April 09, 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: Rescission Proposal (RIN 0991-AB49)

Comments of the National Latina Institute for Reproductive Health, the National Asian Pacific American Women's Forum, the Center for Reproductive Rights, and Other Organizations, In Support of the Department of Health and Human Services' Proposal to 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."

Introduction

We, the undersigned organizations write to express our grave concerns about the current 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" ("Regulation") and to express our support for the proposal to rescind the Regulation.[1] Each of our organizations is committed to ensuring that every woman has access to reproductive health care, placing special emphasis on the needs of low-income women and women of color. Although the Regulation has only been in effect for a few months, it is clear that it detrimentally impacts low-income women seeking reproductive health care, and other vulnerable groups, including those seeking end-of-life care, persons affected by HIV/AIDS, and lesbian, gay, bisexual and trans-sexual individuals. In support of the Rescission Proposal, we highlight below some of the serious flaws in the Regulation, focusing primarily on its impact on low-income and minority women.

[1] 45 C.F.R. §§ 88.1-.6 (2009)

The Regulation undermines access to health care in this country. It dramatically expands the reach of federal laws protecting health care workers, rather than simply clarifying and enforcing them. It creates uncertainty in a number of areas, including whether provisions that protect those opposed to abortion services can be relied on to deny certain forms of contraception. The Regulation also creates potential conflicts with other federal laws, including Title VII, which strikes a careful balance between the employees' right to religious freedom, the rights of employers, and the needs of patients. The Regulation allows a broad range of health care workers, including those only tangentially related to the provision of services, to deny information and access to care.

The Regulation's most glaring defect is its failure to address, much less mention, the rights and needs of patients. Instead, the Regulation limits a patient's access to health care, and creates confusion and uncertainty – the problems it will cause for individual patients is nowhere taken into account. Moreover, the cost-benefit analysis included in the Regulation is based on unfounded assumptions and does not even attempt to measure the cost of the Regulation from the "patient" side of the equation.

The Regulation is hopelessly flawed and unnecessary and must be rescinded. Health care providers in this country who entertain religious or moral objections to the provision of certain health care services are already adequately protected by federal law, and are not in need of further protections. On the other hand, low-income women and women of color struggle every day to obtain the health care they need and the Regulation only makes this struggle more difficult. Too much is at stake for the women who will be denied access to critical reproductive health care to continue on this dangerous course set by the Regulation.

The Regulation Should Be Rescinded Because It Undermines Access to Health Care

The Regulation changes three federal laws governing health care refusals in several ways that will negatively impact patients seeking medical treatment and information. The three laws affected by the Regulation are the Church Amendment,[2] the Weldon Amendment,[3] and Section 245 of the Public Health Service Act,[4] all of which already provide comprehensive protection for health care workers who do not want to provide certain services based on their religious beliefs or moral convictions.

A. The Regulation Could Lead to the Denial of Critical Contraception Options

The Regulation creates dangerous uncertainty as to whether health care providers could now rely on federal law permitting conscientious refusals to provide abortion services to deny common forms of birth control, such as the Pill and IUDs. The Department of Health and Human Services ("the Department") created this ambiguity and the Regulation should be rescinded because it fails to clearly address this issue.

[2] 42 U.S.C. §300a-7 (2008).
[3] Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, Div. G, §508(d), 121 Stat. 1844, 2209 (Dec. 26, 2007)
[4] 42 U.S.C. §238(n) (2008).

A preliminary draft of the Regulation included a definition of "abortion" that encompassed methods of contraception which can in some instances prevent implantation of a fertilized egg, such as the birth control pill and IUDs.[5] As a result, under the preliminary draft, health care providers were given explicit permission to refuse to provide these forms of contraception on the grounds that they were equivalent to providing abortion services. In the final Regulation, the definition of "abortion" was removed altogether, creating uncertainty as to the extent to which the Regulation expands current federal refusal laws. The suggestion from the preliminary draft that abortion could include some forms of contraception has opened the door for health care entities and individuals to define abortion expansively as a justification for denying care.

