

REPORT BY THE SEX AND LAW COMMITTEE

**COMMENTS RESPECTFULLY SUBMITTED IN RESPONSE TO
HEALTH AND HUMAN SERVICES DRAFT STRATEGIC PLAN FOR FY 2018-2022**

The Sex and Law Committee of the New York City Bar Association addresses issues pertaining to gender and the law in a variety of areas that aim to reduce barriers to gender equality in health care, the workplace and civic life and to promote respect for the rule of law. The Committee’s members work and practice in a wide range of areas, including, violence against women, reproductive rights, gender discrimination, poverty, matrimonial and family law, employment law, and same-sex marriage. In light of the Committee’s long history and expertise in promoting gender equality and defending constitutional rights, we are well positioned to submit comments on that portion of the HHS Draft Strategic Plan for FY 2018-2022 (hereinafter “Draft Plan”) that impacts women’s reproductive health and healthcare for racial and ethnic minorities and the LGBT community.

More specifically, we are concerned that the Draft Plan, if adopted, would threaten the rights and health of millions of Americans. This comment focuses on three specific elements of the Draft Plan: (1) the implication that legal personhood begins at the moment of conception; (2) the implication that the religious and moral beliefs of service providers override the religious liberty, autonomy, and safety of patients; and (3) the removal of strategies specifically addressing the needs of racial and ethnic minorities and the LGBT community.

I. THE DRAFT PLAN’S SUGGESTION THAT FERTILIZED EGGS ARE JURIDICAL PERSONS FROM THE MOMENT OF CONCEPTION IS CONTRARY TO THE LAW AND THREATENS WOMEN’S HEALTH

The Draft Plan contains several references to “serving and protecting Americans at every stage of life, beginning at conception”¹ and “unborn” people.² We agree that attention to maternity care is timely and critical given the alarming rates of adverse maternal and infant outcomes, particularly among communities of color.³ And protecting women who are or wish to

¹ HHS Draft Strategic Plan FY 2018-2022, lines 61, 830, 846, 1143, 1134, <https://www.hhs.gov/sites/default/files/hhs-draft-strategic-plan-fy2018-2022.pdf> (all sites last visited Oct. 27, 2017).

² *Id.*, lines 115, 975.

³ See SisterSong Women of Color Reproductive Justice Collective, National Latina Institute for Reproductive Health, Center for Reproductive Rights, *Reproductive Injustice: Racial Discrimination in U.S. Health Care, a Shadow Report for the UN Committee on the Elimination of Racial Discrimination* (2014),

become pregnant from exposures, such as the Zika virus or environmental toxins from industrial waste that may harm pregnancy outcomes, should remain a priority of HHS. However, the repeated use of language that suggests that fetuses and embryos — and even fertilized eggs from the moment of conception — have a juridical status that could be described as an “American” or a “person” is contrary to the law,⁴ and threatens women’s health and equality under the law.

Suggestions that fertilized eggs are persons, which can trigger legal protections, have serious consequences for women’s agency in determining whether to become or remain pregnant. Such claims, even if well-intended to improve prenatal care, have the potential to be misused to deny women access to highly effective forms of contraception, such as intrauterine devices, emergency contraception, and even daily hormonal pills, based on claims that these contraceptives make the uterus inhospitable to a fertilized egg.⁵ Language suggesting that life begins at conception is in direct opposition to jurisprudence starting with *Roe v. Wade*⁶ and repeatedly reaffirmed, most recently in *Whole Woman’s Health v. Hellerstedt*⁷ that our law does not define when life begins, and that prior to viability, the state may not “limit[] women’s access to abortion for reasons unrelated to maternal health.”⁸

But women seeking to avoid pregnancy are not the only ones affected when a new protected status is created for fertilized eggs; much of the law pertaining to pressing issues in assisted reproductive technology, such as disposition of unused embryos, is predicated on the notion that frozen embryos are not persons.⁹ The language of the Draft Plan signals a shift that has the potential to create upheaval and uncertainty for people planning their families. Intimate decisions such as whether or not to become pregnant and carry to term, and the size and spacing of one’s family are protected by the Constitution,¹⁰ and language in the Draft Plan that threatens – or can be interpreted to threaten – these decisions should therefore be reconsidered.

