# Nos. 19-4254(L), 20-31, 20-32, 20-41

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE SECOND CIRCUIT**

STATE OF NEW YORK; CITY OF NEW YORK; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF OREGON; COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; COMMONWEALTH OF VIRGINIA; STATE OF WISCONSIN; CITY OF CHICAGO; AND COOK COUNTY, ILLINOIS,
Plaintiffs-Appellees,

*(Caption continued on inside cover)*

On Appeal from the United States District Court
for the Southern District of New York

**JOINT APPENDIX VOLUME V OF X**

*Of Counsel:*

ROBERT P. CHARROW
*General Counsel*

SEAN R. KEVENEY
*Deputy General Counsel*
*U.S. Department of Health & Human Services*

JOSEPH H. HUNT
*Assistant Attorney General*

MICHAEL S. RAAB
LOWELL V. STURGILL JR.
SARAH CARROLL
LEIF OVERVOLD
*Attorneys, Appellate Staff*
*Civil Division, Room 7226*
*U.S. Department of Justice*
*950 Pennsylvania Avenue NW*
*Washington, DC 20530*
*(202) 532-4631*
*Counsel for Defendants-Appellants and Consolidated-Defendants-Appellants*

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.; NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; AND PUBLIC HEALTH SOLUTIONS, INC.

Consolidated-Plaintiffs-Appellees,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR, II, in his official capacity as Secretary of the United States Department of Health and Human Service; AND UNITED STATES OF AMERICA,

Defendants-Appellants,

DR. REGINA FROST AND CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS,

Intervenors-Defendants-Appellants,

ROGER T. SEVERINO, in his official capacity as Director, Office for Civil Rights, United States Department of Health and Human Services; AND OFFICE FOR CIVIL RIGHTS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Consolidated-Defendants-Appellants.

## TABLE OF CONTENTS

**Page**

# Exhibit 63

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

March 27, 2018

Office for Civil Rights
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, D.C. 20201

*Submitted Electronically*

**Attention: Comments in Response to Department of Health and Human Services, Office for Civil Rights, Conscience NPRM, RIN 0945-ZA03**

Dear Secretary Azar,

The National Women's Law Center ("the Center") is writing to comment on the Department of Health and Human Services' ("the Department") and the Office for Civil Rights' ("OCR") proposed rule "Protecting Statutory Rights in Health Care" ("Proposed Rule").[1] Since 1972, the Center has worked to protect and advance the progress of women and their families in core aspects of their lives, including income security, employment, education, and reproductive rights and health, with an emphasis on the needs of low-income women and those who face multiple and intersecting forms of discrimination. To that end, the Center has long worked to end sex discrimination and to ensure all people have equal access to the full range of health care, including abortion and birth control, regardless of income, age, race, sex, sexual orientation, gender identity, ethnicity, geographic location, or type of insurance coverage.

Despite the Department's claims, the Proposed Rule is unnecessary. It is also illegal. The Proposed Rule attempts to create new rights for individuals and entities to refuse to provide patient care by expanding existing, harmful religious exemption laws in ways that exceed and conflict with both the plain language of the statutes and Congressional intent. The Proposed Rule also asserts authority over other federal laws, attempting to create new refusals to provide care. In creating these new rights and expanding its reach, the Proposed Rule conflicts with federal law thereby fostering confusion and chaos.

The Proposed Rule emboldens discrimination. By making it easier for institutions and individuals to refuse to provide comprehensive health care, the Proposed Rule endangers the health and lives of women and lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people across the country. While the Center's comments focus in particular on the harm to women and access to reproductive health care, it is clear that the Proposed Rule will undermine the provision of health care and exacerbate health disparities for many patient populations, as other commentators will discuss. And yet the Department fails to take this harm into account. Contrary

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88) [hereinafter *Rule*].

to the Department's claims, the Proposed Rule harms rather than helps the provider-patient relationship and burdens providers who want to provide comprehensive care.

For all of these reasons, explained in more detail below, the Center is strongly opposed to the Proposed Rule and calls on the Department and OCR to withdraw the Proposed Rule in its entirety.

## I. Despite the Department's Claims, the Proposed Rule is Unnecessary, Emboldens Discrimination in Health Care, and Goes Far Beyond the 2008 Rule.

The Department claims that the Proposed Rule is necessary to protect individuals and health care providers from "discrimination, coercion, and intolerance."[2] But there is no need to address the so-called discrimination the Department purports to protect against. There are already ample religious exemptions in federal law, including in Title VII,[3] the Americans with Disabilities Act,[4] and the "ministerial exception" courts have read into the U.S. Constitution.[5] In addition, there are already a number of existing federal religious exemption laws that unfortunately allow individuals and entities to opt of providing critical health care services, in particular abortion and sterilization.[6] The Proposed Rule claims that more authority and enforcement of the religious exemption laws is needed, but the Notice of Proposed Rulemaking cites only forty-four complaints in ten years, which OCR is capable of handling without additional resources or authority.[7] Moreover, OCR already has authority to investigate complaints and, where appropriate, either collect funds wrongfully given while the entity was not in compliance or terminate funding altogether, and already educates providers about their rights under these laws.[8]

The reality is that the Department is seeking not to enforce existing laws but to expand them and create new rights under these laws. As explained below, this is unlawful and creates conflicts with other federal laws. Further, the Proposed Rule does not merely expand rights under existing refusal of care laws. Instead, it pulls in a host of new laws over which OCR has never before had authority, creating new rights and enforcement powers under these laws as well.

In so doing, the Proposed Rule does not address discrimination in health care, it emboldens it. The Proposed Rule intends to change existing law in order to allow any individual or entity involved in a patient's care – from a hospital's board of directors, to an insurance company, to the receptionist that schedules procedures – to use their personal beliefs to determine a patient's access to care. The Proposed Rule would further entrench discrimination against women and

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[2] *Id.* at 3903.
[3] 42 U.S.C. § 2000e-2 (1964).
[4] 42 U.S.C. § 12101 (1990).
[5] *See* Hosanna-Tabor Evangelical Lutheran Church v. Equal Emp't. Opportunity Comm'n, 132 S. Ct. 694, 704 (2012) (holding for the first time that the First Amendment requires a "ministerial exception").
[6] "Weldon Amendment", Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018); "Church Amendments" 42 U.S.C. § 300a-7 (2018); "Coats Amendment" 42 U.S.C. § 238n (2017).
[7] *Rule*, *supra* note 1, at 3886.
[8] *See* Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 45 C.F.R. pt. 88 (2011).

LGBTQ patients who already face high rates of discrimination in health care, including as a result of providers' religious beliefs. As explained in more detail below, this not only harms individuals and subjects them to discrimination, it is unlawful.

The Department tries to hide how far-reaching and dramatic this Proposed Rule is by claiming it is merely a reinstatement of the rule promulgated by the Bush Administration in 2008 and later rescinded by the Obama Administration in 2011.[9] Even if this was the case, the Proposed Rule would be dangerous. The 2008 rule was the subject of widespread opposition, including from 28 U.S. Senators and 131 Members of the U.S. House of Representatives, 14 state attorneys general, 27 state medical societies, the American Medical Association (AMA), American Hospital Association, National Association of Community Health Centers, American College of Emergency Physicians, and commissioners on the Equal Employment Opportunity Commission.[10] In fact, the AMA and several leading medical organizations argued the 2008 Rule would "seriously undermine patients' access to necessary health services and information, negatively impact federally-funded biomedical research activities, and create confusion and uncertainty among physicians, other health care professionals, and health care institutions."[11] But, the Proposed Rule reaches much further than the 2008 Rule. When compared to the 2008 Rule, the Proposed Rule seeks to allow more individuals and more entities to refuse care to patients and allow more services, or even information, to be refused, forces more entities to allow their employees to refuse care, imposes additional, unnecessary notice and compliance requirements, and invites states to further expand refusal laws.

