*Filed Electronically*

September 7, 2022

Department of Health & Human Services
Office for Civil Rights
Attention: 1557 NPRM (RIN 0945-AA17)
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, SW
Washington, DC 20201

Subj: Nondiscrimination in Health Program and Activities
RIN 0945-AA17

Dear Sir or Madam:

On behalf of the United States Conference of Catholic Bishops, Catholic Medical Association, The National Catholic Bioethics Center, National Association of Catholic Nurses, U.S.A., Council for Christian Colleges & Universities, and The Catholic University of America, we respectfully submit the following comments on the proposed rule, published in 87 Fed. Reg. 47824 (Aug. 4, 2022), on nondiscrimination in health programs and activities.

We applaud HHS's effort to ensure that everyone has access to health care and health coverage, but we object to language in the proposed regulations that can be read to require the provision and coverage of procedures that are medically ineffective or cause harm, violate professional and evidence-based judgments as to an appropriate course of treatment, or conflict with the religious and moral convictions of health care providers, insurers, plan sponsors, and other stakeholders. We agree with and support the Department's proposal to apply the regulation only to health programs and activities, and its proposed treatment of notices for non-English speakers.

## I. Access to Health Care

Ensuring access to health coverage and health care, and removing barriers to these, is without question a laudable goal. "Concern for the health of its citizens requires that society help in the attainment of living conditions that allow them to grow and reach maturity … [which includes] health care…." *Catechism of the Catholic Church*, no. 2288. The U.S. Catholic bishops have advocated longstanding moral principles in discerning health care policy: respect for life and dignity, access to all, honoring conscience rights, true affordability, and comprehensive and high quality.[1] Health care should be available to everyone and, toward that end, no one should be without health coverage nor discriminated against in that regard.

## II. Mandated Services and Coverage

Unfortunately, the proposed regulations go beyond access to care by suggesting that health care providers must provide, and that health plans must cover, procedures that are not medically indicated, may harm rather than heal, and may violate the religious and moral convictions of an insurer, plan sponsor, provider, or other stakeholder. Especially problematic is the suggestion in the preamble that HHS might be open to imposing requirements with respect to abortion. Also problematic is language in the text of the proposed regulations that relates to "gender identity" and that, read in conjunction with the preamble, would effectively mandate the provision and coverage of "gender transition" procedures.

We address these issues below, starting with abortion.

### A. Abortion

The proposed regulations would rescind a regulatory provision that ensures neutrality on abortion, and the preamble implies that at least some requirements with respect to abortion are under consideration. The preamble nevertheless also solicits comment on whether and how to incorporate the abortion neutrality provision of Title IX of the Education Amendments of 1972, and whether and how to add more specific provisions on "pregnancy-related conditions."

For several independent reasons, section 1557 of the Affordable Care Act (ACA), 42 U.S.C. § 18116, in our view is not reasonably construed to relate to abortion.

*First*, the abortion-neutral provision in Title IX, codified at 20 U.S.C. § 1688, states that "Nothing *in this chapter* shall be construed to require … any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to an abortion." [Emphasis added.] HHS has said that it will not recognize statutory exceptions in Title IX in the section 1557 context, and it proposes to repeal the current cross reference to section 1688 in the section 1557 regulations. But section 1688 is not an exception. It is a rule of construction that

[1] *See, e.g.,* USCCB Letter to U.S. Senate on Moral Framework for Healthcare During COVID-19 Pandemic (May 7, 2020), at https://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/2020-05-07-Senate-Letter-on-Health-Care-and-COVID-19-1.pdf.

applies to all of Title IX, including that title's prohibition on sex discrimination. Since section 1557 forbids discrimination on any basis prohibited *by Title IX*, it necessarily adopts the sex discrimination prohibition of Title IX as read through the lens of section 1688.

Further to this point, the Notice of Proposed Rulemaking (NPRM) indicates that prohibited discriminatory actions are to be understood with reference to the statutes and regulations from which the respective grounds originate. 87 Fed. Reg. at 47859, 47916 (proposing to amend 45 C.F.R. § 92.101(b)). In the case of Title IX, the NPRM thus expressly references 45 C.F.R. Part 86. That part includes section 86.18, implementing Title IX's statutory abortion neutrality provision. Since, as explained, Title IX's abortion neutrality is a rule of construction rather than an exemption, exception, or protection, the proposed provision regarding discriminatory actions related to sex that references Title IX, 87 Fed. Reg. at 47916, should also include the abortion neutrality construction in order to faithfully reflect the originating statute's understanding of what constitutes discriminatory actions.

In sum, it follows that nothing in section 1557 can or should be construed to require any person to provide or pay for any benefit or service, including the use of facilities, related to an abortion.

*Second*, the Weldon amendment expressly forbids the federal government from discriminating against any health care provider, facility, or plan on the basis that it does not provide, perform, or cover abortion. If there were any conflict between section 1557 and the Weldon amendment (given our first point, we believe there is none), then the Weldon amendment would govern because it is more specific to abortion and has continued to be enacted after passage of the ACA.[2] As the NPRM notes, other federal conscience laws likewise protect health care providers and professionals from being dragooned into performing or participating in abortion.

*Third*, section 1303 of the ACA, codified at 42 U.S.C. § 18023, states that "*Nothing in this Act* [i.e., the ACA] shall be construed to have any effect on Federal laws" regarding "conscience protection," the "refusal to provide abortion," or "discrimination on the basis of the … refusal to provide, pay for, cover, or refer for abortion…." [Emphasis added.] Section 1303 also states that "*Notwithstanding any other provision of this title*," i.e., Title I of the ACA, which includes section 1557, "*nothing in this title* … shall be construed to require a qualified health plan to provide coverage" of abortion. [Emphasis added.] By its very terms, then, section 1303 forecloses any construction of section 1557 that would require the provision or coverage of abortion. Finally, section 1303 gives states the option to prohibit abortion coverage in health plans, so construing section 1557 to require such coverage would contradict that statutory option.[3]

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[2] It is a longstanding rule of statutory construction that if two statutes conflict, the more recent enactment governs over the earlier and the more specific governs over the more general. *RadLAX Gateway Hotel v. Amalgamated Bank*, 566 U.S. 639, 645 (2012) (specific governs over the general); *Watt v. Alaska*, 451 U.S. 259, 266 (1981) (more recent of two conflicting statutes governs).