The negative impact of the ambiguity over whether federally funded health care providers can refuse to provide contraceptives falls directly on patients, and specifically on low-income women whose only access to prescription birth control is through federal programs such as Medicaid and Title X. While there are legal and administrative procedures in place that will ultimately determine if a health care provider was within its rights to equate contraception with abortion, those processes will not ameliorate the harm done to individual women who have been denied timely access to the birth control option that best meets their needs.

B. The Regulation Extends the Ability to Deny Services to Those with Minimal Connection to Patient Care

The Regulation extends the right to refuse health services to a broader range of workers than previously permitted, including those who are only tangentially related to the provision of health care. The Regulation defines the term "assist in the performance"[6] for the first time, and also defines some of the terms included in this definition and used elsewhere in the statutes, including, "individual,"[7] "workforce,"[8] and "health service/health service program."[9] In the description of the definition for "assist in the performance," the Department has previously stated that it "seeks to provide broad protection for individuals' consciences," and that it "seeks to

[5] The definition proposed in the preliminary draft was contrary to definitions accepted by both the American Medical Association and the American College of Obstetricians and Gynecologists. *See*, Department of Health and Human Services Proposed Rule at 30; Rachel Benson Gold, Guttmacher Inst., *The Implications of Defining When a Women Is Pregnant*, 8 Guttmacher Rep. on Pub. Pol'y 7-10, 7-8 (May 2005), *available at* http://www.guttmacher.org/pubs/tgr/08/2/gr080207.pdf (*citing* American College of Obstetricians and Gynecologists).

[6] "Assist in the Performance" is defined as "to participate in any activity with a reasonable connection to a procedure, health service or health service program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity. This includes counseling, referral, training, and other arrangements for the procedure, health service, or research activity." Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices In Violation of Federal Law, 45 C.F.R. § 88.2 (2009).

[7] "Individual" is defined as "a member of the workforce of an entity / health care entity." Id.

[8] "Workforce," "includes employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Department-funded entity, is under the control or authority of such entity, whether or not they are paid by the Department-funded entity." Id.

[9] "Health Service / Health Service Program," "includes any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the Department. It may also include components of State or local governments." Id.

avoid judging whether a particular activity is genuinely offensive to an individual."[10] In defining "health service program," the Department has stated that it should be understood to "include an activity related in any way to providing medicine, health care, or any other service related to health or wellness..."[11]

By defining all of these terms broadly, the Regulation expands the protection of the Church Amendment to individuals far outside the scope of those who would have reasonably been considered to provide health services under previous law, such as physicians, physician's assistants, and nurses. These new definitions allow almost any worker in a health care setting to refuse to provide services to a patient based on his or her religious or moral beliefs. Indeed, one of the two examples in the description for the definition of "assist in the performance," is of an employee whose task it is to clean instruments following a particular procedure.[12] The Regulation thus expands the right to refuse to a range of workers performing a variety of services, such as receptionists who make appointments, claim adjustors at health insurance companies, and custodians who work in clinics and hospitals. Under the Regulation, health care institutions could struggle to effectively provide care, and women could be delayed or even prevented from receiving reproductive health care.

The Regulation's extension to the actions of such a broad range of non-medical personnel who "assist in the performance of" objectionable procedures clearly illustrates its lack of consideration for the needs of patients. In no other area of medicine are tangentially related individuals allowed to interfere with the provision of services in a way that may delay or deny health care. The Regulation goes too far in extending the right to deny services to individuals who are marginally related to the medical care being provided. This broad expansion could lead to serious disruptions in care and hamper the ability of health care institutions to meet the needs of patients. Once again, the Regulation tips the balance perilously away from what is best for patients, and for this reason it should be rescinded.

C. Inclusion of Counseling and Referrals in Federal Refusal Laws Could Deny Patients Timely Access to Care and Information Necessary to Make Informed Health Care Decisions

An additional problem, which justifies rescission of the Regulation is its expansive definition of what conduct amounts to "assisting in the performance" of health care services. This definition is critical because federal law allows health care providers to not only refuse to perform objectionable services, but also to refuse to "assist in the performance" of those services. The definition provided in the Regulation states that "assist in the performance" includes "counseling, referral, training, and other arrangements for the procedure, health service or research activity."[13] While referrals are already included in the Weldon Amendment and Section 245 of the Public Health Service Act, the Church Amendment does not currently include

[10] Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices In Violation of Federal Law, 73 Fed. Reg. 50274, 50277 (August 26, 2008).
[11] Id. at 50278.
[12] Id. at 50277.
[13] Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices In Violation of Federal Law, 45 C.F.R. § 88.2 (2009).

referrals in its language. The preliminary draft of the Regulation did not include counseling within the definition.