Notions such as those implied in the Draft Plan that fetuses are entitled to legal protections that are separate from those provided to the pregnant women upon whom they are

https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf
; See also Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, *Committee Opinion 649: Racial and Ethnic Disparities in Obstetrics and Gynecology*, Dec. 2015.

⁴ See, e.g. *Roe v. Wade*, 410 U.S. 113, 156-69 (1973) (“[T]he word ‘person,’ as used in the Fourteenth Amendment, does not include the unborn.”)

⁵ See Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, *Committee Opinion 615: Access to Contraception*, Jan. 2015.

⁶ *Roe v. Wade*, 410 U.S. 113 (1973); see also *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)

⁷ *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

⁸ *Id.* at 2320.

⁹ See Mark Strasser, *The Next Battleground? Personhood, Privacy, and Assisted Reproductive Technologies*, 65 Okla. L. Rev. 177, 201 (2013). See, e.g., *Kass v. Kass*, 696 N.E.2d 174 (N.Y. 1998), *Davis v. Davis*, 842 S.W.2d 588 (Tenn. 1992).

¹⁰ See, e.g., *Eisenstadt v. Baird*, 405 US 438, 453 (1972) (people have a right under the Fourteenth Amendment “to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”); *Carey v. Population Servs. Int’l*, 431 U.S. 678 (1977); *Griswold v. Connecticut*, 381 US 479 (1965).

dependent are also used to support surveillance, control, and punishment of pregnant women. Research has identified more than 400 instances between 1973 and 2005 of women being deprived of their liberty (including arrests, civil detentions, and forced medical interventions) based on arguments that the state or a private actor sought to protect a fetus.¹¹ Approximately 500 additional women have been arrested in Alabama alone since 2008 under a state high court decision ruling that fetuses from the moment of conception are entitled to protection under a criminal child abuse statute.¹² In other instances, hospitals seeking to force pregnant patients into unconsented care such as blood transfusions or cesarean sections through the use of court orders have based their claims in fetal protection.¹³ Although the ethical standards of the medical profession,¹⁴ the Constitution, and the common law protect women from such incursions,¹⁵ the language of the Draft Plan embraces rhetoric that has been used against pregnant women to devastating effect.

Maternal and fetal outcomes are inextricably linked, and any attempt to separate the two is counterproductive to women's health. For example, concerns about in-utero opioid exposure and Neonatal Abstinence Syndrome led Tennessee lawmakers to amend that state's fetal assault law (intended to punish people who assault pregnant women) to permit criminal charges against women who used criminalized drugs during pregnancy.¹⁶ After two years, that law was allowed to pass out of operation pursuant to a sunset clause when medical and public health experts pointed out that the law was not improving outcomes and was in fact causing women to avoid prenatal care for fear of arrest.¹⁷ Leading medical groups recognize that attempts to protect fetuses that include the potential for criminal or civil penalties for pregnant women destroy the necessary trust between the woman and her doctor and insert the fear of arrest into seeking

¹¹ Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299, 332 (2013).

¹² See *Ankrom v. State*, 152 So.3d 397, 411 (Ala. 2013); see also Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, PROPUBLICA, Sept. 23, 2015, <https://www.propublica.org/article/when-the-womb-is-a-crime-scene>.

¹³ Julie D. Cantor, *Court-Ordered Care — A Complication of Pregnancy to Avoid*, 366 NEW ENGLAND J. MED. 2237 (June 14, 2014).

¹⁴ See Am. Coll. of Obstetricians & Gynecologists, Comm. on Ethics, *Committee Opinion 664: Refusal of Medically Recommended Treatment During Pregnancy*, June 2016.

¹⁵ See, e.g., *In re A.C.*, 573 A.2d 1235, 1252 (D.C. App. 1990)(en banc) (A pregnant woman's wishes must be honored "in virtually all cases unless there are truly extraordinary or compelling reasons to override them. Indeed, some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a caesarean section, against that person's will."); *In re Baby Boy Doe*, 632 N.E.2d 326, 328 (Ill. App. Ct. 1994). ("[A] woman's competent choice in refusing medical treatment as invasive as cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus.")