[3] Section 1303 deals expressly and specifically with abortion, while section 1557 says nothing about abortion. The same rule of construction as to the more specific governing over the general therefore applies again. *See* n.2 *supra*.

*Fourth*, HHS has spent several years now unsuccessfully litigating an earlier regulatory mandate, issued under section 1557, relating to abortion. *Franciscan Alliance v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016). If the Department decides to renew an abortion mandate in the section 1557 regulations, it will face renewed litigation, and any new mandate will almost certainly meet with the same fate as the earlier one. Indeed, a renewed abortion mandate would arguably place the Department in contempt of court by reinstituting what courts have already enjoined.

*Fifth*, even if these arguments lacked merit, which they do not, the Religious Freedom Restoration Act (RFRA) bars an abortion mandate as to those stakeholders with religious objections to abortion. *Franciscan Alliance v. Becerra*, 553 F. Supp. 3d 361 (N.D. Tex. 2021), amended No. 7:16-cv-00108-O, 2021 WL 6774686 (N.D. Tex. Oct. 1, 2021) (enjoining the Department from interpreting or enforcing section 1557 in a manner that would require faith-based plaintiffs with a religious objection to abortion from having to perform or provide coverage of abortion), *aff'd in relevant part*, 2022 WL 3700044 (5th Cir. Aug. 26, 2022); *see* 87 Fed. Reg. at 47826 (citing the district court opinion in *Franciscan Alliance*).

*Sixth*, an abortion-related mandate would defeat the underlying purpose of section 1557, which is to forbid discrimination. Such a mandate would *require* discrimination against providers, plans, and pre-born children: providers and plans because of their decision not to participate in or cover abortion, respectively, and pre-born children because such a mandate would encourage, if not require, their intentional killing. An abortion mandate thus would not *prevent*, but would instead *introduce*, a form of discrimination against classes of persons, which cannot possibly be what Congress intended when it enacted section 1557.

## B. Gender Identity

Protecting patients from discrimination on the basis of gender identity, as the proposed regulations in part aim to do, need not, and ought not, include a mandate to perform or cover gender transition procedures. Nondiscrimination should guarantee persons, regardless of the gender with which they self-identify, the same medical care as anyone else across all indications, such as treatment for the flu or a broken leg, without harassment or difference in care. Declining to perform or cover a particular procedure because it is harmful or ineffective, or because the procedure itself is morally objectionable regardless of the identity of the patient in question, is, on the otherhand, not discrimination at odds with the goals of the Department in ensuring access to care for everyone.

### 1. General Principles

A mandate to perform or cover gender transition procedures is in tension with two principles that animate health care and health insurance.

*First*, the health care profession, precisely because it is a profession, requires the exercise of judgment on the part of a patient's physician or other health care provider, which is necessarily

related to an insurer's or plan administrator's evidence-based judgment as to what is appropriately covered. Patients, to be sure, have a right to be involved in their own health care, but they do not have a right to a treatment that professional medical judgment concludes will (a) fail to cure the patient, (b) fail to alleviate his or her condition, or (c) do affirmative harm. The health care profession is not a vending machine. A patient does not simply put in a token and obtain any item or procedure of his or her choosing.

*Second*, many health providers, insurers, and plan sponsors, especially those with a religious affiliation, provide evidence-based health services and coverage because of their underlying religious and moral views about the dignity and sanctity of human life. The provision of medical services and health coverage by religious organizations, employers, and insurers is part and parcel of their religiously motivated goal to provide services and coverage for medical procedures that will heal or otherwise benefit their patients, employees, and insureds. No health care provider should be required as a condition of practicing medicine, and no insurer or plan sponsor should be required as a condition of participating in the market for health plans, to violate the very religious and moral convictions that prompt them to provide those services and offer those benefits in the first place.

### 2. Procedures Relating to Gender Identity

In tension with these two principles, the proposed regulations would forbid both individual decisions not to provide or cover, and a "categorical" exclusion or limitation on performing or covering, procedures and other interventions that would stunt human sexual development, mutilate the body, and cause sterilization.

Like many health care providers, we believe that such interventions are not properly viewed as health care because they do not cure, prevent, or ameliorate disease or illness and, in fact, are detrimental to patients regardless of the identity asserted by the patient. Surgical alteration of the genitalia, in particular, mutilates the body by taking a healthy bodily system and rendering it dysfunctional. *See* Richard P. Fitzgibbons, M.D., et al., *The Psychopathology of "Sex Reassignment" Surgery: Assessing its Medical, Psychological and Ethical Appropriateness*, National Catholic Bioethics Quarterly 97, 10 (Spring 2009). We expect that many individual and institutional providers, health care workers, insurers, plan sponsors, and individual purchasers will find mandatory provision or coverage of such procedures objectionable—not because of any discriminatory animus, but because they understand them not to be in the best interest of the patients.

Changes in attitudes and conceptualizations of gender, gender dysphoria, and gender-related procedures, no matter who embraces them, do not eliminate the serious questions that medical research has raised concerning the health outcomes of such procedures. In 2020, for example, a study employing the world's largest data set on patients receiving "gender-affirming" surgeries was corrected, saying that "the results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care." The same study had already similarly found no benefit from hormonal procedures. Richard Branstrom & John E. Pachankis, *Reduction*

*in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study*, AM. J. PSYCHIATRY, 177:734 (Aug. 2020) (republished for correction).