Allowing federally-funded individuals to deny women information and referrals for reproductive health services and other health care options has the potential to eliminate some women's ability to make informed health care decisions and to provide informed consent. For instance, if health care providers refused to provide information and counseling on the full range of options to pregnant women, including those with fetal anomalies and victims of rape and incest, those women would not be able to provide informed consent for related health procedures. Women might also be denied information about the possibility of using some forms of contraception to control their reproduction, or prevent other health problems, and may not be informed of the possibility of using emergency contraception to prevent unwanted pregnancies.

Additionally, certain types of services, such as end-of-life care, may now be included based on the new definition of "health service program." The inclusion of counseling and referrals in the definition of "assist in performance" would allow health care providers to deny dying patients the full range of information about their options.

A particularly troubling aspect of the Regulation is its silence regarding Title VII, the federal law that provides protection to employees' religious beliefs, while at the same time establishing that employers need only make "reasonable accommodations" in respecting those beliefs. [14] The concerns raised by the expansion of the range of health care workers who may exercise conscientious objection and the expansive definition of "assisting in the performance," are heightened by the fact that the interaction of the Regulation with Title VII is not explicitly addressed. The Regulation should therefore be rescinded.

The Regulation's Impact on Low-Income Women and Women of Color

A. A Disproportionate Number of Low-Income Women and Women of Color Use Public Health Care and Will Be Adversely Affected By the Regulation.

A disproportionate number of low-income women and women of color rely on public health care programs. In the U.S., where access to health care depends on insurance coverage, lack of health insurance is the primary barrier to receiving reproductive health care. Overall, the number of people enrolled in public health insurance programs is decreasing and private insurance coverage continues to shrink.[15] Hence, a greater number of low-income people lack insurance of any kind because they do not have employer-based coverage and do not qualify for public insurance. Women of color, who disproportionately work in low-wage jobs that do not offer benefits,[16] have lower rates of insurance coverage: 39% of Latinas, 19% of API women,

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[14] 42 U.S.C § 2000e-1(a) (2008).

[15] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* 18-19 (Aug. 2007), *available at* http://www.census.gov/prod/2007pubs/p60-233.pdf, (showing a decrease from 27.3 million people covered in 2005 to 27.0 covered in 2006).

[16] Kaiser Family Found., *Racial and Ethnic Disparities in Women's Health Coverage and Access to Care: Findings from the 2001 Kaiser Women's Health Survey* 2 (Mar. 2004), *available at* http://www.kff.org/womenshealth/upload/Racial-and-Ethnic-Disparities-in-Women-s-Health-Coverage-and-Access-

and 18% of African-American women are without affordable health care compared to only 10% of white women.[17]

Without affordable health care, these women turn to public programs such as Medicaid and Title X of the Public Health Service Act (Title X). Medicaid covers all prenatal and pregnancy-related care for eligible women. As of 2005, women of reproductive age (15-44) comprised 11.5% of U.S. women covered by Medicaid,[18] many of whom are women of color. In 2006, women of color made up 51% of non-elderly Medicaid beneficiaries, but less than 20% of the general population.[19] In addition, Title X, a program that funds reproductive health clinics that provide contraceptive services and supplies, STI testing and treatment, and preventative screenings, benefits 6.6 million low-income women, 40% of whom are women of color.[20]

B. Impact of the Regulation on Low-Income Women and Women of Color

Women of color are disproportionately affected by the Regulation because many of them rely heavily on federally-funded health care programs. As noted, the Regulation creates three significant problems: that "abortion" may be broadly defined to include contraception; that a broad range of individuals can refuse to "assist in the performance" of a health service; and that clinics can withhold information and deny informed consent. All these problems directly affect low-income women and women of color.

