoided seeking needed health care in the past year due to fear of discrimination or mistreatment due to their gender identity.").

seeking necessary care. Obtaining referrals to providers is particularly crucial for LGBTQ patients because of the shortage of LGBTQ-friendly healthcare providers that can properly serve this population, particularly in rural areas where such providers are fewer and far between.²⁴

C. The Proposed Rule Will Harm Lower-Income Patients and Lead to Direct Costs on the States

Finally, the Proposed Rule will disproportionately harm lower-income patients.²⁵ As previously acknowledged by HHS, patients with lower incomes already face prohibitive barriers to accessing care, such as affordability.²⁶ The Proposed Rule would only exacerbate these obstacles. Patients with lower incomes typically have lower health literacy levels.²⁷ The Proposed Rule permits the withholding of information, making it even more difficult for these patients to navigate an already complicated healthcare system. Moreover, any roadblock on the way to receiving care is aggravated for lower-income patients. For example, getting to a medical appointment can require monumental efforts from lower-income patients, who must often obtain time off from work, arrange childcare, and use public transportation.²⁸ Being denied a referral to medically necessary services would further impede access to care for these patients, leading to lower health outcomes.

By eliminating protections necessary to improve access to adequate healthcare to women, LGBTQ patients, and lower-income patients, the Proposed Rule will decrease access to health services, thus imposing significant costs on the States. As already discussed above, denying access to health services will negatively affect public health. Moreover, individuals denied coverage and healthcare as a result of discrimination will turn to government-funded programs that act as both providers and insurers of last resort. This includes care provided at public

²⁴ *Id.* (“A total of 13 states—mainly those in the central United States—do not have any LGBTQ community health centers.”).

²⁵ Title X clients, for example, are among the nation’s most vulnerable populations: Two-thirds have incomes at or below the federal poverty level, nearly half are uninsured, and another 35% have coverage through Medicaid and other public programs. Kinsey Hasstedt, *Why We Cannot Afford to Undercut the TitleX National Family Planning Program*, Guttmacher Institute (May 17, 2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2002017.pdf.

²⁶ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Financial Condition and Health Care Burdens of People in Deep Poverty* (July 16, 2015), <https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>.

²⁷ American Hospital Association, *Transportation and the Role of Hospitals* (Nov. 2017), <https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/sdoh-transportation-role-of-hospitals.pdf>.

²⁸ *Id.*; Corinne Lewis et al, *Listening to Low-Income Patients: Obstacles to the Care We Need, When We Need It*, The Commonwealth Fund, <https://www.commonwealthfund.org/blog/2017/listening-low-income-patients-obstacles-care-we-need-when-we-need-it>.

healthcare facilities and paid for through State-funded programs, including Medicaid. Finally, the Proposed Rule also fails to account for increased costs to state regulatory agencies from an uptick in complaints alleging discrimination in healthcare. This will be particularly true in States that have civil rights laws and regulations that explicitly prohibit discrimination on the basis of gender identity and sexual orientation in healthcare. *See, e.g.*, Cal. Gov't Code § 11135; 775 ILCS 5/1-103(O-1); 775 ILCS 5/5-102.1(a); M.G.L. c. 272, § 98; N.J. Stat. Ann. § 10:5-12(f).

II. The Proposed Rule is Contrary to Law

The Administrative Procedure Act (APA) requires a reviewing court to “hold unlawful and set aside agency action” that is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” 5 U.S.C. § 706(2)(A). “[N]ot in accordance with law” . . . means, of course, *any* law, and not merely those laws that the agency itself is charged with administering.” *F.C.C. v. NextWave Pers. Commc’ns Inc.*, 537 U.S. 293, 300 (2003) (emphasis in original); *see Michigan v. E.P.A.*, 268 F.3d 1075, 1081 (D.C. Cir. 2001) (noting agency’s power to promulgate legislative regulations is limited to the authority delegated to it by Congress).