A study by the Karolinska Institute in Sweden, tracking patients over a 30-year period, "revealed that beginning about 10 years after having the surgery, the transgendered began to experience increasing mental difficulties. Most shockingly, their suicide mortality rose almost 20-fold above the comparable nontransgender population." Paul R. McHugh, M.D., *Transgender Surgery Isn't the Solution: A Drastic Physical Change Doesn't Address Underlying Psycho-Social Troubles*, WALL STREET JOURNAL (June 12, 2014); *see* Cecilia Dhejne, et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden* (Feb. 22, 2011) ("Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population"); *see also* David Batty, *Sex Changes Are Not Effective, Say Researchers*, THE GUARDIAN (July 30, 2004) ("There is no conclusive evidence that sex change operations improve the lives of transsexuals, with many people remaining severely distressed and even suicidal after the operation," according to a review of more than 100 international medical studies of post-operative transsexual individuals).

HHS itself has expressed reservations about the efficacy and outcomes of "gender reassignment surgery." During the Obama administration, the Department declined to issue a national coverage mandate for such surgery in its own programs. Center for Medicare & Medicaid Services, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery, CAG-00446N (Aug. 30, 2016) (finding that "the clinical evidence is inconclusive," that "there is not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes," and that "we cannot exclude therapeutic interventions as a cause of the observed excess morbidity and mortality").

Hormonal treatment also poses risks. Puberty-delaying hormones often administered to children to facilitate later sex-change surgery, for example, "stunt [their] growth and risk causing sterility." McHugh, *Transgender Surgery Isn't the Solution*, *supra*. In fact, such products (such as Gonadotropin-releasing hormone agonists) are not even approved by the Food and Drug Administration to be used for treatment of gender dysphoria and thus can only be prescribed off-label for that purpose, which would seem to make them a counterintuitive object for a provision and coverage mandate.

By contrast, decisions not to provide hormonal or surgical interventions have yielded positive results. Vanderbilt University and London's Portman Clinic had previously reported, for example, that a large percentage of children (70 to 80%) who reported transgender feelings but received no medical or surgical intervention ultimately lost those feelings. *Id.*; *see also* Thomas D. Steensma, et al., *Desisting and Persisting Gender Dysphoria after Childhood: A Qualitative Follow-up Study*, CLINICAL CHILD PSYCHOLOGY AND PSYCHIATRY, 16:4, 499-516 (Oct. 2011); Kelley D. Drummond, Susan J. Bradley, Michele Peterson-Badali, and Kenneth J. Zucker, *A Follow-up Study of Girls with Gender Identity Disorder*, DEV. PSYCHOLOGY, 44:1, 34-35

(2008); Madeleine S.C. Wallien and Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-dysphoric Children*, J. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, 47:12, 1413-23 (2008).[4]

The European medical community has expressed special caution with respect to treatment of children experiencing gender dysphoria. Just this July, it was announced that Britain's National Health Service will be shutting down the United Kingdom's predominant gender clinic, in part due to its practice of pushing large numbers of children into medical gender transition procedures, in favor of an approach that will consider other contributing factors and treatments. Jasmine Andersson and Andre Rhoden-Paul, *NHS to Close Tavistock Child Gender Identity Clinic*, BBC News (July 28, 2022). In February of this year, Sweden's National Board of Health updated guidelines for the treatment of gender dysphoria in minors, backing away from the previously dominant hormone therapy approach. Society for Evidence-based Gender Medicine, *SEGM Summary of Key Recommendations from the Swedish National Board of Health and Welfare* (Socialstyrelsen/NBHW) (Feb. 27, 2022), citing https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdaterade-rekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/.[5] The same month, France's National Academy of Medicine similarly advised "great medical caution" and "the greatest reserve" with respect to treatment of children identifying as transgender. Académie Nationale de Médecine, *Medicine and Gender Transidentity in Children and Adolescents* (Feb. 25, 2022), *available at* https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang-en. Last year, Finland's Health Authority likewise issued guidelines preferring psychotherapy over medicalized interventions for minors. Society for Evidence-based Gender Medicine, *One Year Since Finland Broke with WPATH "Standards of Care"* (July 2, 2021), *citing original at* https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Original.pdf.

These outcomes and developments suggest that patients may not be well served, and indeed that their health may actually be harmed, by attempts to "change" their sex. We realize that studies relied upon by organizations cited in the NPRM produce contrary recommendations. Yet,

[4] Cross-sex hormones present their own physical health risks by, in addition to potential sterility, possibly heightening the chances of cardiac disease, high blood pressure, blood clots and stroke, diabetes, gallbladder disease, breast cancer in men, and sleep apnea in women. *See* T. Alzahrani, *Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population*, CIRCULATION: CARDIOVASCULAR QUALITY AND OUTCOMES (2019); N.M. Nota, et al., *Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy: Results From a Large Cohort Study*, CIRCULATION, 139, 1461-62 (2019); D. Getahun, et al., *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, ANN. INTERN. MED., 169:4 (2018); M.S. Irwig, *Cardiovascular Health in Transgender People*, REV. ENDOCR. METAB. DISORD., 19:3 (2018); S. Maraka, et al., *Sex Steroids and Cardiovascular Outcomes in Transgender Individuals: A Systematic Review and Meta-Analysis*, J CLIN. ENDOCRINOL. METAB., 102:11 (2017); J. Feldman, G.R. Brown, M.B. Deutsch, et al., *Priorities for Transgender Medical and Healthcare Research*, CURR. OPIN. ENDOCRINOL. DIABETES OBES., 23, 18-87 (2016); D. Macut, I. B. Antić, and J. Bjekić-Macut, *Cardiovascular Risk Factors and Events in Women with Androgen Excess*, J. OF ENDOCRINOLOGICAL INVESTIGATION, 38:3 (2015); E. Moore, A. Wisniewski, A. Dobs, *Endocrine Treatment of Transsexual People: A Review of Treatment Regimens, Outcomes, and Adverse Effects*, J. CLIN. ENDOCRINOL. METAB., 88, 3467-73 (2003).

