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Office of the Assistance Secretary for Planning and Evaluation
Strategic Planning Team
Department of Health and Human Services
200 Independence Ave. S.W.
Room 415F
Washington, D.C. 20201

VIA ELECTRONIC MAIL: HHSPlan@hhs.gov

Attn: Comments on HHS Draft Strategic Plan for FY 2018 - 2022

To Whom It May Concern:

The National Center for Lesbian Rights (NCLR) appreciates the opportunity to provide comments on the Department of Health and Human Services (HHS or the Department) Draft Strategic Plan for FY2018 – 2022 (the Draft Plan).

NCLR is a non-profit, public interest law firm that litigates precedent-setting cases at the trial and appellate court levels, advocates for equitable public policies affecting the lesbian, gay, bisexual, and transgender (LGBT) community, provides free legal assistance to LGBT people and their advocates, and conducts community education on LGBT issues. NCLR has been advancing the civil and human rights of LGBT people and their families across the United States through litigation, legislation, policy, and public education since its founding in 1977. We also seek to empower individuals and communities to assert their own legal rights and to increase public support for LGBT equality through community and public education. NCLR recognizes the critical importance of access to affordable health care for all people. Our comments focus on four areas: 1) problems with the manner in which the Draft Plan was developed and its overall approach; 2) the erasure of key underserved populations, including LGBT people; 3) significant threats to reproductive health care; and 4) inappropriate emphasis on specific religious viewpoints.

I. Process and Content (General)

The Government Performance and Results Act (GPRA) Modernization Act of 2010 (P.L. 111-352) requires agencies to develop a performance plan that expresses performance goals for each strategic objective “in an objective, quantifiable, and measurable form”; performance goals must include “clearly defined milestones.”¹ The performance plan must also establish a

¹ 31 U.S.C. §§ 1115(b)(2), 1115(c), 1115(b)(5)(B).

balanced set of performance indicators to be used in measuring or assessing progress toward each performance goal.² Unfortunately, much of the Plan fails to contain performance indicators and instead includes political goals – such as focusing on life beginning at conception and furthering certain religious viewpoints – rather than the requirements for a strategic plan.

Past Strategic Plans have included benchmarks to measure progress, such as increasing a percentage of adults who are screened for depression, or decreasing the total morphine milligram equivalents dispensed.³ The Draft Plan contains no specific measurable performance goals, only “strategies” expressed in vague, precatory terms, such as “promote,” “collaborate,” or “engage with.” The Draft Plan as it stands does not meet the requirements under law to create a work plan that is measurable.⁴ Coupled with the unnecessary and harmful anti-abortion language as well as open-ended support for religious and “moral” exemptions, the overall effect is that the Draft Strategic Plan comes across as a political agenda to message support for HHS’ perceived allies under the current administration, rather than an actual plan to better the health of Americans. Further, the Draft Plan diminishes, rather than ensures, government accountability, by failing to establish data-driven, evidence-based measurable goals.

The Plan also omits “a description of how the goals and objectives incorporate views and suggestions obtained through congressional consultations.”⁵ When developing a strategic plan, HHS “shall consult periodically with the Congress, including majority and minority views from the appropriate authorizing, appropriations, and oversight committees, and shall solicit and consider the views and suggestions of those entities potentially affected by or interested in such a plan.”⁶ The current strategic plan cannot be considered compliant unless and until HHS consults with the appropriate members of Congress; a public comment period is insufficient to meet these requirements.

² 31 U.S.C. § 1115(b)(6)-(7).

³ HHS Strategic Plan 2014-2018, Strategic Goal 1 Objective E; *Id.* at Strategic Goal 1 Objective B.

⁴ GPRA Modernization Act of 2010, 5 U.S.C. § 306 (2012) (“Such plan shall contain . . . (2) general goals and objectives, including outcome-oriented goals, for the major functions and operations of the agency; (3) a description of how any goals and objectives contribute to the Federal Government priority goals required by section 1120(a) of title 31; (4) a description of how the goals and objectives are to be achieved, including—(A) a description of the operational processes, skills and technology, and the human, capital, information, and other resources required to achieve those goals and objectives; and (B) a description of how the agency is working with other agencies to achieve its goals and objectives as well as relevant Federal Government priority goals . . . (8) a description of the program evaluations used in establishing or revising general goals and objectives, with a schedule for future program evaluations to be conducted.”).

⁵ 5 U.S.C. § 306(a)(5).

⁶ 5 U.S.C. § 306(d).