The Regulation allows a clinic worker to refuse to assist in the performance of a health service if it is "contrary to his religious beliefs or moral convictions." Some individuals conflate contraceptive use with abortion and therefore deem it morally wrong. However, in 2004, women attending publicly funded clinics avoided an estimated 1.4 million unintended pregnancies and the decline in unintended pregnancies over the years is largely attributed to the availability of contraceptives.[21] If the Regulation is not rescinded, clinics may refuse to distribute some contraceptives to patients, a large proportion of whom are low-income women and minority women.

The Regulation also allows a broad range of individuals to refuse to "assist in the performance" of a health service if they find it contrary to their religious beliefs or moral

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to-Care.pdf. White women (70%) are more likely to have employer provided health coverage than African American women (59%) or Latinas (39%). Nat'l Inst. of Health, *Women of Color Health Data Book: Adolescents to Seniors* 107 (2006), *available at* http://orwh.od.nih.gov/pubs/WomenofColor2006.pdf [hereinafter NIH Women of Color Health Data Book].

[17] NIH Women of Color Health Data Book, *supra* note 36, at 107; Kaiser Family Found., *Women's Health Policy Fact Sheet: Women's Health Insurance Coverage* 2 (Dec. 2007), *available at* http://www.kff.org/womenshealth/upload/6000_06.pdf.

[18] Kaiser Family Found., and Guttmacher Instit., *Issue Brief: A Critical Source of Support for Family Planning in the United States* 1 (April 2005), *available at* http://www.kff.org/womenshealth/upload/Medicaid-A-Critical-Source-of-Support-for-Family-Planning-in-the-United-States-Issue-Brief-UPDATE.pdf..

[19] Kaiser Family Found., *Issue Brief: Medicaid's Role for Women* 1 (May 2006) *available at* http://www.kff.org/womenshealth/upload/Medicaid-s-Role-for-Women-May-2006.pdf.

[20] Guttmacher Inst., *Title X and the U.S. Family Planning Effort* 3 (1997), *available at* http://www.guttmacher.org/pubs/ib16.html.

[21] Heather D. Boonstra, Guttmacher Inst., *The Impact of Government Programs on Reproductive Health Disparities: Three Case Studies*, 11 Guttmacher Pol'y Rev. 3 at 8, (Summer 2008).

convictions. As stated above, this suggests many scenarios that could affect a woman's reproductive health. For instance, a receptionist may refuse to make an appointment for an individual seeking contraceptives or a nurse may refuse to sterilize equipment used in the performance of abortion. Hence, there is not only a danger that many low-income women and women of color who go to public health clinics to seek contraceptives or reproductive health options may be turned away, but also the creation of potential health hazards to the patients.

In addition, the Regulation allows clinics to withhold information and deny informed consent, which directly contradicts the requirement to provide information and counseling on prenatal care and pregnancy termination set forth in Title X.[22] Under the Regulation, health care centers and institutions could not only refuse to give information about abortion or contraceptives, but also refuse to refer their patients to someone who will answer those questions.

The impact of the Regulation falls most heavily on low-income women seeking reproductive health care services in federally-funded health care settings. When low-income women, non-English speakers, rural women, and women who depend upon public transportation seek reproductive health services such as abortion care, they often face significant obstacles associated with missed work, child care, and other logistics, such as transportation. If these women are then turned away from health care providers, they may not have the resources to locate another provider and make their arrangements a second time. For example, if a woman visits a clinic to obtain contraceptives, and is denied, she may not have the means or opportunity to go to another clinic.

The Regulation also affects low-income women's ability to access health care services outside of reproductive health. Many low-income women already experience discrimination in the health care system based on their inclusion in a specific class of persons, such as those with HIV/AIDS, those of a certain race or ethnicity, or based on immigration status. Because the regulation expands the types of workers covered and types of services that can be denied under federal refusal laws, discrimination against persons in those vulnerable groups could increase.