## II. The Proposed Rule Unlawfully Creates and Expands Rights to Refuse to Provide Care.

Under the Proposed Rule the Department intends to extend the reach of already harmful religious exemption laws so that any individual or entity, no matter how attenuated their involvement, can refuse to provide, participate in, or give information about any part of any health care service based on the assertion of a religious or moral belief. Furthermore, the Proposed Rule hamstrings the ability of an enormous range of entities to ensure that patients get the care they need. These expansions represent unlawful overreach by the Department and contradict the plain language of underlying federal law and Congressional intent.

### *a. The Proposed Rule Expands Existing Harmful Religious Exemption Laws*

Although the Proposed Rule purports to merely interpret existing harmful federal laws that allow health care providers to refuse to treat an individual seeking an abortion and/or sterilization –

[9] *Rule, supra* note 1, at 3885. *See also* Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law 73 Fed. Reg. 78,071(Dec. 19, 2009) (2008 Rule) (rescinded in large part by 76 Fed. Reg. 9,968 (Feb. 23, 2011)(codified at 45 C.F.R. pt. 88)).
[10] Comment Letters on Proposed Rule Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law 73 Fed. Reg. 50,274 (Aug. 26, 2008) (on file with National Women's Law Center).
[11] American Medical Assoc. et al. Comment Letter on Proposed Rule 73. Fed. Reg. 50,274 (Aug. 26, 2008)(on file with National Women's Law Center).

namely the so-called Church, Coats, and Weldon Amendments – in fact it creates new rights that are not specifically and currently enumerated in those laws.

It does this in part by redefining words in harmful, expansive ways that belie common understandings of the terms in order to create new rights. For example:

- The Proposed Rule's definition of "assist in the performance" greatly expands not only the types of services that can be refused, but also the individuals who can refuse. It includes those merely making "arrangements for the procedure" no matter how tangential and could be read to include individuals such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees. In fact, the definition includes participation "in any program or activity with an *articulable connection* to a procedure…" (emphasis added).[12] While what is meant by "articulable connection" is not clear, the use of the term in case law indicates an intention for it to be interpreted broadly – a mere connection that one can articulate may suffice.[13]
- Through a broad definition of "entity" the Proposed Rule attempts to expand the individuals and types of entities covered by religious exemption laws and allow an even broader swath of individuals within those entities to refuse to do their jobs.[14] For example, under the Proposed Rule a Department grantee that provides health care transportation services for individuals with disabilities could attempt to claim a right to refuse to provide that service to a person who needs a sterilization procedure. Or an employee at a research and development laboratory could claim the right to refuse to accept the delivery of biomedical waste donated from a hospital with an obstetrics and gynecology practice that performs abortions.
- The Proposed Rule's definition of "referral" goes beyond any common understanding of the term, allowing refusals to provide any information that could help an individual to get the care they need. [15] The Proposed Rule does not even require that patients be informed of the individual's or entity's refusal to provide care, information, referrals, or other services, leaving patients unaware that their health care providers is not providing the care or information they need.
- The Proposed Rule's definition of "workforce" attempts to expand refusals of care to an even broader range of people and would allow almost all staff levels within an entity, including volunteers or trainees, to assert a new right to refuse to do their job.[16] For example, a volunteer at a hospital could claim a right to refuse to deliver medicine to a patient's room or even deliver meals to a patient who is recovering from a surgery to which the volunteer objects.

[12] *Rule, supra* note 1, at 3923.
[13] *Cf.* Jamerson v. Runnels, 713 F.3d 1218, 1229 (9th Cir. 2013) (describing the standard for evaluating whether a peremptory challenge was impermissibly based on race as "require[ing] only that the prosecutor express a believable and *articulable connection* between the race-neutral characteristic identified and the desirability of a prospective juror…"(emphasis added)).
[14] *Rule, supra* note 1, at 3924.
[15] *Id.*
[16] *Id.*

*b. These New Rights are Contrary to Existing Law and Congressional Intent*

The expansions and new and unwarranted definitions exceed and conflict with the existing federal laws the Proposed Rule seeks to enforce. For example, the Proposed Rule expands the definition of "health care entity" under existing law to include plan sponsors and third-party administrators.[17] Adding plan sponsors to the definition of "health care entity" under the Weldon Amendment is a blatant attempt to add words that plainly do not exist in the underlying federal law.[18] Indeed, just two years ago, OCR determined that the Weldon Amendment – according to its plain text – does not apply to plan sponsors.[19] This also holds true for the other ways in which the Proposed Rule attempts to expand the definition of "health care entity." Under the Coats and Weldon Amendments, "health care entity" is defined to encompass a limited and specific range of individuals and entities.[20] The Proposed Rule attempts to create a new definition of this term by combining statutory definitions of "health care entity" found in different statutes and applicable in different circumstances. Such an attempt to expand the meaning of a statutory term Congress already took the time to define goes directly against Congressional intent.[21]

The legislative history of the existing federal refusal of care laws reinforces that the Proposed Rule violates Congressional intent. For example, Congress adopted the Coats Amendment in response to a decision by the accrediting body for graduate medical education to rightfully require obstetrics and gynecology residency programs to provide abortion training. The legislative history of Coats states, "[p]roviders will continue to train the management of complications of induced abortion as well as train to handle [a] situation involving miscarriage and still birth or a threat to the life of the mother. The amendment requires no change in the practice of good obstetrics and gynecology."[22] The attempted expansion under the Proposed Rule to allow anyone to refuse to provide abortion regardless of the circumstances was clearly not intended. Similarly, proponents of the Weldon Amendment made "modest" claims about the Amendment, suggesting that the additional language was necessary only to clarify existing "conscience protections" not for it to be the sweeping license to refuse the Proposed Rule attempts to create.[23]

The Proposed Rule's expanded use of sections (c)(2) and (d) of the Church Amendments also violates Congressional Intent. These two sections were passed under Title II of the National Research Services Act in 1974, which specifically dealt with biomedical and behavioral research.[24] This Act was designed to ensure that research projects involving human subjects are

[17] *Id.*
[18] *See* Weldon Amendment, *supra* note 6.
[19] *See* Letter from Jocelyn Samuels, Director of Office for Civil Rights, to Catherine W. Short, Esq. et al. (June 21, 2016), *available at* http://www.adfmedia.org/files/CDMHCInvestigationClosureLetter.pdf.
[20] Weldon Amendment, *supra* note 6; Coats Amendment, *supra* note 6.
[21] The doctrine of *expressio unius est exclusion alterius* (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[22] 141CONG. REC. S17293 (June 27, 1995) (statement of Rep. Coats).
[23] 150 CONG. REC. H10090 (Nov. 20, 2004) (statement of Rep. Weldon).
[24] National Research Services Act of 1974, Pub. L. No, 93-348, 88 Stat. 348 § 214.

performed in an ethical manner.[25] Congress did not intend, as the Proposed Rule implies, to allow health care personnel to refuse to participate in any health care service. Such an expansion of the meaning of the Church Amendment was clearly not intended by Congress in the passage of the statute and would turn Congress' intent to protect patients on its head.

In other words, in greatly expanding the existing federal refusal laws relating to treating an individual seeking abortion or sterilization or refusing in the biomedical or behavioral research context, the Proposed Rule exceeds the scope of federal law and conflicts with congressional intent. It is therefore unlawful.

*c. The Proposed Rule Overreaches Into Other Federal Laws, Undermining Congressional Intent*

However, the Department does not limit its overreach to the aforementioned laws. Instead, under the Proposed Rule, the Department has unlawfully asserted authority over a greater number of federal statutes in an attempt to create new refusal provisions and to give the Department authority it previously did not have. For example, the Proposed Rule would prohibit a State agency that administers a Medicaid managed care program from requiring an organization "to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization objects."[26] However, the underlying Medicaid statute merely provides a rule of statutory construction which states that nothing in the statute should be construed to require a state agency that administers a Medicaid managed care program to use its funds for such purposes.[27] By misrepresenting the limited scope of this provision in order to create a new refusal provision, the Proposed Rule directly contradicts Congressional intent.