[5] *See also* English summary, p. 10, *available at* https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-2-7774.pdf.

such studies are often critically limited either to the short-term or by failure to adequately consider a high number of persons who are lost to follow-up and do not respond in the long-term. *See generally* Lawrence S. Mayer and Paul R. McHugh, *Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences*, THE NEW ATLANTIS, no. 50 (Fall 2016). Moreover, popular reporting on these studies, reporting that often drives policy making in this area, sometimes conflates suicidal ideation, attempted suicide, and the commission of suicide, each of which should be prevented and warrant their own distinct care and consideration. Since the goal of health coverage in every case is to preserve and promote good health, attempts to change sex should not be made a mandatory item of coverage.[6] Indeed, given the research and experience, such attempts could expose health care providers to claims of medical malpractice. It is unquestionably poor regulatory policy for the federal government to require the performance or coverage of a procedure in any circumstance where the provision of that procedure itself would subject a health professional to a malpractice claim.[7]

### 3. Patient Privacy

Defining sex discrimination to include differential treatment based on gender identity, as the proposed rule does, raises questions about arrangements and practices involving patients who share intimate space with, or require intimate personal assistance from, other individuals.

In the preamble with respect to proposed section 92.206(b)(3), the NPRM appropriately acknowledges that "[f]or example, the practice of assigning patients to dual-occupancy rooms in hospitals and in-patient treatment facilities on the basis of sex is not, standing alone, a form of discrimination," yet then goes on to propose the apparent evisceration of this patient-centered approach by requiring patients to be treated consistently with their asserted gender identity. 87 Fed. Reg. at 47866-67. Does the Department take the position that, for example, a resident in a long-term care facility must room with someone of the opposite biological sex who asserts the same gender identity as the former? This would seem to violate an expectation of privacy in intimate settings for vulnerable and older adults. Further, it may violate certain faith-based homes' duty to honor the dignity of, and the virtue of modesty with respect to, residents in their care.

A similar question arises in the context of patients or residents of a hospital or care facility who need very personal assistance, such as with bathing. For example, would the proposed rule require that a nursing home resident be bathed by an employee of the opposite biological sex, against the patient's wishes and when appropriate staff of the same biological sex is available,

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[6] Problems similar to those that we have identified with respect to gender identity may also arise with respect to the inclusion of sexual orientation as a protected category. For example, a person who is a counselee of a mental health care provider may seek affirmation of a relationship or conduct that conflicts with the provider's religious or moral convictions. *E.g.*, *Ward v. Polite*, 667 F.3d 727 (6th Cir. 2012) (graduate student expelled from counseling program because of opposition to homosexual conduct stated triable free speech and free exercise claims).

[7] *See*, *e.g.*, Kurt Zindulka, *Disgraced Tavistock Trans Kids Clinic Faces Lawsuits from 1,000 Families* (Aug. 12, 2022), available at Disgraced Trans Child Clinic Faces Lawsuits From 1,000 Families (breitbart.com).

based on the employee's assertion of a gender identity corresponding to that of the resident? One might also imagine on the other hand a resident patient requesting bathing or restroom assistance from an employee of the opposite biological sex on account of the resident's asserted gender identity. These issues should be approached in a manner that respects the rights and sensibilities of patients and employees, with operational flexibility being preferable to one-sided mandates.

We also note that certain faith-based long-term care facilities that include couples who are married as cohabiting residents may consider it a substantial burden on their sincerely held religious beliefs if mandated to treat as married a same-sex civilly married couple.

## III. Religious Freedom

In March 2022, four bishop chairmen of USCCB committees sent a letter[8] to Secretary Becerra identifying principles that should inform HHS's rulemaking on section 1557, and that urged HHS to recognize protections for religious exercise under both the law and a sound conception of public policy. HHS apparently did not take the letter to heart. Treating a decision not to provide or cover gender transition procedures as discrimination is not only inappropriate for the reasons stated above, but will create unnecessary conflicts with RFRA and other federal statutory protections for conscience and religious freedom in health care, as well as the Religion Clauses of the First Amendment. The text of the proposed rule dealing with religious exemptions is inadequate, and the preamble contains ominous suggestions that HHS specifically intends to target the religious exercise of religious health care workers and organizations.

### A. Proposed Rule Text Regarding Religious Exemptions

To its credit, HHS has included a provision in the proposed rule text, at section 92.302, that provides for the application of religious freedom laws to the proposed rule's requirements. However, while this provision may be laudable in its intent, it fails in its execution, and may cause more problems than it solves.

Neither the preamble to the proposed rule nor the rule text ever mentions the Conscience Rule, 84 Fed Reg. 23170 (May 21, 2018), but that rule looms large over section 92.302. Among other things, the Conscience Rule defines terms used in numerous federal statutes protecting conscience and religious freedom in health care, explains how the Department's Office for Civil Rights (OCR) would apply those definitions, and describes the processes and means by which OCR would investigate complaints. Unfortunately, HHS has announced via the Unified Regulatory Agenda its plans to rescind the Conscience Rule.

The proposed section 92.302, by contrast, offers covered entities no assurance in the form of either substance or process. Paragraph (b) appears to contemplate that recipients would wait until they are investigated or subject to an enforcement action before notifying OCR of their view that federal conscience and religious freedom laws protect them—or that paragraph at least provides no incentive for recipients to notify OCR any earlier than that, since it imposes no obligation on

[8] A copy of the letter is attached and incorporated herein by reference.

OCR to weigh the claim until such an investigation or enforcement action is at hand.

Paragraph (c) says that OCR will assess whether the factual record is sufficiently developed for OCR to make a decision, but it does not say what happens if the factual record is not fully developed, what sort of facts would assist OCR in making that determination, or how OCR might go about obtaining the facts. By omitting any discussion of a covered entity's potential recourse in the event of an adverse decision from OCR, the provision implies that the only choice is to file a lawsuit, but that is left unsaid.