Moreover, because it does not provide a definition of "moral convictions," the Regulation could create avenues for providers and entities to refuse services or information because of discrimination, self-interest, or distaste for certain procedures. This creates a unique problem for low-income women and women of color. They may be easily discriminated against due to their socioeconomic status, gender, sexual orientation, or race under the guise that the action to be taken is contrary to the providers' "moral convictions." For example, a same-sex couple could be denied infertility services.[23]

Thus, the Regulation creates a myriad of ways for health care institutions and individuals to refuse to provide health services and/or information or referrals. It is clear that these issues will directly affect low-income women and women of color because many of them rely on public health programs for these services.

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[22] 42 C.F.R. § 59.5 (2008).

[23] American College of Obstetricians and Gynecologists, *The Limits of Conscientious Refusal in Reproductive Medicine*, Committee Opinion Number 385, at 4 (Nov. 2007).

The Regulation Does Not Meaningfully Address Important Issues of Diversity in the Workplace

The text of the Regulation discusses "an environment in the health care field that is intolerant of individual conscience" as a factor that may discourage diversity in the health care workforce, claiming that people of various religious, ethnic and cultural groups might be excluded without this regulation in place. This claim is misguided in several ways.

First, the implication that religious, ethnic and cultural minorities feel a specific way regarding reproductive health services is a simplistic and inaccurate generalization. Communities of color have been and continue to be instrumental in the fight for access to reproductive health care, and to imply that these communities are opposed to basic reproductive health procedures on a larger scale than other communities is an unfounded assumption.

Second, the notion that making it easier to refuse to provide services will diversify the health care workforce is questionable at best. While diversifying the health care workforce is a commendable objective, and one that is sorely needed ─13% of the United States population identifies as Latino/a and 12% identify as Black,[24] but only 6.4% and 6.5% of medical school graduates in 2004 were Latino/a or Black, respectively,[25] and only 2.8% and 3.3% of physicians practicing in 2004 were Latino/a or Black, respectively[26]─ the Regulation does not accomplish this objective. Diversifying the health care workforce would mean establishing a pipeline for minority physicians, researchers, and other health care professionals through the elimination of obstacles that communities of color face in educational attainment. Some ways these obstacles can be addressed include the creation of federal and state funded scholarships, loan forgiveness, mentoring programs for young people of color, tuition assistance, increased financial aid and affirmative action; it is steps like these that truly begin to eliminate the barriers to a diverse health care workforce.

Another area of concern is that the Regulation takes no account of diversity among patients. The Regulation is written broadly enough so that health care workers may not only refuse to participate in particular procedures, but also refuse to treat particular groups of people. This kind of 'moral' refusal is not unheard of. Lupita Benitez was refused artificial insemination by two physicians in her provider network because she is a lesbian, Not only did she have to incur the monetary costs of an out-of-network provider to receive the insemination during the critically short fertility time window, she also had to endure the emotional burden incurred due to this kind of discrimination.[27] The Regulation seems to condone and encourage this kind of discrimination, the brunt of which will be felt by visible minorities and marginalized populations, such as LGBT people, undocumented people, immigrants, and people living with HIV/AIDS. Whether these actions are actually within the realm of the law will be of little

[24] U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, *Census 2000 Brief, Overview of Race and Hispanic Origin* 3 (March 2001) *available at* http://www.census.gov/prod/2001pubs/c2kbr01-1.pdf

[25] Association of American Medical Colleges, *Minorities in Medical Education: Facts and Figures 2005* at 27 (Spring 2005).

[26] Association of American Medical Colleges, *Diversity in the Physician Workforce: Facts and Figures 2006*, at 15 (Summer 2006).

[27] Lambda Legal, *Benitez v. North Coast Women's Care Medical Group Questions and Answers (*June 22, 2005), *available at* http://www.lambdalegal.org/our-work/publications/facts-backgrounds/page.jsp?itemID=31987395.

relevance to the countless patients whose health will suffer due to the refusal of treatment that this Regulation will foster.