By attempting to create new refusal provisions, the Department also seeks to give OCR unlawful enforcement authority over these provisions. For many of these, Congress already established an enforcement scheme in the statute at issue. The Department should be reminded that "regardless of how serious the problem an administrative agency seeks to address … it may not exercise its authority 'in a manner that is inconsistent with the administrative structure that Congress enacted into law.'"[28] Not only is it unlawful for the Department to alter the enforcement mechanisms contemplated by the statute, in many cases it would be nonsensical. For example, the Proposed Rule is attempting to re-delegate oversight of youth suicide early intervention and prevention strategies to OCR, despite the specific existing authority held by the Center for Substance Abuse Treatment.[29] Congress specifically created a "Center for Substance Abuse Treatment," the director of which is already charged with administering block grants and ensuring compliance with applicable law for development of youth suicide early intervention and prevention strategies.[30] The Department's attempt to alter this statutory scheme by attempting to give OCR

[25] *See, e.g.*, Todd W. Rice, *The Historical, Ethical, and Legal Background of Human-Subjects Research*, 53 RESPIRATORY CARE 2325 (2008), http://rc.rcjournal.com/content/respcare/53/10/1325.full.pdf.
[26] *Rule*, *supra* note 1, at 3926.
[27] *See* 42 U.S.C. § 1395w-22 (2010).
[28] *See* Food and Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 125-26 (2000).
[29] *See Rule*, *supra* note 1, at 3927.
[30] *See* Center for Substance Abuse Treatment, 42 U.S.C. § 290bb (2016); Youth Suicide Early Intervention and Prevention Strategies, 42 U.S.C. § 290bb-36 (2004).

authority to enforce certain provisions of the block grant is unlawful. Moreover, this change is nonsensical, given that the provision of statutory construction found within the statute outlining the program's requirement was never intended to be used to create a right to refuse.[31]

## III. The Proposed Rule Conflicts with Federal Laws.

The Proposed Rule generates conflict and confusion, creating chaos with existing federal laws. It appropriates language from landmark civil rights laws while entirely failing to even mention important laws that protect patients from discrimination and unreasonable barriers to health care access, that already govern employment discrimination based on religious belief, and that ensure patients get the care they need, particularly in emergency situations. By unilaterally attempting to broaden existing refusal of care laws, the Department jettisons the careful balance present in existing federal law. The Department attempts to upset this existing federal balance without legitimate statutory authority or even a reasoned explanation.

### *a. The Proposed Rule Would Subvert Civil Rights Statutes by Attempting to Appropriate their Language*

The Department has exceeded its authority by appropriating language from civil rights statutes and regulations that were intended to improve access to health care and applying that language to situations for which it was not intended. By taking the language of civil rights laws and regulations out of context, the Proposed Rule creates a regulatory scheme that is not only unlawful, but is nonsensical and affirmatively harmful. For example, the notice and certification of compliance and assurance requirements simply do not make sense when applied to the laws the Proposed Rule seeks to enforce. They will place a significant and burdensome requirement on health care providers, taking resources away from patient care without adding any benefit.

Moreover, the Proposed Rule defines "discrimination" for the first time[32] and does so in a way that subverts the language of landmark civil rights statutes to shield those who would discriminate rather than to protect against discrimination. In this context, this broad definition is inappropriate. Further such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements thereby fostering confusion.

### *b. The Proposed Rule Conflicts with Sections 1554 and 1557 of the Affordable Care Act*

The Proposed Rule conflicts with two provisions of the Affordable Care Act.

Section 1554 of the Affordable Care Act prohibits the Secretary of Health and Human Services from promulgating any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care."[33] As discussed in more detail below, religious refusals have been used to discriminate and deny patients the care they need based on the assertion of a religious or personal belief. By expanding the reach of refusals and permitting

[31] *See* 42 U.S.C. § 290bb-36 (2004).
[32] *Id.* at 3923-924.
[33] 42 U.S.C. § 18114(1) (2010).

objecting individuals and health care entities to deny patients needed health care services, the Proposed Rule erects unreasonable barriers to medical care and impedes access to health care services such as abortion and sterilization.[34]

Section 1557 of the Affordable Care Act prohibits discrimination in health care programs or activities on the basis of race, color, national origin, sex, age, or disability.[35] Prior to Section 1557, no broad federal protections against sex discrimination in health care existed. The ACA was intended to remedy this, as evidenced not only by the robust protection provided by Section 1557 itself, but also by the ACA's particular focus on addressing the obstacles women faced in obtaining health insurance and accessing health care.[36] As discussed in more detail below, by emboldening refusals for services that women and LGBTQ patients disproportionately or exclusively need, the Proposed Rule entrenches sex discrimination in health care and undermines the express purpose of Section 1557.

*c. The Proposed Rule Conflicts with Title VII*

The Proposed Rule makes no mention of Title VII, the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[37] With respect to religion, Title VII requires reasonable accommodation of employees' or applicants' sincerely held religious beliefs, observances, and practices when requested unless the accommodation would impose an "undue hardship" on an employer.[38] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal

[34] The Proposed Rule therefore also violates § 706(2) of the APA, which instructs a reviewing court under arbitrary and capricious standard of review to consider and hold unlawful agency action found to be (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (D) without observance of procedure required by law; (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

[35] 42 U.S.C. § 18116 (2010).

[36] *See* 42 U.S.C. § 300gg(a) (2015) (allowing rating based only on family size, tobacco use, geographic area, and age, but not sex); 45 C.F.R. § 147.104(e) (2015) (prohibiting discrimination in marketing and benefit design, including on the basis of sex); *see also, e.g.*, 156 CONG. REC. H1632-04 (daily ed. March 18, 2010) (statement of Rep. Lee) ("While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children."); 156 CONG. REC. H1891-01 (daily ed. March 21, 2010) (statement of Rep. Pelosi) ("It's personal for women. After we pass this bill, being a woman will no longer be a preexisting medical condition."); 155 CONG. REC. S12026 (daily ed. Oct. 8, 2009) (statements of Sen. Mikulski) ("[H]ealth care is a women's issue, health care reform is a must-do women's issue, and health insurance reform is a must-change women's issue because . . . when it comes to health insurance, we women pay more and get less."); 155 CONG. REC. S10262-01 (daily ed. Oct. 8, 2009) (statement of Sen. Boxer) ("Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform."); 156 CONG. REC. H1854-02 (daily ed. March 21, 2010) (statement of Rep. Maloney) ("Finally, these reforms will do more for women's health . . . than any other legislation in my career.").

[37] *See* 42 U.S.C. § 2000e-2 (1964); Title VII of the Civil Rights Act of 1964, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

[38] *Id.*

obligations.[39] The Proposed Rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both the Proposed Rule and Title VII. Indeed, when similar regulations were proposed in 2008, EEOC commissioners and the Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[40]

Furthermore, the language in the Proposed Rule would seem to put health care entities in the position of being forced to hire people who intend to refuse to perform essential elements of a position even though Title VII would not require such an "accommodation." For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician who refuses to provide non-directive options counseling to women with positive pregnancy tests even though it is an essential job function. The employer would not be required to do so under Title VII. It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

*d. The Proposed Rule Conflicts with Federal Law on Treatment of Patients Facing Emergency Situations*

The Proposed Rule fails to address treatment of patients facing emergency health situations, including an emergency requiring miscarriage management or abortion. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists and to stabilize the condition or, if medically warranted, to transfer the person to another facility.[41]

Because the Proposed Rule does not contain an explicit exception for situations in which an abortion – or other health service the Proposed Rule may empower individuals or entities to refuse – is needed to protect the health or life of a patient, the Proposed Rule is confusing to institutions regarding their obligations under the Proposed Rule as they relate to EMTALA. Every hospital is required to comply with EMTALA; even a religiously-affiliated hospital with an institutional objection to abortion must provide the care required in emergency situations.[42]

*e. The Proposed Rule Violates the Establishment Clause*

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[39] *Id.*

[40] Equal Emp't. Opportunity Comm'n. Legal Counsel Comment Letter on Proposed Rule 73 Fed. Reg. 50,274 (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html; Equal Emp't Opportunity Commissioners Christine Griffiin, Stuart Ishimaru Comment Letter on Proposed Rule 73 Fed. Reg. 50,274 (on file with National Women's Law Center).