¹⁶ Rewire News, *Tennessee Fetal Assault Law (SB 1391)*, Jan. 10, 2017, <https://rewire.news/legislative-tracker/law/tennessee-pregnancy-criminalization-law-sb-1391/>.

¹⁷ Blake Farmer, *Tennessee Lawmakers Discontinue Controversial Fetal Assault Law*, NPR.ORG, Mar. 23, 2016, <http://www.npr.org/2016/03/23/471622159/tennessee-lawmakers-discontinue-controversial-fetal-assault-law>; Shiela Burke, *Doctors Applaud End of Tennessee's Fetal Assault Law*, ASSOCIATED PRESS, Apr. 1, 2016, <https://apnews.com/08ce8448799148bf852babadc33d1aef>; Amnesty International, AMR 51/3623/2016, USA: *Tennessee "Fetal Assault" Law a Threat To Women's Health and Human Rights*, Mar. 11, 2016.

ob/gyn care.¹⁸ This is not only cruel and costly; it contravenes the principle that policies must in fact advance the goals they purport to serve without unnecessarily burdening women’s constitutional rights.¹⁹ It also harkens back to a rule of law, now long-defunct, in which discrimination against women was justified on the grounds that “the physical well-being of woman [was] an object of public interest and care in order to preserve the strength and vigor of the race.”²⁰ We encourage HHS to revise the Draft Plan to eliminate this language that frustrates the purpose of the document and threaten the rights and health all pregnant women.

II. THE DRAFT PLAN IMPLIES THAT THE RELIGIOUS AND MORAL BELIEFS OF SERVICE PROVIDERS TAKE PRECEDENCE OVER THE RELIGIOUS LIBERTY, AUTONOMY, AND SAFETY OF PATIENTS

The Draft Plan contains only one reference to the “religious or conscience needs and wishes” of patients,²¹ but refers repeatedly to HHS’s intention to partner with and “remove barriers” to the participation of service providers with religious and moral beliefs in HHS programs.²² These references should be further considered and revised to avoid the potential for such language to be misunderstood as a rejection of the constitutional barriers to government imposition of religious doctrine on unwilling patients.

The Establishment Clause of the First Amendment bars the government from coercing its citizens “to support or participate in any religion or its exercise.”²³ The government is also barred from “endorsing, favoring, or promoting religion.”²⁴ While the Draft Plan is unclear as to what, for example, “removing barriers to, and promoting participation in HHS conducted, regulated, and funded programs by persons and organizations with religious beliefs or moral convictions”²⁵ would entail in terms of policies, the repetition of language to that effect — and

¹⁸ See, e.g., Am. Med. Ass’n, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2667 (1990) (“Pregnant women will be likely to avoid seeking prenatal or open medical care for fear that their physician’s knowledge of substance abuse or other . . . behavior could result in a jail sentence”); Am. Coll. of Obstetricians & Gynecologists, Comm. on Ethics, *Committee Opinion 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (2011, reaffirmed 2014) (“Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus. Incarceration and the threat of incarceration have proven to be ineffective in reducing the incidence of alcohol or drug abuse.”), <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Substance-Abuse-Reporting-and-Pregnancy-The-Role-of-the-Obstetrician-Gynecologist>.

¹⁹ *Whole Woman’s Health*, 136 S. Ct. at 2309, 2311–2312.

²⁰ *Muller v. Oregon*, 208 U.S. 412, 421 (1908). Now, the government must show an “exceedingly persuasive justification” for discrimination on the basis of sex. See *United States v. Virginia*, 518 U.S. 515 (1996); *Frontiero v. Richardson*, 411 U.S. 677 (1973); *Reed v. Reed*, 404 U.S. 71 (1971).

²¹ *Supra* note 1, line 542.

²² *Id.*, lines 169, 359, 365, 371, 399, 402, 435, 476.

²³ *Town of Greece v. Galloway*, 134 S. Ct. 1811, 1825 (2014) (plurality opinion) quoting *County of Allegheny v. ACLU*, 492 U.S. 573 (1989) (Kennedy, J., concurring in judgment in part and dissenting in part).