The Regulation Creates a Culture of Refusal

In addition to the specific concerns detailed above, the Regulation also further exacerbates the imbalance between the rights of conscience and women's rights to reproductive health care. The Regulation is intended to expand a network of federal and state conscientious refusal laws that have created a "culture of refusal," in which women's reproductive health care needs and rights are accepted as being secondary to the conscience of providers. These laws often ignore health care providers' responsibilities and ethical duties to provide care to patients in a way that is respectful of patient autonomy, timely, effective, evidence-based and non-discriminatory.[28] Instead, together with numerous other federal and state laws, they are politically motivated attempts to prevent women from accessing abortion and family planning services that use conscience as a smokescreen for their goals.

Refusal laws exist in significant numbers at the federal and state levels. As noted, the Church Amendment,[29] the Weldon Amendment, [30] and the Public Health Service Act Sec. 245[31] already provide strong protection for individual health care providers and institutions to exercise their religious or moral beliefs regarding reproductive rights. These laws, along with Title VII,[32] already allow individuals, health care entities, and research programs that receive federal funding to refuse to participate in or provide training for abortions, sterilizations, and in some cases any activity that is contrary to their moral convictions or religions beliefs.

Additionally, nearly every state has a policy explicitly allowing some health care professionals or certain institutions to refuse to provide or participate in abortion, contraceptive services or sterilization services. Forty-six states allow some individual health care providers to refuse to provide abortion services, and forty-three of those states allow health care institutions to refuse to provide abortion services.[33] Thirteen states allow some individual health care providers to refuse to provide services related to contraception and nine of those states allow health care institutions to refuse to provide services related to contraception.[34] Seventeen states allow some health care providers to refuse to provide sterilization services and fifteen of those states allow health care institutions to refuse to provide sterilization services.[35] Even in states without explicit refusal statutes, an individual health care professional's actions may be legally protected by statutes prohibiting discrimination against employees, based on their religious objections.[36]

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[28] Id. at 3.
[29] 42 U.S.C.A. §300a-7 (2008).
[30] Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, Div. G, §508(d), 121 Stat. 1844, 2209 (Dec 26, 2007).
[31] 42 U.S.C.A. §238(n) (2008).
[32] 42 U.S.C § 2000e-1(a) (2008).
[33] Guttmacher Inst., *State Policies in Brief, Refusing to Provide Health Services Factsheet* (Sept. 1, 2008), *available at* http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.
[34] Id.
[35] Id.
[36] Id.

Expanding the culture of refusal, as the Regulation does, has a particularly severe impact on women of limited means, who are disproportionately women of color in this country. These women already face significant barriers in accessing health care overall, even without the added difficulties created when providers in under-resourced communities refuse care to women. The United States Office of Women's Health found "[s]everal…factors limit the access of minority women to the U.S. health care system. They include social disadvantages, cultural values, discrimination, lack of culturally appropriate services, inadequate childcare, and transportation…"[37] Additionally, a study by the Kaiser Family Foundation found that low-income women faced twice as much difficulty as other women in obtaining the flexible work schedules, transportation, and child care necessary to access health care services for themselves.[38]

The existing barriers that women face in accessing health care become especially burdensome when coupled with refusal clauses as sweeping as those in the Regulation. As the American College of Obstetricians and Gynecologists recently recognized, when low-income women and minority women are refused services, turned away, or given incomplete information about their reproductive health care options, they often do not have the opportunity to access other health care providers. "For instance, a refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not realistically available to her."[39]

The Regulation also puts the United States increasingly out of step with international human rights standards and norms. International standards require a balance between health and conscience and require a recognition that health is of primary importance.[40] So, while practitioners have a right to respect for their conscientious convictions and should not suffer from discrimination on the basis of their convictions, refusal clauses must reflect prevailing standards of medical ethics that make patient's health care of primary consideration. Refusal clauses cannot be overbroad: only those providers participating in the procedure may object, not those providing care before or after, or those performing administrative services.[41] Providers

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[37] U.S. Dept. of Health & Human Services, Office on Women's Health, *The Health of Minority Women* 4 (July 2003), *available at* http://www.4woman.gov/owh/pub/minority/minority.pdf.

[38] Kaiser Family Found., *Women and Health Care: A National Profile* 24 (July 2005), *available at* http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf.

[39] American College of Obstetricians and Gynecologists, *The Limits of Conscientious Refusal in Reproductive Medicine*, Committee Opinion Number 385, at 4 (Nov. 2007).