[41] *See* 42 U.S.C. § 1395dd(a)-(c) (2003).

[42] In order to effectuate the important legislative purpose, institutions claiming a religious or moral objection to treatment must comply with EMTALA, and courts agree. *See, e.g.*, Shelton v. University of Medicine and Dentistry of New Jersey, 223 F.3d 220, 228 (3rd Cir. 2000); *In re* Baby K, 16 F.3d 590, 597 (4th Cir. 1994); Nonsen v. Medical Staffing Network, Inc. 2006 WL 1529664 (W.D. Wis.); Grant v. Fairview Hosp. & Healthcare Servs., No. Civ. 02–4232JNEJGL, 2004 WL 326694, at *2 (D. Minn. 2006); Brownfield v. Daniel Freeman Marina Hosp., 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); Barris v. County of Los Angeles, 972 P.2d 966, 972 (Cal. 1999).

The Proposed Rule unlawfully establishes and adopts one subset of religious views while denying health care to those with differing views. In fact, staff within the Department have indicated that the Department intends to support evangelical beliefs over others.[43] These statements are consistent with the Department's actions.[44] The Department cannot promulgate proposed rules in reliance on unconstitutional preferences such as religious beliefs. Such actions are unlawful and out of line with the Department's historical mission.[45]

## IV. The Proposed Rule Will Harm Patients, and the Department Has Failed to Take This Into Account.

The Proposed Rule is contrary to the Department's stated mission: "to enhance and protect the health and well-being of all Americans." In order to achieve that mission, one of the Department's primary goals is to "eliminate[ ] disparities in health, as well as [to increase] health care access and quality."[46] In its singular focus on what the Department claims is discrimination on the basis of religious or moral beliefs, it abdicates its mission. The Department ignores the pervasive discrimination in health programs and activities that individuals face, particularly those who seek reproductive health care, or because of their sex, gender identity, or sexual orientation. The Department unlawfully ignores how this discrimination is compounded by refusals of care based on personal beliefs and how the Proposed Rule will amplify that harm.

### *a. Certain Groups of Patients Routinely Face Discrimination in Health Care*

Women have long been the subject of discrimination in health care.[47] Despite the historic achievements of the Affordable Care Act, women are still more likely to forego care because of cost,[48] and women – particularly Black women – are far more likely to be harassed by a

[43] Dan Diamond, *The Religious Activists on the Rise Inside Trump's Health Department*, POLITICO (Jan. 22, 2018), https://www.politico.com/story/2018/01/22/trump-religious-activists-hhs-351735.
[44] *See, e.g.*, Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding, 82 Fed. Reg. 49,300 (proposed Oct. 25, 2017); Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47, 792 (proposed Oct. 13, 2017).
[45] *OCR's Mission and Vision*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").
[46] *See HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, DEP'T OF HEALTH AND HUMAN SERVS., at 7, https://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.
[47] Prior to the Affordable Care Act (ACA), women were charged more for health care on the basis of sex and were continually denied health insurance coverage for services that only ciswomen, transgender, and gender non-conforming patients need. *See Turning to Fairness*, NAT'L WOMEN'S L. CTR. 1, 3-4 (2012), https://nwlc.org/wp-content/uploads/2015/08/nwlc_2012_turningtofairness_report.pdf (noting that while the ACA changed the health care landscape for women in significant ways, women still face additional hurdles).
[48] *See* Shartzer, et al., *Health Reform Monitoring Survey*, URBAN INST. HEALTH POLICY CTR. (Jan. 2015), http://hrms.urban.org/briefs/Health-Care-Costs-Are-a-Barrier-to-Care-for-Many-Women.html.

provider.[49] These barriers mean women are more likely not to receive routine and preventive care than men. Moreover, when women are able to see a provider, women's pain is routinely undertreated and often dismissed.[50] And due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[51]

LGBTQ individuals encounter high rates of discrimination in health care. According to one survey, eight percent of lesbian, gay, bisexual, and queer individuals had an experience within the year prior to the survey where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation and seven percent experienced unwanted physical contact and violence from a health care provider.[52] Twenty-nine percent of transgender individuals were refused to be seen by a health care provider on the basis of their perceived or actual gender identity in the previous year.[53] Additionally, the 2015 U.S. Transgender Survey found that 23 percent of respondents did not see a provider for needed health care in the previous year because of fears of mistreatment or discrimination.[54]

And these barriers disproportionately impact those facing multiple and intersecting forms of discrimination, including women of color, LGBTQ persons of color, and individuals living with disabilities and those struggling to make ends meet. In one report, Black women disclosed that their doctors failed to inform them of the full range of reproductive health options regarding labor or delivery possibly due to stereotypes about Black women's sexuality.[55] Even though women living with disabilities report engaging in sexual activities at the same rate as women who do not live with disabilities, they often do not receive the reproductive health care they need for multiple reasons, including lack of accessible provider offices and misconceptions about their reproductive health needs.[56] These barriers also are often made worse by the complex web of

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[49] *See Discrimination in America: Experiences and Views of American Women*. NPR & HARVARD T.H. CHAN SCH. OF PUB. HEALTH (Dec. 2017), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2017/12/NPR-RWJF-HSPH-Discrimination-Women-Final-Report.pdf.

[50] *See, e.g.*, Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29:1 J. OF L., MED., & ETHICS 13, 13-27 (2001).

[51] *See, e.g.*, Judith H. Lichtman et al., Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction, 10 J. OF THE AM. HEART ASS'N 1 (2015).

[52] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AMERICAN PROGRESS, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

[53] *Id*.

[54] *The Report of the 2015 U.S. Transgender Survey*, NAT'L CTR. FOR TRANSGENDER EQUALITY 5 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[55] *See The State of Black Women & Reproductive Justice*, IN OUR OWN VOICE (2017), http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.

[56] RM Haynes et al., *Contraceptive Use at Last Intercourse Among Reproductive-Aged Women with Disabilities: An Analysis of Population-Based Data from Seven States*, CONTRACEPTION (2017), https://www.ncbi.nlm.nih.gov/pubmed/29253580; *see generally* Alex Zielinski, *Why Reproductive Health Can Be A Special Struggle for Women with Disabilities*, THINK PROGRESS, Oct. 1, 2015, https://thinkprogress.org/why-reproductive-health-can-be-a-special-struggle-for-women-with-disabilities-73ececea23c4/.

federal and state laws and policies that restrict access to care, particularly around certain health services like abortion.

*b. Refusals of Care Based on Personal Beliefs Compound the Harm to Patients*

This discrimination in health care against women, LGBTQ persons, and those facing multiple and intersecting forms of discrimination is exacerbated by providers invoking personal beliefs to deny access to health insurance and an increasingly broad range of health care services, including birth control, sterilization, certain infertility treatments, abortion, transition-related care, and end of life care.[57] For example, one woman experiencing pregnancy complications was rushed to the only hospital in her community, a religiously-affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[58] A transgender man was denied gender affirming surgery at a religiously-affiliated hospital that refused to provide him a hysterectomy.[59] A woman called an ambulance after experiencing abdominal pain, but the ambulance driver refused to take her to get the care she needed.[60]

When refusals of care happen, many patients are forced to delay or forego necessary care, which can pose a threat not only to their health, but their lives. This is particularly true for patients with limited resources and options. For many patients, such refusals do not merely represent an inconvenience but can result in necessary or even emergent care being delayed or denied outright. These refusals are particularly dangerous in situations where individuals have limited options, such as in emergencies, when needing specialized services, in rural areas, or in areas where religiously-affiliated hospitals are the primary or sole hospital serving a community. The reach of these types of refusals to provide care continues to grow with the proliferation of both the types of entities using religious beliefs to discriminate and the number of religiously-affiliated entities that provide health care and related services.[61]

*c. The Proposed Rule Will Further Harm Patients, Yet the Department Unlawfully Ignores that Harm*

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[57] Directive 24 denies respect for advance medical directives. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. Moreover, religiously-affiliated individuals have challenged key provisions of the federal law and implementing regulations that prohibit discrimination on the basis of sex, gender identity, or sexual orientation in health care. *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care*, NAT'L WOMEN'S LAW CTR. (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf.; *see also Health Care Denied*, AM. CIVIL LIBERTIES UNION (May 2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[58] *See* Kira Shepherd, et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[59] *See id.* at 29.