²⁴ *Freedom from Religion Found. v. Hanover Sch. Dist.*, 626 F.3d 1, 10 (1st Cir. 2010) (citing *County of Allegheny*, 492 U.S. at 593-94).

²⁵ *Supra* note 1, line 475-76.

the near exclusion of language concerning the beliefs of patients — invites the concern that HHS seeks to fund and promote religiously-based care at the possible expense of patients’ religious freedom and safety. This would implicate patients’ rights as well as questions of medical ethics.²⁶

A variety of harms have befallen patients who lack access to secular healthcare either due to geography or lack of notice as to how religiously-based policies would impact their treatment. For example, doctors have reported that religiously-based policies such as those barring the termination of a nonviable pregnancy if a fetal heartbeat is still detectable have jeopardized their ability to provide urgent, life-saving care to miscarrying patients.²⁷ In a recent instance, a patient who was 18 weeks pregnant presented at a hospital suffering from “a fever, excruciating pain, and bleeding.”²⁸ Her treating physician believed she had a serious bacterial infection that can cause infertility or death, but rather than informing the patient that her fetus had little chance of survival and that continuing the pregnancy was a threat to her life, the hospital sent her home. The hospital had a policy forbidding providing or discussing pregnancy termination based on the *Ethical and Religious Directives for Catholic Health Care Services* promulgated by the United States Conference of Catholic Bishops. The patient returned to the hospital in pain twice more and ultimately underwent an unnecessarily risky delivery because she was unaware that physicians would withhold the vital information that her pregnancy was doomed and her life was at risk.

At hospitals with similar policies, patients with ectopic pregnancies — a life-threatening condition involving a pregnancy outside of the uterus that cannot come to term — have experienced delays that can result in rupture of the fallopian tube and undergone surgeries that are more invasive than necessary and may render them infertile.²⁹ Additionally, information about testing for fetal anomalies has been withheld from expectant parents due to the possibility that such tests could lead to pregnancy termination.³⁰

At hospitals with policies against the discussion or use of contraception, victims of sexual assault have been denied the opportunity to take timely action to prevent pregnancy resulting from rape,³¹ and participants in trials of drugs that may cause fetal anomalies have not been

²⁶ See generally *The Limits of Conscientious Refusal in Reproductive Medicine*, Am. Coll. Of Obstetricians & Gynecologists (2007), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co385.pdf?dmc=1&ts=20171024T1926442350>.

²⁷ Lori R. Freedman, Uta Landy & Jody Steinauer, *When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH 1774, 1774 & 1777 (2008).

²⁸ *Means v United States Conf. of Catholic Bishops*, 836 F.3d 643, 647 (6th Cir. 2016), <https://law.justia.com/cases/federal/appellate-courts/ca6/15-1779/15-1779-2016-09-08.html>.

²⁹ Angel M. Foster et al., *Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study*, 21 WOMEN’S HEALTH ISSUES 104, 106 (2011).

³⁰ Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1521 (2012).

³¹ Steven S. Smugar et al., *Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims*, 90 AM. J. PUB. HEALTH 1372, 1372, 1373 (2000) (employees in twelve of twenty-seven Catholic hospitals surveyed reported that their institutions prohibit the discussion of emergency contraception with rape victims).

provided with contraception or advised to use it.³² Hospitals have also had policies in place against advising HIV-positive patients to use condoms and clean needles for intravenous drugs to prevent transmission.³³ Individuals seeking to terminate pregnancies have been subjected to proselytizing and delayed in accessing care after seeking treatment at anti-abortion “crisis pregnancy centers” that present themselves as reproductive health clinics.³⁴

Patients and their families have also learned only after seeking care at a religiously affiliated facility that their end of life wishes would not be honored. At one religiously-affiliated hospital, the family of a vegetative patient was unable to donate his organs in accordance with his wishes, due to a policy of which even the treating physician was not previously aware.³⁵

When religiously-affiliated facilities have policies that forbid providing care in keeping with standard medical practices or the wishes of the patient, they often transfer patients to secular facilities. However, as courts have implicitly recognized,³⁶ patients have the right not just to have their wishes honored eventually, but to avoid unnecessary ordeals and delays stemming from initially undergoing treatment at an inappropriate facility. Without access to secular health facilities and advance notice of religiously-based policies, patients and their families cannot avoid unnecessary hardships such as hospital transfers, treatment delays, withholding of accepted treatment options, having to argue with physicians for medically-accepted care, or having to seek or oppose court orders.