II. Erasure of Underserved Groups

HHS must continue to undertake activities to identify and address health disparities with the ultimate goal of eliminating them. In activities spanning the Office for Civil Rights, Office of Minority Health, Office of Women's Health and the Centers for Medicare & Medicaid Services, all of HHS' endeavors must ensure that disparities are not worsened but instead are ameliorated. We appreciate recognition of the need to address disparities within the Strategic Plan, but believe that HHS must strengthen these sections to ensure that all individuals are given opportunities to achieve maximal health and well-being.

Further, the Strategic Plan should ensure that all of HHS' activities are undertaken in a culturally competent manner. Providing culturally competent services is critical to ensure that services are client/patient centered and are appropriate for not just the particular program at issue but also for the clients/enrollees served. We urge HHS to include more specific and measurable goals and strategies to address cultural competency in a holistic manner including race, ethnicity, language, immigration status, age, disability, sex, gender identity and sexual orientation. We recommend that HHS include a broad definition of health care disparities in its final strategic plan.

The current HHS Strategic Plan for FY2014-2018 establishes specific measurable goals to improve the health outcomes of all Americans by specifically recognizing the health disparities that persist among populations, including racial and ethnic minorities, individuals with disabilities, refugees, lesbian, gay, bisexual, and transgender (LGBT) individuals.⁷ To give just one example of stark health disparities that exist in the United States, black women are three to four times more likely to die from pregnancy complications than white women are, and they are twice as likely to suffer maternal morbidity.⁸ The 2014-2018 Plan recognizes and highlights the need for active efforts to reduce existing disparities among specific populations and to ensure that the most vulnerable populations within the United States receive access to health care. Furthermore, the 2014-2018 Plan details a data-driven agenda to support research that will increase our understanding of population subgroups such as racial and ethnic minorities, the re-entry population, and LGBT populations.

In contrast, while the Draft Plan promotes "culturally-competent care" and recognizes that health disparities exist generally, it removes all language identifying these communities and sub-populations specifically by name. At best, this makes the objectives and goals within the Draft Plan less measurable and meaningful; at worst, these omissions indicate that the agency will deprioritize work on closing gaps in health care services and outcomes across these

⁷ See, e.g., HHS Strategic Plan 2014-2018, Strategic Goal 1 Objective E; HHS Action Plan to Reduce Racial and Ethnic Health Disparities (2011).

⁸ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Reproductive Health: Pregnancy Mortality Surveillance System*, (last updated June 29, 2017), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>; Andrea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, 210 AM. J. OBSTET. GYNECOL. 435, 437 (2014).

groups. We strongly urge HHS to include, as it has in the past, specific objectives and goals relating to the persistent health disparities that continue to exist for ethnic and racial minorities, individuals with disabilities, refugees, LGBT individuals, and re-entry populations.

LGBT People

LGBT people are a vulnerable population with respect to health. Members of the LGBT community face higher rates of HIV/AIDS, depression, an increased risk of some cancers, and are twice as likely as their heterosexual peers to have a substance use disorder. Transgender people in particular are at higher risk for a range of poor health outcomes. For example, the 2015 U.S. Transgender Survey, a national study of nearly 28,000 transgender adults, found that respondents were nearly five times more likely to be living with HIV than was the general population, with even higher rates for some populations: for example, nearly one in five (19%) Black transgender women are living with HIV, more than 63 times the rate in the general population. Transgender respondents were nearly eight times more likely than the general population to be living with serious psychological distress based on the Kessler 6 scale, with higher rates correlating with experiences of discrimination, violence, and rejection.

The medical community and scientific research have repeatedly demonstrated that the poor health outcomes that LGBT people face are not associated with any inherent pathology, but rather high rates of poverty, discrimination in the workplace, schools, and other areas, and barriers to nondiscriminatory health care that meets their needs. Recognizing these disparities and the impact they have on LGBT people, improving the health, safety, and well-being of LGBT people was made a goal of Healthy People 2020. LGBT people were included in a number of other health objectives including mental health and mental illness, tobacco use, usual source of care, and health insurance coverage, and the National Institutes of Health (NIH) formally designated sexual and gender minorities as a health disparity population in 2011 for purposes of NIH research.⁹

A major factor in these health disparities is the discrimination that LGBT people face when trying to access health care. While the Affordable Care Act has significantly increased the percentage of LGBT people with insurance and has helped prohibit discrimination against LGBT people in coverage and care, LGBT people are still more likely than are non-LGBT adults to lack insurance, and LGBT people still face discrimination. A recent survey found that transgender respondents were over five times more likely than their cisgender counterparts to avoid doctors' offices due to the risk of experiencing discrimination. Additionally, the 2015 U.S. Transgender Survey found that, in just the prior year, 33% of those who saw a health care provider faced some form of mistreatment or discrimination because of being transgender, such as being refused care, harassed, or physically or sexually assaulted, and 23% avoided seeing a doctor when needed due to fear of discrimination. We expect HHS to continue