A. Removing the Referral Requirement Flies in the Face of the Nondirective Pregnancy Counseling Mandate

The Proposed Rule violates Congress’s nondirective mandate. In appropriations bills since 1996, Congress has mandated that “all pregnancy counseling” in Title X family planning projects “shall be nondirective.” Omnibus Consolidated Rescissions and Appropriations Act of 1996, PL 104–134, April 26, 1996, 110 Stat 1321; *see, e.g.*, Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, PL 115-245, September 28, 2018, 132 Stat 2981, Div. B, Tit. II, 132 Stat 2981, 3070–71 (2018); Further Consolidated Appropriations Act, 2020, PL 116-94, 133 Stat 2534 (2019). This accords with the statutory requirement that all Title X grants support only “voluntary family planning projects,” 42 U.S.C. § 300, *see also* Pub. L. 115-245, 132 Stat. at 3070-71 (reiterating the “voluntary” nature of services in setting forth the nondirective mandate).

Here, the Proposed Rule allows providers to opt out from providing *any* referrals to patients. Yet, HHS explicitly does not prohibit providers from making referrals, should they so choose. 85 Fed. Reg. 2983 (clarifying that “nothing in this proposed rule would prevent a faith-based social service provider from making . . . a referral” to an alternative provider). This would permit a scenario where a faith-based provider chooses to give referrals for prenatal services while refusing to refer for contraception or abortion. Counseling is only nondirective if the medical professional is not suggesting or advising one option over another.²⁹ 84 Fed. Reg. 7716

²⁹ Statute, regulations, industry practice, and HHS’s own “Quality Family Planning” recommendations all state that referrals are part of counseling. *See State v. Azar*, 385 F. Supp. 3d 960, 988-91 (N.D. Cal. 2019); *see also Louisiana Pub. Serv. Comm’n v. F.C.C.*, 476 U.S. 355, 357 (1986) (articulating “the rule of construction that technical terms of art should be interpreted by reference to the trade or industry to which they apply”) (citing *Corning Glass Works v.*

(March 9, 2019). When faith-based providers willingly provide referrals for certain services, but refuse to provide referrals for others—like abortion or to obtain contraception—this omission of safe, legal, and relevant medical options flies in the face of the nondirective mandate.

B. Removing the Referral Requirement Clashes with the Provisions of the Affordable Care Act and the Establishment Clause

By permitting entities to decline to provide information and referrals, the Proposed Rule clashes with several provisions of the Affordable Care Act, most notably section 1554, which prohibits the Secretary of HHS from creating barriers to healthcare, and section 1557, which prohibits discrimination in health programs or activities. 42 U.S.C. §§ 18114, 18116.

The Proposed Rule violates the Establishment Clause by accommodating religious beliefs to such an extent that it places an undue burden on third parties—patients. *See, e.g., Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985); *Cutter v. Wilkinson*, 544 U.S. 709, 722 (2005) (“[A]n accommodation must be measured so that it does not override other significant interests”). The Constitution also prohibits government conduct that, as a primary effect, advances a particular religious practice. When there is no “exceptional government-created burden[] on private religious exercise,” or when the government goes beyond what is needed to alleviate burdens that it, itself, has imposed (*see Cutter*, 544 U.S. at 720), its action crosses the line of permissible religious accommodation and “devolve[s] into ‘an unlawful fostering of religion,’” *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327, 334–35 (1987). There is no substantial burden here, *see supra* Section III(A), yet the Proposed Rule seeks to unlawfully foster the religious views of some over the lives of patients and the public health.

III. The Proposed Rule is Arbitrary and Capricious Because It Eliminates Critical Patient Protections Without Adequate Justification

HHS offers several justifications for why, despite the harm that will follow, the Proposed Rule must (1) eliminate the referral requirement, (2) eliminate the notice requirement, and (3) revise the definition of “indirect Federal financial assistance.” None, however, is adequate.

A. Referral Requirement

i. First Amendment Law, RFRA, and the Attorney General Memorandum Do Not Justify the Proposed Rule

HHS justifies the removal of the referral requirement as necessary to bring the regulations into accord with recent Supreme Court decision *Trinity Lutheran Church of Columbia, Inc. v. Comer*, 137 S. Ct. 2012 (2017), the requirements under the Religious Freedom Restoration Act (RFRA), and the Attorney General’s Memorandum for All Executive

Brennan, 417 U.S. 188, 201–02 (1974)); *Alabama Power Co. v. E.P.A.*, 40 F.3d 450, 454 (D.C. Cir. 1994) (“[W]here Congress has used technical words or terms of art, it is proper to explain them by referring to the art or science to which they are appropriate.”).