The preamble seems to suggest that OCR's decisions would be case-specific and therefore would offer covered entities no guarantee of protection from a future enforcement action arising out of a separate set of facts. The preamble (87 Fed. Reg. at 47886) states:

> Considering recipients' religious- or conscience-based concerns in the context of an open case (i.e., when OCR first has cause to consider the recipient's compliance) will allow OCR to make an informed, case-by-case decision…. [T]he Department also maintains a strong interest in taking a case-by-case approach to such determinations, which will allow it to account for any harm an exemption could have on third parties….

If OCR will only make an exemption determination with regard to a particular *case*—that is, a finding that a covered entity is exempt from a particular *application* of a rule provision against *past* or present conduct—it is unclear why paragraph 92.302(a) invites religious entities to express their view that they are exempt from a certain *provision* of the rule, presumably with regard to present or *future* conduct. After all, the latter does not appear to be an exemption that OCR is willing to grant. So section 92.302 seems to be based on two inconsistent positions on how religious exemptions work under RFRA and other applicable conscience and religious freedom statutes. This creates further confusion for religious entities trying to understand what the rule requires of them.

Lastly, and perhaps most significantly, aside from noting that OCR's application of the federal conscience and religious freedom laws will consider third-party harms—which foes of religious freedom frequently assert as a basis for challenging the constitutionality of *any* protection for religious exercise—the proposed rule offers no guidance about what OCR thinks any of those laws mean, nor any guarantee that OCR's understanding of those laws will remain the same from case to case. Of course, covered entities may glean some additional, albeit discouraging, insight based on positions that the Department of Justice has taken on HHS's behalf in three separate cases where HHS is fighting court rulings that the 2016 Rule violated RFRA.[9]

In short, reliance on the proposed section 92.302 is a high-risk, low-reward venture for

[9] *Franciscan All., Inc. v. Becerra*, 553 F. Supp. 3d 361 (N.D. Tex. 2021), *aff'd in relevant part*, 2022 WL 3700044 (5th Cir. Aug. 26, 2022); *Religious Sisters of Mercy v. Azar*, 513 F. Supp. 3d 1113 (D.N.D. 2021); *Christian Emp'rs All. v. EEOC*, No. 21–cv–00195, 2022 WL 1573689 (D.N.D. May 16, 2022).

covered entities with religious beliefs that forbid what the proposed rule would mandate, and section 92.302's lack of both process and substance will tend to generate arbitrary and capricious applications of conscience and religious freedom protections.

These deficiencies are significant, and fixing them will require major revisions to section 92.302, because that section tries to do in four paragraphs more than the entire Conscience Rule did. The more sensible approach, in our view, would be for HHS simply to incorporate the Title IX religious exemption by reference, as we have previously argued HHS must do,[10] and as the district court in *Franciscan Alliance* ruled it is required to do.

**B. <u>Troubling Passages in the Preamble</u>**

In the preamble's discussion of HHS's reasons for refusing to incorporate the Title IX religious exemption, HHS argues (87 Fed. Reg. at 47840-41):

> [H]ealth care consumers are not always aware that the health care entities from which they seek care may be limited in the care they provide. Incorporation of Title IX's religious exception would therefore seriously compromise Congress's principal objective in the ACA of increasing access to health care.

In support of this point, the preamble (*id*. at 47841 n.217) cites to articles entitled "Market Share of US Catholic Hospitals and Associated Geographic Network Access to Reproductive Health Services" and "Most Catholic Hospitals Don't Disclose Religious Care Restrictions."

In light of the materials cited, it is difficult to read this passage as anything other than an expression of HHS's intent to use section 1557 to force Catholic hospitals to provide drugs and procedures that they cannot, as a matter of religious belief, provide.

In the preamble's discussion of the meaning of paragraph (b)(2) of section 92.206, HHS explains that "prohibited discrimination may take the form of attempted restrictions on individual providers, such as attending physicians, that have the effect of discriminating against patients" and that "a covered entity is also prohibited from punishing or disciplining a provider for providing clinically appropriate care where doing so would have the impact of limiting that provider's ability to provide such care on the basis of a patient's assigned sex at birth, gender identity, or gender otherwise recorded." 87 Fed. Reg. at 47866. This passage appears to take direct aim at the USCCB's Ethical and Religious Directives for Catholic Health Care Services, which set out the moral principles of Catholic teaching that guide Catholic health care ministry.

In both cases, we call on HHS to disavow the apparent intent of these passages and affirm HHS's support for the value of religiously-affiliated health care and the right of faith-based

[10] *See* Comments of USCCB et al. (Nov. 6, 2015), pp. 14-18*, available at* https://www.usccb.org/sites/default/files/about/general-counsel/rulemaking/upload/Comments-Proposal-HHS-Reg-Nondiscrimination-Federally-Funded-Health.pdf.

hospitals to continue to operate in accord with their faith.

## IV. Additional Considerations

### A. Scope of "Health" Programs and Activities

In the NPRM, the Department requests comment on its proposal to limit the proposed nondiscrimination regulation to its "health" programs and activities, rather than applying that regulation to all of its programs and activities. 87 Fed. Reg. at 47838-39. We support this aspect of the proposal and believe it reflects the only appropriate interpretation of the authorizing statute on this point.

Section 1557 specifically states that "an individual shall not … be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, … or under any program or activity that is administered by an Executive Agency or any entity established under this title." The plain and unambiguous meaning of the statute as applied to federal financial assistance is therefore limited to health programs and activities. Insofar as any other programs or activities administered by an Executive Agency or an entity established under Title I of the ACA lack the modifier "health," it would be a vast departure from both a natural reading and practicality to imagine that Congress could have intended the nondiscrimination provision of the ACA—a statute principally concerned with health care—to apply potentially to *all* programs and activities administered by *all* executive agencies. Moreover, that the only entities listed in addition to "an Executive Agency" are those established under Title I of the ACA, which the NPRM states are "as a whole, health programs or activities" (87 Fed. Reg. at 47838), is suggestive of the scope that Congress had in mind.