The language of the Draft Plan is likely to exacerbate the problem of federally-funded institutions with religious affiliations providing non-standard medical care, often with no notice to patients. The Draft Plan should be revised to avoid encouraging the misperception that it is permissible for religiously-affiliated service providers to impose their religious beliefs on patients and to give greater attention to the religious freedom, autonomy, and safety of patients.

³² Sepper, *supra* note 31, at 1521.

³³ *Id.*

³⁴ Caroline Mala Corbin, *Compelled Disclosures*, 64 ALABAMA L. REV. 1277, 1342-43 (2014) available at <https://ssrn.com/abstract=2258742>; see also Sofia Resnick, *Taxpayer-Funded Crisis Pregnancy Centers Use Federal Dollars to Proselytize and Spread Medical Lies*, REWIRE NEWS (Apr 24, 2012), <https://rewire.news/article/2012/04/24/jobs-christians/>.

³⁵ Bridgette Dunlap, *Self-Certification and the Contraceptive Coverage Rule: What Does it Mean for an Institution to “Hold Itself Out as Religious?”*, REWIRE NEWS (Apr 1, 2013), <https://rewire.news/article/2013/04/01/the-problem-with-self-certification-in-the-new-contraceptive-coverage-rule-what-does-it-mean-for-an-institution-to-hold-itself-out-as-religious/>.

³⁶ See *In re Jobes*, 108 N.J. 394, 425-26, 529 A.2d 434, 450 (1987) (refusing to permit a religiously-affiliated facility to transfer a patient in a vegetative state to another facility and ordering withdrawal of life support); see also *In re Requena*, 213 N.J. Super 475, 481, 517 A.2d 886, 889 (Super. Ct. 1986) (noting it would be “emotionally and psychologically upsetting” for the patient to have to go to a different hospital to have her wish not to be fed through a nasogastric tube honored).

III. THE DRAFT PLAN SHOULD BE REVISED TO INCLUDE STRATEGIES THAT SPECIFICALLY ADDRESS THE NEEDS OF RACIAL AND ETHNIC MINORITIES AND THE LGBT COMMUNITY SO AS TO BETTER ACHIEVE ITS MISSION OF PROTECTING THE HEALTH AND WELL-BEING OF ALL AMERICANS

Americans who are members of vulnerable populations, namely racial and ethnic minorities³⁷ and members of the LGBT community³⁸ are particularly in need of outreach. While the HHS Draft Strategic Plan for FY 2014-2018 (“2014-2018 Strategic Plan”) included strategies for HHS to “support the safety, well-being, and healthy development of . . . LGBT youth,”³⁹ the Draft Plan delegates to “programs by persons and organizations with religious beliefs or moral convictions and other community organizations”⁴⁰ the task of “[h]ealth promotion and wellness strategies”⁴¹ among “populations at risk for poorer health outcomes.”⁴² Although the Draft Plan cursorily discusses addressing the needs of these broad and diverse populations,⁴³ the strategies that specifically support these two historically underserved groups that were demonstrated in the 2014-2018 Strategic Plan⁴⁴ have been purged from the Draft Plan. HHS under the last administration worked with the Office of Civil Rights to promulgate a rule implementing Section 1557 of the Affordable Care Act to prohibit discrimination on the basis of gender identity in health programs administered by HHS,⁴⁵ consistent with the objectives the administration set for FY 2016.⁴⁶ The Draft Plan, on the other hand, plans to achieve its objectives specifically by “[promoting] participation in HHS . . . programs by persons and organizations *with religious*

³⁷ Erin Schumaker, *The Quality of Health Care You Receive Likely Depends on Your Skin Color*, Huffington Post: Healthy Living (June 29, 2015, 3:24 p.m.), https://www.huffingtonpost.com/2015/06/29/racial-inequality-health-care-black-v-white_n_7164140.html.