Departments and Agencies, “Federal Law Protections for Religious Liberty,” 82 Fed. Reg. 49,668 (October 26, 2017) (“AG Memo”).

As to the *Trinity* decision, HHS argues that because the alternative provider requirement applies to faith-based organizations, it is treating faith-based providers unequally based on religion in violation of the Free Exercise Clause. 85 Fed. Reg. 2976. However, the policy at issue in *Trinity* explicitly disqualified churches and other religious organizations from receiving grants under a playground resurfacing program, thus requiring religious organizations to essentially “disavow” their religious character in order to qualify for the benefit. 137 S. Ct. at 2021–22. The Court held that this violated the Free Exercise Clause. Here, by contrast, the referral requirement does not categorically disqualify faith-based organizations from receiving a benefit, it merely ensures that patient interests are also considered. The referral requirement, further, does not require disavowal of an organization’s religious character. The referral requirement merely requires that faith-based organizations provide accurate medical information to a patient who does not agree with the organization’s religious beliefs, or who may need a level of care that extends beyond the services provided by the organization. This is a far cry from the explicit exclusion of faith-based organizations at issue in *Trinity*.

In the same vein, HHS contends that requiring a referral be provided to a patient upon request is a “substantial burden” to the exercise of religion under RFRA. *See* 42 U.S.C. 2000bb-1(a). But HHS offers no reason for concluding that referring a patient to another provider imposes a *substantial* burden on the exercise of religion. A “‘substantial burden’ is imposed [] when individuals are . . . coerced to act contrary to their religious beliefs by the threat of civil or criminal sanctions . . .” *Navajo Nation v. U.S. Forest Serv.*, 535 F.3d 1058, 1070 (9th Cir. 2008). Providers who refuse to refer risk not qualifying for the receipt of federal funds, but they are certainly not coerced “by the threat of civil or criminal sanctions.” *Id.*

Moreover, eliminating the referral requirement would impose substantial harm on third parties by limiting the care options available to patients. And, courts typically do not permit discrete groups of citizens to be singled out to bear the costs of another’s religious exercise. For example, in a Free Exercise case, the Court rejected religious claims that would “impose the employer’s religious faith on the employees.” *United States v. Lee*, 455 U.S. 252, 260–61 (1982) (refusing to exempt Amish employer and his employees from social security taxes). Conversely, courts have invoked the Establishment Clause to invalidate accommodations which “would require the imposition of significant burdens on other employees . . .” *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 710 (1985) (invalidating Connecticut statute which gave Sabbath observers an absolute and unqualified right not to work on the Sabbath). The Proposed Rule completely fails to acknowledge that patients’ care will be delayed or denied if providers do not refer patients upon request. HHS’s failure to take into account this third-party harm is unlawful. *Burwell v. Hobby Lobby*, 573 U.S. 682, 729 n.37 (2014) (explaining that “courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries”).

HHS’s reliance on the AG Memo to justify the Proposed Rule is also misplaced. The AG Memo at issue was released by the Attorney General on October 6, 2017 under the direction of President Trump’s Executive Order 13798. The AG Memo lists 20 principles of religious liberty

and includes interpretive guidance of federal law protections for religious liberty. Whether an Attorney General memorandum is binding on executive agencies “is not a settled issue of law.” *County of Santa Clara v. Trump*, 267 F. Supp. 3d 1201, 1212 (N.D. Cal. 2017) (holding that the government had not persuasively demonstrated that Attorney General Jeff Sessions’ memorandum interpreting an executive order was binding legal opinion); *see also City of Seattle v. Trump*, 2017 WL 4700144, at *5 (W.D. Wash. 2017) (finding that statutes and regulations were “silent on whether such advice [from the Attorney General] would bind other agencies”). HHS not only relies on the AG Memo as justification to change the 2016 Rule, in revising the regulations, it seeks to include explicit references to the AG Memo. *See* 85 Fed. Reg. 2976, 2986 (to be codified at Section 87.3(a) and note 1 to Section 87.3(c)). Because Attorney General memoranda have questionable legal authority, baking references to such memoranda directly into the proposed regulations confers undue authority to the AG Memo, and will cause unnecessary confusion.