Even if a universal interpretation to all non-health programs and activities were possible, implementing it to the fullest possible scope would be unworkable through a single agency rulemaking such as the one herein under consideration, for multiple reasons, at least one of which the Department recognizes in this proposal. As stated in the preamble to the NPRM, the Department "believe[s] this is an appropriate limitation for this regulation given the specificity of the vast majority of the regulatory provisions to health programs and activities." *Id*. We agree, in terms of the specificity within the NPRM; the great detail and specificity required for health care regulations in general that may not readily fit other programs or activities facing equivalent regulations; and similarly the necessity for non-health programs and activities to be treated with area-specific implementing regulations, if any. Further, the vast number and variety of programs administered by the Department touch so many partner organizations in different fields of operation that a new regulatory burden on them should not come unexpectedly through this health care rulemaking. If it were to come at all, it should be through particularized rulemakings in which specific comment is sought from respective stakeholders who are thereby given a fairer notice and opportunity to respond. For these reasons, we agree with the Department's decision to apply this proposed rulemaking only to health programs and activities.

## B. Information for Non-English Speakers

HHS proposes instituting requirements that certain information, including what was formerly referred to as "taglines," be provided in pertinent languages to patients and the public. 87 Fed. Reg. at 47852-56. This information, as proposed by the Department, will now include a notice of nondiscrimination and information as to the availability of language assistance services and appropriate auxiliary aids and services for non-English speakers. *Id*. We support that proposal. The notifications in question, if accurate, will facilitate access to health care, and having such information in languages that recipients can clearly understand is of utmost importance.[11]

## Conclusion

For all these reasons, we believe HHS should exclude from the regulations any language that requires the provision or coverage of abortion or any benefit or service related to abortion. The Department should also exclude language that is unnecessary to protect people from discrimination in receiving health care, and that could instead be construed to require the provision or coverage of procedures or treatments that health care providers or insurance issuers have determined are unsupported by medical evidence or that violate the religious and moral convictions of providers, insurers, and other stakeholders. We agree with and support the Department's proposal to apply the regulation only to health programs and activities, and its proposed inclusion of notices for non-English speakers.

Thank you for the opportunity to comment.

Respectfully submitted,

Anthony R. Picarello, Jr.
Associate General Secretary and General Counsel
Michael F. Moses
Director, Legal Affairs
Daniel E. Balserak
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Craig L. Treptow, M.D.
President
The Catholic Medical Association

Joseph Meaney, Ph.D.
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[11] To be clear, any discussion of nondiscrimination requirements in the notices should reflect a correct understanding of section 1557, as we believe is reflected in our comments.

Patricia Sayers, DNP, RN
President
National Association of Catholic Nurses, U.S.A.

Shirley V. Hoogstra
President
Council for Christian Colleges & Universities

Dr. Peter K. Kilpatrick
President
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Attachment: Letter to HHS (also available at https://www.usccb.org/resources/Letter_to_HHS_on_1557_3-11-22.pdf)

**ADDENDUM**

United States Conference of Catholic Bishops
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March 11, 2022

The Honorable Xavier Becerra
Secretary, U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Becerra,

We understand that the U.S. Department of Health and Human Services ("HHS") plans to revise its regulations implementing Section 1557 of the Affordable Care Act. We are mindful that the Section 1557 regulations promulgated in 2016 (the "2016 Rule") imposed severe burdens on religious liberty, and that HHS may be considering reinstating the provisions in question. We are also aware of a June 8, 2021 memorandum from the Leadership Conference requesting a host of additional regulations that, if implemented, would burden religious exercise still more severely. We are writing therefore, as chairmen of committees of the U.S. Conference of Catholic Bishops (USCCB) on how HHS might approach the religious liberty issues raised by these regulations. Our purpose here is not to provide an exhaustive treatment or detailed legal analysis, nor to articulate the fullness of Church teaching on the implicated matters, but rather to identify certain key principles that might help inform HHS on the specific question of how and why these regulations could be crafted to respect religious freedom and so avoid needless church-state conflict.

I. For Catholics, health care is religious exercise

Catholics have been called to care for the sick since the earliest days of our faith. Here in America, the Ursuline nuns ran the Royal Hospital in New Orleans before our country declared its independence from Britain.[1] Today, with hundreds of hospitals and health care facilities affiliated with the Catholic Church in operation, Catholic entities taken together are the largest nonprofit health care provider in this country.[2] We do this in fulfillment of the direct command of Jesus Christ (Mt. 10:8-10)[3] and in imitation of his divine ministry here on Earth.

We serve all in need, without regard to race, religion, sex, or any other characteristic, because we believe that health care is a basic human right. As the USCCB's predecessor organization, the National Conference of Catholic Bishops, stated in 1993, "This right flows from the sanctity of human life and the dignity that belongs to all human persons, who are made in the image of God."[4] The same core beliefs about human dignity and the wisdom of God's design that motivate Catholics to care for the sick also shape our convictions about care for preborn children, marriage, sex, and the immutable nature of

[1] John E. Salvaggio, *New Orleans' Charity Hospital: A Story of Physicians, Politics, and Poverty* 8 (1992).
[2] Catholic Health Ass'n, Catholic Health Care in the United States, at 1 (Mar. 2021), www.chausa.org/about/about/facts-statistics.
[3] "Cure the sick, raise the dead, cleanse lepers, drive out demons. Without cost you have received; without cost you are to give. Do not take gold or silver or copper for your belts; no sack for the journey, or a second tunic, or sandals, or walking stick. The laborer deserves his keep."
[4] https://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/health-care-comprehensive-care.pdf

the human person. These commitments are inseparable.