[60] *Put Patient Health First*, NAT'L WOMEN'S LAW CENTER 1 (August 2017), https://nwlc.org/resources/continued-efforts-to-undermine-womens-access-to-health-care/.

[61] *See, e.g., Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

By stretching refusals of care far beyond their current reach, the Proposed Rule leaves patients seeking reproductive or sexual health care services facing even greater threats to their health, life, and future fertility than they did before. In addition, the expansion of refusals of care under the Proposed Rule has far reaching implications for those providing or seeking services and information in a wide range of areas including HIV, drug addiction, infertility, vaccinations, psychology, sexually transmitted infections and end-of-life care, among others. This means that the Proposed Rule will compound harm to patients in multiple new ways, imposing additional hurdles patients must overcome to get the care they need. For example, young people in federal custody, including foster youth and unaccompanied immigrant children, already face enormous hurdles to accessing health care. Yet, the Proposed Rule seeks to allow foster parents, social service agencies, and shelters that provide services to young people to refuse even minor assistance to a young person in their care who needs health services, including STI testing or treatment and abortion care.

The reach of the Proposed Rule will create a vicious cycle where those already subject to multiple forms of discrimination in the health care system may be the most likely to find themselves seeking care from a health care professional who refuses to provide it. For example, in many states women of color are more likely than white women to give birth at a Catholic hospital.[62] By expanding refusals of care, the Proposed Rule will exacerbate the barriers to health care services patients need.

Yet despite the overwhelming evidence of discrimination against patients seeking health care services and the harm of refusals of care that are based on personal beliefs, the Department issued this Proposed Rule. The Department fails entirely to consider the impact of the Proposed Rule on patients, particularly individuals seeking reproductive health care, patients of color, and LGBTQ individuals. At no point does the Proposed Rule acknowledge the many ways it will harm patients. This consideration is required by law and by the U.S. Constitution, and the Department's failure to account for these requirements renders the Proposed Rule invalid and unlawful.

## III. The Proposed Rule Erodes the Core Tenants of the Medical System.

The Proposed Rule undermines the trust in the provider-patient relationship and unduly burdens those health care providers who want to fulfill their obligations to provide patients with the care they need.

### *a. The Proposed Rule Undermines the Provider-Patient Relationship*

A strong provider-patient relationship is the foundation of our medical system. Patients rely on their providers to give full information about their treatment options and to provide medical advice and treatment in line with the standards of care established by the medical community. Yet, the Proposed Rule allows providers to do the opposite, threatening informed consent,

[62] *See* Kira Shepherd, et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

undermining standards of care, and eroding patient trust in their providers and ultimately the medical system.

Informed consent is intended to help address the knowledge and power imbalance between providers and their patients, so patients can make their own competent and meaningful decisions about their treatment options.[63] The Proposed Rule acknowledges the importance of open, honest conversations in health care, stating "open communication in the doctor-patient relationship will foster better over-all care for patients."[64] Yet, it would allow providers, including hospitals and health care institutions, to ignore the patient's right to receive information and refuse to disclose relevant and medically accurate information about treatment options and alternatives. To make matters worse, the Proposed Rule includes provisions that specifically remove statutory requirements that health care entities at least notify patients they may be refused health care services or information. For example, it omits requirements enumerated in the counseling and referral provisions of the Medicaid managed care statute. These provisions require organizations that decline to cover certain treatments to notify enrollees of the policy.[65] The Department's attempts to affirmatively remove notice requirements underscore how little it cares about patients receiving full information. Allowing refusals to provide information and then barring patients from receiving any notice that they may not be given full information makes open communication impossible.

In addition to receiving non-biased information from their providers, patients also expect to receive treatment in line with medical practice guidelines and standards of care. Yet, the Proposed Rule seeks to allow providers, including hospitals and other health care institutions, to ignore the standards of care, particularly surrounding reproductive and sexual health. This completely undermines the provider-patient relationship and will create uncertainty and doubt where there should be trust and respect.

*b. The Proposed Rule Burdens Providers that Want to Uphold the Hippocratic Oath and Provide Comprehensive Care*

As the American Medical Association Code of Medical Ethics states, "the relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest."[66] Yet, the Proposed Rule flips this principle on its head – attempting to expand the ability of institutions to use personal beliefs to dictate patient care. In doing so, the Department allows institutions to block providers that want to provide patients with necessary or comprehensive care.

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[63] As the AMA Code of Ethics makes clear, "Informed Consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care." *Informed Consent*, AMERICAN MED. ASSOC., https://www.ama-assn.org/delivering-care/informed-consent (last visited Mar. 23, 2018).
[64] *Rule*, *supra* note 1, at 3917.
[65] The requirements of 42 U.S.C. § 1396u-2(b)(3)(B)(ii) excluded from the Proposed Rule's requirements surrounding Medicaid managed care organization. *See Rule*, *supra* note 1, at 3926.
[66] *Code of Medical Ethics: Patient-Physician Relationships*, AMERICAN MED. ASSOC., https://www.ama-assn.org/delivering-care/code-medical-ethics-patient-physician-relationships (last visited Mar. 23, 2018).

Most providers believe they should and must treat patients according to medical standards regardless of their personal beliefs. Moreover, many providers have deeply held moral convictions that affirmatively motivate them to provide patients with certain services, including abortion, transition-related care, and end-of-life care. Existing refusal of care laws already burden these providers. Hospital systems across the country use religious beliefs to prevent their employees from treating patients regardless of the professional, ethical, or moral convictions of these providers. The Proposed Rule would exacerbate these problems by expanding the number and types of institutions that can bind the hands of providers and limit the types of care, or even information, they can provide.

The Proposed Rule egregiously misuses research to falsely claim that a majority of obstetrician-gynecologists are unwilling to provide abortion.[67] In fact, the survey underlying the cited study found that over 80% of obstetrician-gynecologists are willing to help a patient obtain an abortion in the vast majority of cases. The survey also found that even where providers had a moral objection to providing abortion in a particular situation, a majority would still help the patient obtain an abortion.[68] Hospitals already discriminate against health care providers by preventing them from providing certain health care services, particularly abortion, even in life-threatening situations.[69] In fact, researchers have found that over a third of obstetrician-gynecologists experience conflict with their employers over religiously based patient care policies, with a majority of obstetrician-gynecologists at Catholic institutions reporting such conflicts.[70]

The Proposed Rule's expansion of entities that can constrain their employees not only ignores the barriers facing health care professionals who are committed to providing patients with comprehensive care regardless of personal beliefs, but it also ignores the Department's duty to enforce federal law that protects those who support abortion or sterilization. The Proposed Rule fails to acknowledge the Church Amendments' protection for health care professionals who support or participate in abortion or sterilization services. No health care professional should face discrimination from their employer because they treated or provided information to a patient seeking an abortion. But instead of acting to protect health care providers who put patients first, the Proposed Rule allows more institutions to interfere and prevent employees from providing care.