[40] International Covenant on Civil and Political Rights, Art. 18, *opened for signature* December 19, 1966, 999 U.N.T.S. 85 (entered into force March 23, 1976).

[41] *See, e.g., Janaway v. Salford Health Authority*, 2 All E.R. 1079 (H.L. 1988) (conscience objection clause in UK abortion law only applies to participation in treatment); Regulations for the Implementation of the Act dated June 13 1995 no. 50 concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978 no. 66 cf. § 12 of the Act, laid down by Royal Decree, 1 December 1978, § 20 (Nor.) (Regulations implementing Norway's abortion law expressly provide that the right to refuse to assist in an abortion belongs only to the personnel who perform or assist the actual procedure).

must promptly tell patients that they refuse to provide certain health services and patients are entitled to be referred immediately, in good faith, for procedures that providers object to undertaking.[42] Despite growing international consensus on these standards, none of these protections for patient care are included in the Regulation.

The Cost-Benefit Analysis Purporting to Support the Regulation is Inadequate.

The cost-benefit analysis conducted by the Department was poorly performed and therefore provides no reliable information on the Regulation's actual impact. As described in greater detail in the attached analysis prepared by the Institute for the Study of Regulation at the New York University School of Law ("ISR Analysis"):

> The Department has engaged in an incomplete, cursory, and inadequate cost-benefit analysis in support of the proposed rule. First, the rule fails to prove the existence of the problem it is designed to solve. Second, the analysis fails to quantify benefits of the regulation. Finally, the analysis fails to identify and account for serious costs arising from, *inter alia*, potential failures to inform women of their health choices and a decreased availability of medical procedures and/or contraception. The analysis performed by the Department falls below a reasonable standard of an appropriate cost-benefit analysis as required by EO 12,866. Accordingly, this flawed cost-benefit analysis cannot be used to justify the promulgation of the proposed rule. Under EO 12,866, the Department is obligated to undertake a more formal accounting of the impacts of the proposed regulation in economic terms.

Of particular concern is the Department's failure to adequately address the costs associated with the Regulation, and in particular its impact on subgroups including low-income women and women of color. As the ISR Analysis points out, the Department is required "to assess how the costs and benefits are distributed among subpopulations." In spite of this mandate, the Department's cost-benefit analysis makes no attempt to assess the impact on these vulnerable groups.

Given the gravity of the interests at stake – access to health care by low-income women and women of color who already disproportionately experience poorer reproductive health – the failure of the Department to meet its obligation to undertake a well-conducted and balanced cost-benefit analysis is reason enough to rescind the Regulation.

Conclusion

Women seeking reproductive health care services already face tremendous obstacles. If left in place, the Regulation will exacerbate those problems. For all of the foregoing reasons, we urge you to rescind this dangerous, unnecessary and misguided regulation.

Sincerely,

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[42] *See, e.g.*, Code de la Santé Publique, arts. L22212-8 and R4127-18 (Fr.) (2001) (France's Public Health code places a legal obligation on providers to immediately communicate their refusal to perform an abortion).

National Latina Institute for Reproductive Health
National Asian Pacific American Women's Forum
Center for Reproductive Rights

Black Women for Reproductive Justice
Cedar River Clinics - Renton, Tacoma, Yakima in Washington State
Center for Health and Gender Equity (CHANGE)
Center for Inquiry Office of Public Policy
Center for Women Policy Studies
Feminist Abortion Network
Feminist Women's Health Center, Atlanta
International Women's Health Coalition
Ipas
Law Students for Reproductive Justice
Law Students for Reproductive Justice- Boston University
Law Students for Reproductive Justice - Cardozo School of Law
Law Students for Reproductive Justice - Hamline University School of Law
Law Students for Reproductive Justice - University of Maryland
Law Students for Reproductive Justice- Rutgers - Newark
Law Students for Reproductive Justice - Seattle University
National Association of Nurse Practitioners in Women's Health (NPWH)
National Network of Abortion Funds
Memphis Center for Reproductive Health
Pro-Choice Public Education Project
Reproductive Health Access Project
Southwest Women's Law Center