ii. The Regulatory Impact Analysis Does Not Adequately Consider Patient Harm

The Proposed Rule is also arbitrary and capricious because it fails to consider the evidence before it and fails to justify the change. HHS notes that the Proposed Rule’s overall economic impact will be “de minimis.” 85 Fed. Reg. 2983. While HHS acknowledges an “opportunity cost” of finding an alternative provider that will be “borne by beneficiaries who request such a referral, but who do not receive one,” HHS summarily dismisses this concern. *Id.* (“However, nothing in this proposed rule would prevent a faith-based social service provider from making such a referral.”). That a provider is not prevented from making a referral does not mean that the provider will make a referral, as demonstrated by the pervasiveness of denials of care to LGBTQ patients and women seeking reproductive services. *See supra* Section I. HHS’s circular reasoning acknowledges, yet fails to adequately consider, the harms and costs to patients as a result of not receiving a referral. *Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 42–43 (1983) (failure to consider a key aspect of the problem is arbitrary and capricious).

In concluding that the 2016 Rule’s estimate that providers would receive approximately 1,372 requests for referrals annually was overblown, HHS states that it “is not aware of having received any reports of any providers’ inability to provide referrals to beneficiaries.” 85 Fed. Reg. 2983-84. A provider’s “inability” to give a referral is starkly different from whether patients requested referrals in the first place, much less whether the provider simply refused to give one. The absence of evidence must not be confused with the evidence of absence. *See Sierra Club v. EPA*, No. 15-1487, slip op. 12-13 (D.C. Cir. July 6, 2018). The Proposed Rule does not account for the possibility that, under the Proposed Rule, providers will be empowered to refuse to provide referrals, and disempowered patients will not realize it is within their rights to request one. Moreover, if there is no evidence of “inability” to provide referrals, as HHS states, then presumably the burden on providers to give referrals is low, and the Proposed Rule’s changes are not justified.

B. Notice Requirements

As to the remaining notice requirements, HHS states that there is “no need for prophylactic protections that create administrative burdens on faith-based providers that are not imposed on similarly situated secular providers.” 85 Fed. Reg. 2977. As an initial matter, the Proposed Rule does not explain why secular providers would need to provide such notices, which were put in place to protect patients from coercion along *religious* lines. *See* 80 Fed. Reg. 47,275 (Aug. 6, 2015); 81 Fed. Reg. 19,363. Moreover, the Proposed Rule acknowledges that providing notices and referrals would only require minimal costs. *See* 85 Fed. Reg. 2984 (noting that previous estimations of the costs of adhering to the notice requirements were no more than \$100 per organization per year). Finally, HHS makes no attempt in its Regulatory Impact Analysis to quantify the harms to patients that will flow from the Proposed Rule.

C. Definition of Indirect Federal Financial Assistance

The 2016 Rule clarified the distinction between “direct” and “indirect” federal financial assistance so as to draw a clear division between when a faith-based organization could and could not use federal funding for explicit religious activities such as worship or proselytization. *See* 80 Fed. Reg. 47,274. Programs that receive direct federal financial assistance may not use direct funding to support explicitly religious activities. Programs that receive indirect federal financial assistance, on the other hand, do not have the same limitation because the indirect funding—typically provided to patient beneficiaries in the form of vouchers or certificates—places the choice of service provider in the hands of the beneficiary, not the federal government. In defining “indirect Federal financial assistance” in the 2016 Rule, HHS considered the Supreme Court opinion *Zelman v. Simmons-Harris*, 536 U.S. 639 (2002), which required that beneficiaries be given a “true private choice” that offered adequate secular options for beneficiaries to choose from. *See* 80 Fed. Reg. 47,274; 81 Fed. Reg. 19,362. HHS established specific criteria for funding to qualify as “indirect Federal financial assistance:” (1) that the government program that provided the funding was neutral toward religion, (2) that the organization receiving funding was chosen by the beneficiary, not the government, and (3) that the beneficiary had “at least one adequate secular option to choose from” in using his or her voucher or certificate. *See* 45 C.F.R. §§ 87.1(c)(1)(i)–(iii).