## IV. The Proposed Rule Burdens States that Want to Protect Patient Access to Care.

As the Department recognized in the preamble of the Proposed Rule, forty-seven states have laws that allow health care providers and/or institutions to refuse health care to individuals based on personal beliefs.[71] These harmful existing state laws have already undoubtedly resulted in the

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[67] *Rule*, *supra* note 1, at 3916.
[68] Lisa Harris et al., *Obstetrician-Gynecologists' Objections to and Willingness to Help Patients Obtain an Abortion*, 118 OBSTETRICS & GYNECOLOGY 905 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4185126/.
[69] *Discrimination Against Health Care Professionals Who Provide or Support Abortion* NAT'L WOMEN'S LAW CENTER (August 2017), https://nwlc.org/resources/discrimination-against-health-care-professionals-who-provide-or-support-abortion/.
[70] Stulberg et al., *Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient Care Policies*, 73 AM. J. OF OBSTETRICS AND GYNECOLOGY e1 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3383370/
[71] *Rule*, *supra* note 1, at 3931; *see also Refusing to Provide Health Services*, GUTTMACHER INSTITUTE (Feb. 2018), https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services.

denial of health care, and in particular have endangered women's health. Now, the Proposed Rule is inviting states to enact even more sweeping laws.[72] The Proposed Rule encourages states to pass laws that go even further than the Proposed Rule does in allowing for refusals of health care. While it is clear that federal laws generally provide a minimum level of protection and allow states to enact more substantial protections, those protections are usually for the purpose of protecting individuals from discrimination and/or ensuring access to important services or benefits. As discussed above, the Proposed Rule subverts this entirely, entrenching discrimination and taking away access to health care services and benefits.

The Proposed Rule also creates a chilling effect on the enforcement of and passage of state laws that protect patient access to health care. The Department argues that the Proposed Rule is needed in order to clarify how federal religious exemption laws interact with state and local laws. To illustrate this purported need, the preamble cites several state laws intended to protect access to care. These include laws that require anti-abortion counseling centers to provide information about the full range of reproductive health care options and inform patients if the facility employs medical providers as well as state laws that ensure that individuals have comprehensive health insurance that includes abortion coverage. The discussion implies these and other laws that protect patient access to care conflict with the Proposed Rule, particularly when read in conjunction with several of the leading questions regarding state law posed in the preamble. This puts states in the untenable position of choosing between passing laws that protect their people and potentially losing millions of dollars in critical federal funding, likely resulting in a chilling effect on states attempting to pass or enforce laws intended to protect patients.

**Conclusion**

The Proposed Rule is illegal and harmful. It attempts to allow religious beliefs to dictate patient care by unlawfully expanding already harmful refusals of care. The Proposed Rule is discriminatory, violates multiple federal statutes and the Constitution, ignores Congressional intent, fosters confusion, and harms patients contrary to the Department's stated mission. For all of these reasons, the Center unequivocally calls on the Department to withdraw the Proposed Rule.

Sincerely,

Fatima Goss Graves

Fatima Goss Graves
President and CEO, National Women's Law Center

[72] *See e.g., Rule, supra* note 1, at 3888-89.

# Exhibit 64

**March 27, 2018**

**Via electronic submission**

**Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (Docket No.: HHS-OCR-2018-0002)**

To Whom It May Concern:

The New York City Commission on Human Rights, the New York City Department of Health and Mental Hygiene, the New York City Department of Social Services, and NYC Health + Hospitals write to express our opposition to the United States Department of Health and Human Services' (HHS) proposed regulations entitled, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.

HHS' proposed rule will cause serious harm to the health and well-being of New Yorkers. It will erect barriers to the delivery and receipt of timely, high quality health care. It will foster a new standard of selective and discriminatory treatment for many of our most vulnerable populations. It will also multiply the administrative burdens that health care organizations shoulder to address time-sensitive health conditions. Finally, it will infringe on the ability of state and local governments to enforce their laws and policies. In the face of these significant harms, we urge HHS to rescind this rule.

**The Proposed Rule Will Harm Patients**

The proposed rule elevates healthcare providers' personal beliefs over patient health. It gives providers wide latitude in opting out of treating patients. Undoubtedly, providers will deny care to patients who need it. At a minimum, a denial will mean that patients who are turned away will experience delays and increased expenses in receiving care. But in many cases, delay will effectively mean denial, particularly where time is of the essence or locating a suitable alternate provider is not feasible. The denial of care will be the end of the road in many patients' search for treatment.

Indeed, finding an alternate provider is no simple task. Health plans have limited provider networks, caps on the number of specialty visits, and steep cost-sharing obligations. Workers have limited or no sick leave, and forcing them to visit a second provider to accommodate the first provider's beliefs means that many patients will have to decide between taking care of their health and making a living. That is no choice at all, and many patients will forego care that they otherwise would have received.

Similarly, many people live in areas with a limited number of primary care doctors, specialists, and specialty care facilities. They may be forced to travel great distances to find a provider willing to treat them. Patients who are elderly, patients with disabilities, and patients under the age of

majority may be completely unable to access an alternate healthcare provider if refused care. During an emergency such as a national disaster, there may be only one accessible provider.

The denials of care that will result if the proposed rule is adopted will have severe and often irreversible consequences: unintended pregnancies, disease transmission, medical complications and anguish in the last days of life, and death. For example:

- Post-exposure prophylaxis for HIV should be initiated within 36 hours, but not beyond 72 hours after potential exposure.
- Emergency contraception is most effective at preventing pregnancy if taken as soon as possible after sexual intercourse.
- Contraceptives and pre-exposure prophylaxis for HIV are effective only if accessed prior to a sexual encounter.
- There is a window for a safe, legal abortion, and a narrower window for medication abortion. In the case of ectopic pregnancy or other life-threatening complication, an abortion may need to be performed immediately.
- Opiate users denied methadone or buprenorphine remain at increased risk of overdose, and naloxone must be administered quickly to reverse drug overdose.
- Persons with suicidal ideation need immediate care to prevent self-harm.
- Refusing to honor a person's end-of-life wishes prolongs suffering.

In short, the proposed rule will cause long-lasting and irreparable harm to patients.

The breadth of the proposed rule is extraordinary, all but guaranteeing that patients will be denied essential health care. Extending protections to health plans, plan sponsors, and third-party administrators that receive federal funds may prompt health plans to cease coverage for abortion, contraceptives, health care related to gender transition, and other services. Allowing anyone "with an articulable connection to a procedure, health service, health program or research activity" to raise an alleged conscience objection, means that the myriad of participants in a healthcare encounter—from intake and billing staff to pharmacists, translators, radiology technicians, and phlebotomists—can refuse to participate in service delivery. This will cause untold disruptions and delays for patients. And the expansive definitions of "assist in the performance" and "referral" mean that healthcare providers – after refusing to care for a patient – will not even need to provide a referral or other necessary information for a patient to seek care elsewhere.

The negative health impact of denied care is profound. In the case of infectious disease, there is societal impact: delays in diagnosis, prophylaxis and treatment increase the likelihood of individual disease progression and transmission to others. The consequences of untreated substance use disorders are likewise far-reaching. Compounding matters, the harmful effects of the proposed rules will be felt most acutely by individuals and communities that already face great challenges accessing the care that they need: people of color, low-income persons, women, children, people with substance use disorders, and lesbian, gay, bisexual, transgender, queer, intersex and gender nonconforming ("LGBTQI") persons.

**The Proposed Rule Will Lead to Discrimination Against Already Vulnerable Populations**

The rule gives healthcare providers a free pass to discriminate based on a patient's identity and against any patient whose actions or decisions conflict with the provider's alleged conscience objection.

Discrimination by health care providers marginalizes and stigmatizes patients, driving them away from care systems. It has long-term destructive consequences for the health and well-being of patients and communities that already bear the brunt of discrimination. Women and LGBTQI people will find themselves denied care at alarming rates. Providers may refuse to prescribe contraceptives to women who are not married, fertility treatment to same-sex couples, pre-exposure prophylaxis to gay men, or counseling to LGBTQI survivors of hate or intimate partner violence. Transgender patients are likely to be refused medically necessary care like hormone therapy, and substance users may be denied medications to treat addiction or reverse drug overdose.