⁹ Kellan Baker, "Open Doors for All" (Washington: Center for American Progress, 2015), available at <https://www.americanprogress.org/issues/lgbt/reports/2015/04/30/112169/open-doors-for-all/>.

servicing LGBT people and believe the strategic plan is an ideal opportunity for HHS to show that it plans to engage in targeted efforts to ensure that vulnerable populations like LGBT communities get the healthcare they need.

As a population that experiences significant disparities related to health care access, essential services, and economic security described above, LGBT individuals should be specifically mentioned in relevant portions of the Strategic Plan. In previous plans, HHS included explicit references to the LGBT population when discussing goals related to providing access to quality, competent care, improving data collection, supporting the healthy development of youth, and expanding access to culturally competent services, among other goals. We recommend HHS revisit the Strategic Plan taking into consideration the large body of research demonstrating the need for specific and competent inclusion of LGBT people in all aspects of efforts to improve the health of Americans.

Nondiscrimination Protections

The final rule on Nondiscrimination in Health Programs and Activities adopted by HHS in 2016 clarifies nondiscrimination protections under Section 1557 of the ACA prohibiting discrimination based on health status, disability, age, race, gender, gender identity, and sex stereotyping, among other factors.¹⁰ The rule went through a multi-year process of study and public input and incorporated over 20,000 public comments. The final rule ensures consumers receive the full benefit of coverage. It also clarifies that the sex nondiscrimination protections of the Affordable Care Act protect access to health insurance coverage and health care for all individuals regardless of their gender identity or nonconformity with sex stereotypes. The rule is particularly important in addressing insurance discrimination against transgender people, who previously frequently encountered discriminatory insurance plan exclusions that denied them coverage for medically necessary care related to gender transition, even though the same services and procedures were routinely covered for non-transgender individuals.¹¹

These protections are critical to addressing the barriers to coverage and care that LGBT people across the country routinely experience, such as healthcare providers using harsh or abusive language, blaming patients for their health status, being physically rough or abusive, or refusing care outright.¹² As the Institute of Medicine has noted, discrimination and mistreatment by healthcare providers contribute to distrust of the healthcare system among many LGBT people and perpetuate disparities such as higher rates of smoking and tobacco use, higher incidence of depression and other mental health concerns, greater risk of HIV infection, and lower degree of access to preventive screenings for conditions such as breast

¹⁰ 45 C.F.R. part 92 *et seq.* (2016).

¹¹ These services include cancer treatment or prevention, or reconstructive surgery following an injury. More information about common misconceptions about health coverage for transgender individuals can be found in [Why Gender Identity Nondiscrimination in Insurance Makes Sense](#), a report by the Center for American Progress.

¹² When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV (New York: Lambda Legal, 2010). Available at www.lambdalegal.org/health-care-report.

and cervical cancer.¹³ Section 1557 protections are vital to addressing discrimination against LGBT individuals in healthcare settings and we urge HHS to maintain the current rule.

III. Threats to Reproductive Health Care

The Draft Plan defines an American lifespan as from “conception” to “natural death,” and vows to respect “the inherent dignity of persons from conception to natural death.” (Objective 2.4). The explicit connotation that personhood begins at conception runs counter to well-established constitutional case law. *Roe v. Wade* established abortion as a fundamental right for women, declaring that “the word ‘person,’ as used in the Fourteenth Amendment, does not include the unborn.”¹⁴ This central holding of *Roe*, protecting a woman’s right to access abortion, has been consistently upheld and reaffirmed by the Supreme Court, including just last year in *Whole Woman’s Health v. Hellerstedt*.¹⁵ The language in the Draft Plan is an attempt to directly undermine this fundamental right by pushing an unconstitutional definition of persons and living Americans as beginning at conception, which has no basis in science. HHS’ reliance on such unscientific and non-medical terms raises serious concerns about government overreach into the provider-patient relationship and threatens women’s access to crucial healthcare services, including birth control, assisted reproductive technology (ART), stem cell research, and *in vitro* fertilization (IVF). Perhaps most crucially, this unconstitutional non-medical definition threatens autonomous decision-making for all pregnant women, including those intending to carry their pregnancies to term. This is an unacceptable infringement on a woman’s autonomy over her own body, and we urge HHS to remove all language that could threaten women’s access to a broad array of healthcare services.