These foundational beliefs also positively affect the quality of the care we provide. Nonprofit religiously affiliated hospitals "save more lives, release patients from the hospital sooner, and have better overall patient satisfaction ratings."[5] Religious hospitals "demonstrated significantly better results than for-profit and government hospitals on inpatient and 30-day mortality, patient safety, length of stay, and patient satisfaction."[6] Catholic hospitals care for more than one of seven hospital patients in the United States.[7]

Because health care ineluctably raises questions of religious significance – of life and death, and what it means to be healthy and flourish – the protection of religious freedom in health care is particularly important. This is true not only of health care providers, as described above, but of health care consumers as well. A healthcare industry devoid of any sensitivity to, or understanding of, the religious beliefs of its patients would not well serve our religiously diverse citizenry.

## II. Religious liberty is a strong civil right

A proper understanding of how to respect religious liberty in health care must begin with an acknowledgment that religious liberty is itself a civil right – indeed, one of foundational importance. It is a right that flows from the inherent dignity of every human person. In our country, we are fortunate that this right is also deeply rooted in our country's history and law, ultimately enshrined in the First Amendment to our Constitution and continuing throughout every level of law and regulation. The harmony between this fundamental right of the human person and the laws of our nation has proven essential to the flourishing of American society. Religious liberty is not limited to the right to worship or to hold religious beliefs in private, but protects religious *exercise* – that is, *actions* based on religious beliefs, whether in private or in the public square. This right is not boundless, but it is still robust, yielding only to government interests of the highest order that cannot be served in any other way. Accordingly, HHS should not treat religious liberty as a second-tier right.

## III. HHS should be proactive in protecting religious liberty

When government accommodates religious differences, it "follows the best of our traditions."[8] Such accommodations should be embraced and maximized, rather than shunned and minimized. But in the 2016 Rule, HHS did not include any religious exemption at all, taking the position that Section 1557's rule against discrimination "on the ground prohibited under… title IX" did not incorporate Title IX's religious exemption, which provides that certain acts by religious organizations are not prohibited under Title IX. Subsequent lawsuits brought by religious organizations detailed the ways in which the 2016 Rule burdened religious exercise, and the federal district courts in the cases of *Franciscan Alliance* and *Sisters of Mercy* enjoined HHS from enforcing certain aspects of the rule against those organizations. In the preamble to the recent proposed rule regarding discrimination in plans on the Exchanges, HHS acknowledged that the Religious Freedom Restoration Act (RFRA) and other laws might require exemptions or accommodations from the rule's requirements, but did not provide a religious exemption in the text of the proposed rule. In our comments on that proposed rule, we urged HHS to proactively include religious exemptions in the final rule, considering that HHS is well aware from prior experience

[5] David Foster et al., Hospital Performance Differences by Ownership 1 (June 2013), http://docplayer.net/13886677-Hospital-performance-differences-by-ownership.html.
[6] *Id.* at 2.
[7] Catholic Health Ass'n, *supra*, note 2.
[8] *Zorach v. Clauson*, 343 U.S. 306, 314 (1952).

that the rule will burden religious exercise, and that courts have upheld religious freedom challenges substantially the same as those the proposed rule will generate.

We similarly urge HHS to be proactive in protecting religious liberty in its revisions to Section 1557 regulations. Litigation over the 2016 Rule has demonstrated that courts will require religious exemptions to be provided for entities similarly situated to the plaintiffs in *Franciscan Alliance* and *Sisters of Mercy*. HHS should not force religious health care providers to relitigate these issues especially when the outcome is likely to again be in favor of the plaintiff-providers. Furthermore, permitting religious organizations and persons to be true to, and to act upon, their beliefs is good public policy. Our nation's health is better for the faith of those who care for it.

IV. The interplay between religious liberty and nondiscrimination protections is not a zero-sum game

It is frequently argued that purported conflicts between religious liberty and principles of nondiscrimination can only be resolved by the total subjugation of one party's religious belief to the interests of the individual claiming discrimination. Such arguments often invoke the concept of dignitary harm – the idea that simply being denied a requested medical intervention on religious grounds is necessarily discrimination and is a harm in and of itself that the law must prevent or remedy, even when the individual suffers no adverse health effects from that denial.[9] Similarly, in its defense of the HHS contraceptive mandate, HHS argued, albeit late in the litigation, that individuals employed by objecting religious organizations must be able to access contraceptives "seamlessly" – that any inconvenience at all to the employee would be too great a price to pay for the employer's right to follow its religious beliefs.

This zero-sum framing of the interplay between religious liberty and other interests degrades our nation's social fabric by pitting those who hold certain religious beliefs against those who do not. HHS can instead seek solutions that both honor religious liberty and satisfy the policy goals HHS wishes to advance. HHS has a chance to set the tone of the dialogue over religious liberty in health care. It should choose inclusion and understanding over division and strife.

V. A sound conception of religious liberty protects the right not to be complicit in actions the religious entity believes to be wrong

It is uncontroversial to hold that one can be morally culpable for assisting, facilitating, or being otherwise complicit in an action committed by another. Indeed, American law reflects this principle in numerous ways, such as by imposing criminal penalties on those who are accessories to a crime. Federal laws protecting rights of conscience in health care recognize this principle as well, as in the Weldon Amendment's protection against having to refer for abortion (as opposed to performing abortions), or the Church Amendment's protection against having to assist in performing an objectionable part of a health service program (as opposed to performing that part oneself). The U.S. Supreme Court has affirmed that the rights of free exercise protected by the First Amendment and RFRA extend to objections to being made complicit in acts the objector believes to be immoral (*Thomas v. Review Bd.*, *Burwell v. Hobby Lobby*). In approaching its revisions to the Section 1557 regulations, HHS should decline invitations to restrict religious liberty protections to only those who would be required to directly perform the objected-to treatment or procedure.

[9] The endorsement of this line of thinking by HHS would constitute a troublesome value judgment for the federal government to make, since it is precisely the dignity of the human person that the Church upholds through its teachings.