The impact of such discrimination extends far beyond the individual patient encounter. For example, LGBTQI youth that are denied services and psychosocial support show a lasting distrust of systems of care.[i] Concerns regarding stigma may also make patients reluctant to reach out to loved ones for support, as has been shown with women who have had abortions.[ii]

This never-before-seen license to pick and choose the type of patient and nature of care that a clinician or organization will provide runs counter to principles of comprehensiveness and inclusion that have long guided the federal government's oversight of key health care programs and the operation of the country's health care delivery system.

**The Proposed Rule Creates New Administrative Burdens for a Strained Health Care System**

The extraordinary breadth of the proposed rule will result in significant and costly administrative burdens on an already-strained healthcare system. The proposed rule places healthcare entities in the precarious position of having to accommodate various ethical beliefs held by thousands of staff, regardless of how tenuous those staffs' connection to the clinical encounter. Also, by prohibiting employers from withholding or restricting any title, position or status from staff that refuse to participate in care, healthcare entities are limited in being able to move staff into positions where they will not disrupt care and harm patients. Thus, doctors in private practice will be prohibited from firing any staff who refuses to assist, and thereby stigmatizes and harms, LGBTQI patients. Emergency departments, ambulance corps, mental health hotlines, and other urgent care settings may need to increase the number of shift staff to ensure sufficient coverage in case of a refusal to work with a patient. This will have a very real financial impact on healthcare facilities, including government-run and subsidized clinics and hospital systems. This is a costly proposition that flies in the face of the federal government's stated goal of reducing administrative burdens within the health care system.

**The Proposed Rule Infringes on State and Local Governments' Ability to Enforce Their Laws and Policies and Conflicts with Patient Protections**

The proposed rule may impact the ability of State and local governments to enforce the full scope of their health- and insurance-related laws and policies by conditioning the receipt of federal funding on compliance with the rule. Similarly, it may leave providers caught between conflicting mandates. The New York City Human Rights Law ("City Human Rights Law"), for example, like many state and local nondiscrimination laws, protects patients from discrimination based on sexual orientation, gender (including gender identity), marital status, and disability.

Protecting vulnerable populations from discrimination and misinformation is of paramount importance to New York City. The City Human Rights Law is one of the most comprehensive civil rights law in the nation, prohibiting discrimination in health care settings based on, among other things, a patient's race, age, citizenship status, and religion. A provider's refusal to serve a patient pursuant to the proposed rule may be a violation of state and local laws, some of which are enforced through the imposition of injunctive relief and substantial financial penalties. Violations of the City Human Rights Law, for example, can lead to the imposition of penalties of up to $250,000 per violation.

We oppose regulations that allow personal beliefs to trump science at the expense of vulnerable populations' access to health care. We oppose systems that compromise our duty to protect and improve the health of City residents. We oppose actions that sanction discrimination against patients based on who they are or what health conditions they have.

We urge HHS to rescind the proposed rule.

Sincerely,

Steven Banks
Commissioner
New York City Department of Social Services

Mary T. Bassett, MD, MPH
Commissioner
New York City Department of Health and Mental Hygiene

Mitchell Katz, MD
President and Chief Executive Officer
New York City Health and Hospitals

Carmelyn P. Malalis
Commissioner
New York City Commission on Human Rights

[i] Substance Abuse and Mental Health Services Administration. Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
[ii] Shellenberg KM, Tsui AO. Correlates of perceived and internalized stigma among abortion patients in the USA: an exploration by race and Hispanic ethnicity. *Int J Gynaecol Obstet*. 2012;118(2):60015-60010.

# Exhibit 65

NEW YORK STATE
DEPARTMENT of
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

March 21, 2018

Mr. Eric Hargan
Acting Secretary
U.S. Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue SW
Washington, DC 20201
Attn: Conscience NPRM
RIN 0945-ZA03

**Re: Comments on Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

Dear Mr. Hargan:

The New York Department of Financial Services (NYDFS) submits the following comments on the proposed rule 45 CFR 88, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority [HHS-OCR-2018-0002] (Proposed Rule). As set forth below, the Proposed Rule impermissibly attempts to restrict women's access to abortion services and attempts to veil such blatant discrimination of women as conscience rights. NYSDFS urges the retraction of the Proposed Rule.

Specifically, Section 88.3(c) in the Proposed Rule unlawfully deviates from the plain language of the Weldon Amendment – see, e.g., Pub. L. 115-31, Div. H, sec. 507(d) – by expanding the definition of health care entities that are subject to the amendment and by incorporating a definition of the term "discrimination" that far exceeds the recognized, legal meaning of that term. The Proposed Rule also attempts to interfere unlawfully with the operation of State law with respect to ensuring that women have access to medical services. NYDFS strongly supports the compelling governmental interest in providing women access to all medical services, including abortion services, to promote women's health and gender equality. Consistent with this compelling governmental interest, New York law requires that all health insurance plans issued in the state include coverage for medically necessary abortions. Any Department of Health and Human Services ("HHS") proposed rule that seeks to undermine

New York's right to promote and protect women's health and gender equality, violates of the Affordable Care Act ("ACA") and bedrock constitutional principles. NYDFS strongly objects to the unconstitutional, unreasonable, and discriminatory Proposed Rule which takes a drastic step backwards and unnecessarily attempts to curtail women's access full to medical services.

**The Proposed Rule Discriminates Against Women**

The Proposed Rule discriminates against women by hindering their access to abortion and other medically necessary health care services. The U.S. Supreme Court has held that the right to terminate a pregnancy is a fundamental privacy right, protected as a liberty interest under the Fourteenth Amendment of the U.S. Constitution.[1] The number of abortion providers are already in decline,[2] and many states have enacted cumbersome barriers, forcing women to travel to obtain abortion services necessary for their health.[3] The Proposed Rule exacerbates the problem, by not only expanding the persons who may object beyond any by reasonable definition, and also increasing the categories of behavior protected under its scope. Under the Proposed Rule, employers could impose their will on their employees by forcing insurers to deny abortion coverage to women; pharmacists may not need to dispense emergency contraception; objecting health care providers could choose not to refer patients to non-objecting providers, or provide abortion funding information; and pregnant women could be denied life-saving options during an emergency. These provisions are unlawful, discriminatory, and not permissible by regulatory fiat.

The Supreme Court has ruled that an obstacle is substantial when it is created to impede rather than inform a woman of her choices.[4] By allowing plan sponsors and health care providers to obstruct the patient from being able to obtain coverage for or afford abortion services; from receiving medication that her doctor prescribed for her; by limiting medical information or options that patients have a right to know about; or by preventing women from receiving medically necessary procedures, the HHS is creating substantial obstacles and unjustifiably limiting access to the breadth of health services to which women are lawfully entitled.[5] It is neither the government nor employers that have the legal right or moral superiority over women's health care decisions as prescribed by their physicians.

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[1] Roe v. Wade, 410 U.S. 113, 153 (1973); see also Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833 (1992).

[2] The number of clinics providing abortions declined 6% between 2011 and 2014, and declines were steepest in the Midwest (22%) and the South (13%). Rachel K. Jones, Jenna Jerman, Abortion Incidence and Service Availability, National Center for Biotechnology Information (January 17, 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5487028/.

[3] Angie Leventis Lourgos, More Women Seem to be Crossing State Lines to have Abortions in Illinois, Chicago Tribune (February 27, 2018), http://www.chicagotribune.com/news/ct-met-abortion-numbers-illinois-20180222-story.html.

[4] "And a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833, 877 (1992).