Public health programs and policies must be based on research, evidence, and medical and health-related facts, and must be responsive to individual patient and consumer needs and wishes. Religion and conscience are not limited to those who support the idea of life beginning at conception. In fact, the vast majority of patients have religious and conscience needs and wishes that are not served using that limited framework. In order to fulfill the person-centered strategy laid out by HHS, consumers require medically accurate, evidence-based, unbiased comprehensive health care services so that they can use their own decision-making capacity to choose health care services that comport with their individual morality and circumstances. This means that reproductive health care services, including hormonal contraception, sterilization, and pregnancy termination, must be available to all who desire those services in accordance with their own individual beliefs.

¹³ National Academy of Sciences, "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding" (2011), available at <http://www.nationalacademies.org/hmd/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx>.

¹⁴ *Roe v. Wade*, 410 U.S. 113 (1973).

¹⁵ 136 S. Ct. 2292 (2016).

We are concerned that HHS is inserting concepts such as “the unborn” and life “from conception” into its strategic plan. These concepts run contrary to medical and health-related evidence and standards of care, and instead reflect one particular religious point of view that has no role in advancing and protecting the public health of a diverse population. Elevating a fertilized egg to equal status with a person is contrary to U.S. law and establishes a policy framework that would undermine the ability of women and others to make the best decisions for themselves and their families, including decisions affecting their health and well-being, and their ability to participate in public life.¹⁶ Such policies will impede the ability of HHS to cultivate and inform best practices for women’s health, and in turn, interfere with the ability of providers, particularly those who offer reproductive health services, to provide quality care to their patients.

One of the basic functions of government is to ensure the health and well-being of its population. Privileging embryos and fetuses over people threatens the capability of HHS to fulfill this function, and would deprive women of health care benefits that medical and health care experts recognize as critical to ensuring women’s health and well-being.¹⁷ Elevating the status of a fetus over the health needs of pregnant women would result in poorer maternal health and poorer birth outcomes.¹⁸ Moreover, adopting policies that give health rights to fetuses would also undermine a woman’s constitutional right to access abortion, and interfere with the patient-provider relationship by limiting the information, counseling, referral and provision of abortion services that a woman can receive, despite the fact that these are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer. The language is overly broad, confusing, and subject to misuse and abuse by creating a federal health care framework that invites HHS to refuse to participate in the orderly delivery of evidence-based health care services.

The personhood language is also contrary to both the Establishment Clause and the Free Exercise Clause of the U.S. Constitution. The idea that “life begins at conception” is not an evidence-based theory, but a religious one, which the vast majority of Americans that HHS serves do not share. Free speech and religious liberty are concepts that cannot be limited to one specific view; those who do not believe that life begins at conception are entitled to the same free exercise of religion, and any language to the contrary is decidedly discriminatory. The decision to obtain any health service, including reproductive health care, should remain with the individual.

¹⁶ *Roe v. Wade*, 410 U.S. 113, 153 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992).

¹⁷ AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION: INCREASING ACCESS TO ABORTION (2014), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20171019T1538434634>.

¹⁸ CENTER FOR REPRODUCTIVE RIGHTS AND IBIS REPRODUCTIVE HEALTH, EVALUATING PRIORITIES: MEASURING WOMEN’S AND CHILDREN’S HEALTH AND WELL-BEING AGAINST ABORTION RESTRICTIONS IN THE STATES (2017), <https://ibisreproductivehealth.org/sites/default/files/files/publications/Evaluating%20Priorities%20August%202017.pdf>.

We agree with HHS' affirmation of the importance of consumer choice and empowerment, but note that consumer choice and empowerment must be driven by fully informed, patient-centered decision making. We oppose all efforts to limit the provision of health information, including but not limited to when it concerns the full range of contraceptive options, abortion, and LGBTQ-inclusive sexual health information.

Unfortunately we have already seen the pernicious effect of this new emphasis on the unborn in HHS policy and practice. It was exemplified in the case of "Jane Doe," a 17-year-old immigrant in the care of HHS' Office of Refugee Resettlement (ORR), who was held against her will at a government-funded shelter in Texas and forced by HHS to continue a pregnancy against her will for over a month while HHS fought in court to block her from accessing abortion care. She secured her own funding, obtained a judicial bypass as mandated by state law, and arranged transportation through her court-appointed guardian and attorneys. ORR, however, went to extraordinary lengths to prevent her from accessing constitutionally-protected care, including blocking her from traveling to appointments, and forcing her to visit a so-called "Crisis Pregnancy Center," where non-medical personnel made Jane undergo and view a sonogram against her wishes. ORR effectively held Jane hostage to the detriment to her health and rights. And yet, according to an HHS statement, the Department believes that it was "providing excellent care to this young woman and her unborn child." These are the exact sort of unconscionable actions we can expect to flow from HHS' Strategic Plan should the misplaced emphasis on the unborn at the expense of women remain in place.