³⁸ UNDERSTANDING THE HEALTH NEEDS OF LGBT PEOPLE, NAT’L LGBT HEALTH EDUCATION CTR., 4 (Mar. 2016), <http://www.lgbthealtheducation.org/wp-content/uploads/LGBTHealthDisparitiesMar2016.pdf> (surveying the needs of the LGBT community); see also Hudaisa Hafeez et al., *Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review*, 9 CUREUS 4 (Apr. 20, 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5478215/pdf/cureus-0009-00000001184.pdf>.

³⁹ 2014-2018 Strategic Plan, Lines 1118-20.

⁴⁰ *Supra* note 1, lines 475-76.

⁴¹ *Id.*, lines 469-70.

⁴² *Id.*, lines 470-471.

⁴³ *Id.*, lines 211-12. Addressing the complex needs of *all* at-risk populations in the vaguest terms, the Draft Plan discusses, at different points, “patients who are high risk,” (lines 247-48), “individuals and populations at highest risk,” (line 317), “disadvantaged and at-risk populations,” (line 713), “individuals and populations facing or at high risk for economic and social well-being challenges,” (lines 847-48), and other such platitudes.

⁴⁴ See, e.g., *id.*, lines 490-590, 753-56, 1118-20, 1161-63, 1239-44, 1538-41, and 1751-63.

⁴⁵ See *Nondiscrimination in Health Programs and Activities*, 45 C.F.R. 92, <https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities>.

⁴⁶ LGBT HEALTH AND WELL-BEING: HHS LGBT ISSUES COORDINATING COMMITTEE 2015 REPORT, U.S. DEP’T HEALTH & HUMAN SVCS. (2015), <https://web.archive.org/web/20171026115306/https://www.hhs.gov/programs/topic-sites/lgbt/reports/health-objectives-2015.html#2015>.

beliefs and moral convictions and other community organizations – who have *historically* been the primary funders and deliverers of health care and human services” (emphasis added).⁴⁷ The unfortunate reality is that religious beliefs and moral convictions have historically been justifications for denying members of the LGBT community the right to fully participate in society.⁴⁸ Thus, a plan that relies on increased participation by certain organizations, some of which have historically denied access to this particular at-risk group, does little to ensure that the needs of the LGBT community will be met.

When it comes to racial and ethnic minorities, while some disparities in health outcomes have been reduced since the year 2000, overall, these disparities remain entrenched in our nation.⁴⁹ This is the case despite the concerted efforts of prior administrations to explicitly develop strategies that address the different barriers to access faced by specific racial and ethnic minorities.⁵⁰

The gains already made are but a starting point. In order to ensure that progress continues uninterrupted, the Draft Plan must include strategies that specifically continue prior efforts on improving health outcomes for ethnic and racial minorities and protecting access to health care for members of the LGBT community; at the very least, strategies that focus on these specific communities must be made explicit, instead of referring to the needs of “at-risk populations.” Without these focused approaches, the gains that have thus far been made in reducing the disparity in health outcomes will stagnate, or worse, may be lost.

Sex and Law Committee
Mirah Curzer and Melissa Lee, Co-Chairs

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⁴⁷ *Supra* note 1, lines 474-78.

⁴⁸ This conflict is well-documented; in exploring a way forward, the head of the U.S. Equal Opportunity Commission, Chai R. Feldblum, lays out the legal landscape in a manner that sheds light on why reliance on the groups that have *historically* delivered health care and human services sets the stage for depriving LGBT individuals of support, in the absence of a specific antidiscrimination mandate. Chai R. Feldblum, *Moral Conflict and Liberty: Gay Rights and Religion*, 72 BROOK. L. REV. 61 (2006), <http://scholarship.law.georgetown.edu/facpub/80/>.

⁴⁹ 2016 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, 1 (July 2016), <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/nhqdr16/2016qdr.pdf>.

⁵⁰ 2014-2018 Strategic Plan, Lines 490-590, 753-56, 1118-20, 1161-63, 1239-44, 1538-41, 1751-63.