The Proposed Rule removes these criteria from the definition of “indirect Federal financial funding,” making it substantially easier for faith-based organizations to use federal funding while simultaneously engaging in explicit religious activities. HHS contends that it must modify the definition of “indirect Federal financial assistance” to comport with *Zelman*. 85 Fed. Reg. 2977. But, HHS does not explain why it is necessary for HHS to re-interpret *Zelman*, when the 2016 Rule explicitly adopted the *Zelman* framework in creating the definition for “indirect federal Financial assistance.” *See* 81 Fed. Reg. 19,361-62; *see also FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009); *Nat’l Cable & Telecomms. Ass’n v. Brand X Internet Servs.*, 545 U.S. 967, 981 (2005) (“Unexplained inconsistency” between agency actions is “a reason for holding an interpretation to be an arbitrary and capricious change.”).

In fact, removing the “secular option” criteria shifts the definition of “indirect Federal financial assistance” further away from the Supreme Court’s reasoning in *Zelman*. In *Zelman*, while 46 of the 56 private schools were religious schools, the fact that certain of the private schools were secular, and that students could also choose to remain in public school, constituted a “true private choice,” and was not a violation of the Establishment Clause. *Zelman*, 536 U.S. at 2469. Here, removal of the secular option requirement permits a scenario where a patient may have *no* secular options on which to expend his or her voucher. This would allow a faith-based organization to use federal funding to encourage, or even require, explicit religious activity, further degrading the mandate that federal funding not be used for explicit religious activity. This would not provide patients with a “true private choice.”

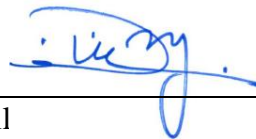
III. Conclusion

The Proposed Rule is symptomatic of the Administration’s continued onslaught on the rights of women and LGBTQ patients in the name of favoring religious providers. Indeed, the Proposed Rule is one of eight total NPRMs issued on January 17, 2020—National Prayer Day—that roll back the referral and notice requirements for faith-based organizations that receive funding from various federal administrative agencies. This latest salvo from HHS ignores research establishing harms that befall patients that are denied referrals, and relies on narrow interpretations of case law and other legal authority that simply cannot support the Proposed Rule’s changes. The consequences—which will include the undermining of public health initiatives—will not only be felt by directly-affected patients, but by the States’ residents as a whole. For these reasons, the States oppose the Administration’s continued unlawful and cruel targeting of vulnerable populations, including women, LGBTQ, and lower-income persons. The States thus urge HHS to withdraw the Proposed Rule.

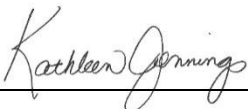
Sincerely,



Xavier Becerra
California Attorney General



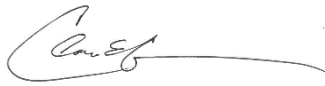
Wil S. Veloso
Connecticut Attorney General



Kathleen Jennings
Delaware Attorney General



Karl A. Racine
Attorney General for the District of Columbia



Clare E. Connors
Hawai'i Attorney General



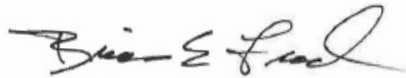
Kwame Raoul
Illinois Attorney General



Tom Miller
Iowa Attorney General



Aaron M. Frey
Maine Attorney General



Brian E. Frosh
Maryland Attorney General



M. Healy
Massachusetts Attorney General



Dana Nessel
Michigan Attorney General



Keith Ellison
Minnesota Attorney General



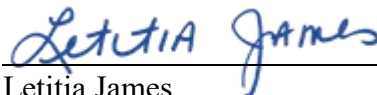
Aaron D. Ford
Nevada Attorney General



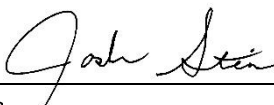
Gurbir S. Grewal
New Jersey Attorney General



Hector Balderas
New Mexico Attorney General



Letitia James
New York Attorney General



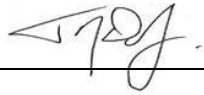
Josh Stein
North Carolina Attorney General



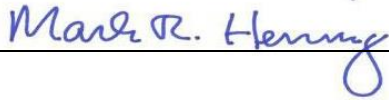
Ellen F. Rosenblum
Oregon Attorney General



JOSH SHAPIRO
Pennsylvania Attorney General



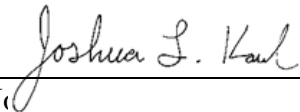
Jr.
Vermont Attorney General



MARK R. HERRING
Virginia Attorney General



BOB FERGUSON
Washington Attorney General



JOSHUA L. KAUL
Wisconsin Attorney General