IV. Overemphasis on Religious and Moral Views

HHS' overarching mission and function is "to enhance and protect the health and well-being of all Americans." Accordingly, HHS establishes the goal of improving patients' access to the health care they need in the Draft Plan. However, the Plan also states that HHS will "promote equal and nondiscriminatory participation by faith-based organizations in HHS-funded or conducted activities," and HHS will "affirmatively accommodate" burdens imposed on the exercise of religious beliefs and "moral convictions" by persons and entities partnering with HHS (Objective 1.3). This language is inappropriate for a strategic plan, as it does not establish measurable goals, and further, the use of this language to qualify broader goals relating to healthcare access improperly implies that limitations on healthcare access may be appropriate based on religious or moral grounds. One individual's personal religious belief should never determine or limit the healthcare services that another individual can receive. When hospitals, clinics, and individual health care providers have the ability to refuse patient care based on religious or moral beliefs, patients may suffer devastating health consequences.¹⁹

¹⁹ For documented examples of religious healthcare providers denying care to patients on the basis of religious beliefs, see Compl. 2, *ACLU of Mich. v. Trinity Health Corp.*, 2016 U.S. Dist. LEXIS 30690 (E.D. Mich. Mar. 10, 2016); Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/>; National Women's Law Center, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*,

The harms caused by refusals to provide care have a disproportionate impact on those who already face multiple barriers to care, including communities of color, LGBTQ individuals, people facing language barriers, and low-income families and individuals.

HHS should be committed to putting measurable goals toward improving individual patient care at the center of any strategic plan, and should work to ensure medical standards of care and individual patient circumstances determine patient care, not politicians' or providers' and insurance companies' religious beliefs. The Draft Plan's repeated commitment to accommodating faith-based entities signals that HHS may prioritize personal opinion and belief over access and care. This is inappropriate for HHS' strategic plan.

Additionally, the Draft Plan fails to acknowledge that many health care providers have moral convictions telling them that they must provide services that patients need, including abortion care. HHS is responsible for enforcing federal law that protects individual health care providers from employment discrimination due to their providing abortions and other care. If HHS cares about protecting individual health care providers' conscience beliefs, as it claims, then it should acknowledge its responsibilities under federal law and articulate a commitment to protecting doctors and nurses who are committed to providing abortions and other services that patients need.

We appreciate HHS' desire to strengthen and expand the healthcare workforce. However, federal law provides ample protections and religious exemptions, such as the Church Amendments, for health care entities and individuals who object to providing certain services based on their religious beliefs. The Strategic Plan cites no evidence that further protections are needed, and we note that additional provisions to shield these providers from delivering evidence-based, quality medical and health-related services that meet the standard of care would be unnecessary and restrictive.

We do not agree with HHS' statement that removing barriers to and promoting participation in HHS programs by persons and organizations with religious beliefs or moral convictions is a solution to assisting targeted populations. Rather, HHS should remain religiously and morally neutral in its funding and activities to ensure that individuals do not feel proselytized by providers or receive access to a limited scope of services due the moral or religious nature of an organization. In particular, we support comprehensive sexual and reproductive health counseling and services from LGBTQ-competent providers, and discourage use of faith-based partners that shame LGBTQ individuals and communities based on specific ideological beliefs.

We strongly oppose the inclusion of Executive Order 13798 of May 4, 2017, "Promoting Free Speech and Religious Liberty," in lines 359 through 371. We believe the enforcement and

<https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/> (last visited Oct. 20, 2017).

implementation of this executive order will further undermine the ability of women and LGBTQ individuals to receive comprehensive health care, including reproductive health care. Moreover, we are concerned that the plan fails to mention other federal civil rights laws and Executive Orders that are relevant to providing healthcare options that are responsive to consumer demands. These include Executive Order 13166, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act. All of these laws must be fully implemented and enforced by HHS to ensure that HHS' programs and activities, and those it supports with federal funds, are responsive to consumer demands.

Thank you for the opportunity to offer input on the Draft Plan. If you have any questions regarding these comments, please contact Julie Gonen, NCLR Policy Director, at jgonen@nclrights.org or 202-734-3547.

National Center for Lesbian Rights