VI. The Church's teachings promote human flourishing and the common good

With respect to matters of "gender identity," the Catholic teaching as expressed through Pope Francis understands that "'biological sex and the socio-cultural role of sex (gender) can be distinguished but not separated.'"[10] Further, each human being, "man and woman, should acknowledge and accept his sexual identity,"[11] which is both biological and God-given. Respect for the immutability of sex does not mean Catholic health care condones unjust discrimination. Persons who experience gender discordance are to receive the same care and treatment as anyone else for any given condition or indication. To continue providing this, Catholic entities must not be forced to perform procedures that, for a given indication and regardless of patients' characteristics, would violate the foregoing teachings of their faith or other tenets, such as those precluding sterilization.

It is similar with regard to the class of "sexual orientation." Individuals who experience same-sex attraction are to be "accepted with respect, compassion, and sensitivity,"[12] including in health care settings where they or their loved ones receive care. This does not mean, however, that providers can be compelled to act contrary to the principle that sexual conduct is specially reserved for lifelong marriage between one man and one woman, ordered by its nature toward the good of the spouses and to the procreation and education of children,[13] who in turn have a right to a mother and a father.[14]

This regard for both marriage and children also illumines the inadmissibility of many assisted reproductive technologies and practices, such as in vitro fertilization or gestational surrogacy (which can also involve the destruction of human life) and contraception. Pope Francis reminds us that "[a] child deserves to be born of that love, and not by any other means, for 'he or she is not something owed to one, but is a gift', which is 'the fruit of the specific act of the conjugal love of the parents.'"[15] Married couples who experience infertility, of course, must be offered pastoral care and community, and encouraged in additional ways of living out their love. Appropriate medical research and means to relieve infertility are to be supported.[16]

The Church teaches that the sexual union of husband and wife is meant to express the full meaning of marriage, marital love, and the gift of life, as well as its power to bind a couple together and its openness to new life. For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means. Regarding contraceptive interventions, the Church teaches that "every action, whether in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, has the purpose, whether as an end or as a means, to render procreation impossible" is intrinsically evil.[17] Such interventions violate "the inseparable connection, established by God…between the unitive significance and the procreative significance which are both inherent to the marriage act."[18]

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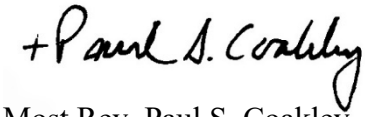
[10] Pope Francis, Apostolic Exhortation *Amoris Laetitia*, no. 56 (2016).
[11] Catechism of the Catholic Church, nos. 2333, 2393.
[12] Catechism of the Catholic Church, no. 2358.
[13] *See* Catechism of the Catholic Church, nos. 2360, 2363; *Gaudium et Spes*, no. 48 (1965).
[14] *See* Pope Francis, colloquium on "The Complementarity of Man and Woman," Rome, 17 Nov. 2014; Pope Francis, audience with International Catholic Child Bureau, 11 Apr. 2014.
[15] Pope Francis, Apostolic Exhortation *Amoris Laetitia*, no. 81 (2016) (*citing* Catechism of the Catholic Church, no. 2378, *and* Congregation for the Doctrine of the Faith, *Donum Vitae*, II, 8 (1987)).
[16] Catechism of the Catholic Church, no. 2375.
[17] Catechism of the Catholic Church, no. 2370.
[18] Pope Paul VI, Encyclical Letter on the Regulation of Birth *Humanae Vitae*, no. 12 (1968).

With respect to abortion, the Church teaches that "human life must be respected and protected absolutely from the moment of conception…[and] must be recognized as having the rights of a person--among which is the inviolable right of every innocent being to life."[19] Therefore, since the first century "the Catholic Church has affirmed the moral evil of every procured abortion. This teaching has not changed and remains unchangeable"[20] because abortion is an "intrinsically evil act."[21]
Abortion is not healthcare; it is the antithesis of healthcare. As Pope Francis stated, "I…appeal to all politicians, regardless of their faith convictions, to treat the defense of the lives of those who are about to be born and enter into society as the cornerstone of the common good." And further, "Their killing in huge numbers…undermines…justice [and] compromise[es] the proper solution of any other human and social issue." [22]

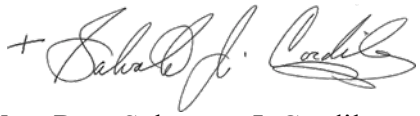
Catholic teaching also states clearly that "direct sterilization, that is, whose aim tends as a means or as an end at making procreation impossible – is a grave violation of the moral law and therefore illicit. Not even the public authority has any right, under the pretext of any 'indication' whatsoever, to permit it, and still less to require it…"[23] Because of this teaching "direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution."[24]
We appreciate HHS's consideration of these principles as you formulate your proposed revisions to the Section 1557 regulations. If you wish to discuss these matters further, we would welcome the opportunity.

His Eminence Timothy Cardinal Dolan, Archbishop of New York
Chairman, Committee for Religious Liberty

Most Rev. William E. Lori, Archbishop of Baltimore
Chairman, Committee on Pro-Life Activities



Most Rev. Paul S. Coakley, Archbishop of Oklahoma City
Chairman, Committee on Domestic Justice and Human Development



Most Rev. Salvatore J. Cordileone, Archbishop of San Francisco
Chairman, Committee on Laity, Marriage, Family Life, & Youth

[19] Catechism of the Catholic Church, no. 2270.
[20] Catechism of the Catholic Church, no. 2271.
[21] Forming Consciences for Faithful Citizenship, no 34.
[22] https://www.vaticannews.va/en/pope/news/2019-02/pope-francis-pro-life-movement-politicians-defend-life.html
[23] Pius XII, Allocution to Midwives, October 29, 1951; Catechism of the Catholic Church, no. 2297.
[24] Ethical and Religious Directive for Catholic Health Care Institutions, no. 53.