[5] "All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential

Moreover, the Proposed Rule favors the rights of a non-protected class over the rights of a protected class. HHS stated in the Proposed Rule that "conscience objectors" should be "allowed a level playing field, and that their beliefs not be held to disqualify them from participation in a program or benefit." HHS erroneously claims that this alleged form of discrimination against conscience objectors "parallels the type of discrimination typically prohibited with respect to other characteristics such as race, color, or national origin." Under the law, "conscience objectors" are not a protected class; therefore, they are not entitled to the same level of protection as other federally protected classes, and, such as gender and race. The Proposed Rule defines "discriminate" as "to withhold, reduce, exclude, terminate, restrict, or otherwise make unavailable or deny any benefit or privilege." In reducing and restricting women's access to abortions, by its own definition, HHS is discriminating against women. HHS compounds the problem by giving employers the new right to invade the confidentiality of women's health care relationship with her doctor, broadening the scope of any possible religious exemption to a "conscience objector" which finds no support in law or health care policy.

**The Proposed Rule Is Inconsistent with the Plain Language of the Weldon Amendment**

Since 2005, HHS appropriations have included a provision that restricted states and other recipients of HHS appropriations from discriminating against a "health care entity" on the ground that the entity does not provide, pay for, provide coverage of, or refer for abortions. The entirety of this restriction – commonly referred as the Weldon Amendment – includes the following two clauses:

> (1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.
>
> (2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

See Pub. L. 115-31, Div. H, sec. 507(d).

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patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. The Limits of Conscientious Refusal in Reproductive Medicine." Committee on Ethics, The Limits of Conscientious Refusal in Reproductive Medicine, The American College of Obstetricians and Gynecologists, Number 385 (reaffirmed in 2016), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine.

Section 88.3(c) in the Proposed Rule, were it to be adopted (and it should not be), would unlawfully and illegally expand the restrictions in the Weldon Amendment in two material respects.

First, the definition of "health care entity" used in the Proposed Rule is impermissibly broader than the definition included in the Weldon Amendment. In the Proposed Rule, the definition of "health care entity" has been expanded to include "a plan sponsor" in addition to various other impermissible additions. The inclusion of "a plan sponsor" in the Proposed Rule's definition would mean that employers that merely purchase or sponsor a group health plan would be subject to the Weldon Amendment, an extension that violates the law. Indeed, this proposed definitional expansion is contrary to the plain language of the Weldon Amendment and its legislative history, which shows that the purpose of the Weldon Amendment was to respect the religious and moral viewpoint of those directly engaged in the delivery of health care services (i.e., doctors and hospitals). Employers or other plan sponsors are not health care entities under any stretch of the term. The proposed regulatory expansion of the Weldon Amendment to cover all employers who merely purchase or sponsor a group health insurance plan for employees is far beyond the plain language and intended scope of the amendment and would impermissibly sanction employers' intervention into private health care decisions. Given that employers (or "plan sponsors") are clearly not included in the definition of "health care entity" in the Weldon Amendment and cannot be characterized as a health care facility, organization or plan, the definition of "health care entity" used in the Proposed Rule is contrary to law and policy. Indeed, all of the additions in the Proposed Rule to the definition of "health care entity" that do not appear in the Weldon Amendment must be removed as illegal.

Second, the definition of "discrimination" in the Proposed Rule is contrary to federal law. As noted above, the Weldon Amendment prevents a state from discriminating against a "health care entity" on the ground that the entity does not provide, pay for, provide coverage of, or refer for abortions. Yet, Section 88.2 of the Proposed Rule would include in the definition of "discriminate or discrimination" the "enactment, application, or enforcement of laws, regulations, policies, procedures … that tends to subject individuals or entities protected under this part to any adverse effect." This newly-minted definition of "discrimination" in the Proposed Rule attempts to prevent a state from enacting, applying or enforcing a neutral law of general applicability that would require coverage for abortion services, which is clearly contrary to federal law. Under applicable Supreme Court precedent, neutral laws of general applicability, including state laws mandating coverage of all medically necessary surgical services including abortions, by definition, are non-discriminatory:

> We have never held that an individual's religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the State is free to regulate. On the contrary, the record of more than a century of our free exercise jurisprudence contradicts that proposition. . . . Conscientious scruples have not, in the course of the long struggle for religious toleration, relieved the individual from obedience to a general law not aimed at the promotion or restriction of religious beliefs. The mere possession of religious

> convictions which contradict the relevant concerns of a political society does not relieve the citizen from the discharge of political responsibilities.

Emp't Div. v. Smith, 494 U.S. 872, 878-79, 110 S. Ct. 1595, 1600 (1990) (emphasis added; internal quotation omitted). The Court in Smith, examining conscience objections, made clear that neutral laws of general applicability do not rise to the level of discrimination. See id. at 886 n 3. The definition of "discrimination" used in the Proposed Rule therefore does not accord with federal law or the U.S. Constitution.

In addition, the definition of "discrimination" in the Proposed Rule does not, in fact, prohibit discrimination. Discrimination is the disparate treatment of an individual or entity. The Proposed Rule actually mandates discrimination by preventing the equal application and enforcement of neutral state laws. The definition of "discrimination" in the Proposed Rule would impermissibly require a state to modify its laws to accommodate religious or moral beliefs of regulated entities. Such an accommodation would result in the disparate treatment of similarly situated individuals, and entities – the textbook definition of discrimination. Such a requirement is far outside the boundary of a non-discrimination rule and renders the definition in the Proposed Rule contrary to law. If the rule proceeds, at a minimum, the definition of discrimination in the Proposed Rule should be revised to correct this legal deficiency.

**The Proposed Rule Violates the Affordable Care Act**

The Affordable Care Act (ACA) expressly authorizes a state to require coverage for medically necessary abortions in health insurance policies issued in the state. See 42 U.S.C. 18023(c)(1) ("[n]othing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions"). In other words, state laws requiring coverage for medically necessary abortion services in insurance policies are expressly permissible under the ACA. The Proposed Rule – which unlawfully attempts to prevent the application and enforcement of abortion coverage mandates in state law – would clearly violate the provision in the ACA by attempting to prevent New York from enforcing its abortion coverage mandates on health insurance policies issued in New York.

In 2010, when the ACA was enacted, the Weldon Amendment had already been included in HHS's appropriation bills for five years. Had the Weldon Amendment prevented (or was intended to prevent) states from enforcing neutral laws that mandate abortion coverage, the ACA could not have included the provision quoted above as it would immediately have been rendered meaningless. Indeed, prior to the release of the Proposed Rule, neither HHS nor any arm of the federal government had ever suggested that the Weldon Amendment prevented a state from enacting, applying or enforcing a neutral law of general applicability that would require coverage for abortion services. The Proposed Rule's attempted expansion of the Weldon Amendment to do just that not only violates the plain language of the statute but also undermines this key provision in the ACA, and therefore lacks a legal foundation.

**The Proposed Rule is an Unconstitutional Violation of the Federal Spending Clause**

The Proposed Rule delegates full enforcement authority to HHS's Office for Civil Rights (OCR) and states that if compliance is not achieved, then HHS would consider all legal options available, including "termination of relevant [federal] funding, in whole or in part, claw backs, referral to the Department of Justice, or other measures." Under settled law, for Congress to place a condition on receipt of federal funds by a State, the condition placed on the State must be unambiguous, and the amount in question cannot be so great that it can be considered coercive to the State's acceptance of the condition.[6] As OCR itself noted in June 2016, it is highly questionable whether the Weldon Amendment is enforceable at all when interpreted consistent with the Proposed Rule, since the revocation of federal funds would violate the Constitution's prohibition on the federal government attempting to compel a State to regulate.[7] Further, the Proposed Rule does not provide a clear methodology for withholding federal funding, or any guidance on how the punitive measures would be warranted, leaving enforcement arbitrary and the Proposed Rule unenforceable. It is clear that the Proposed Rule is intended to force states to adopt a policy of regulation of their health insurance markets in a manner in line with the views of the current federal executive "while the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision."[8] The Supreme Court has consistently held that the use of the Congressional Spending Clause power to coerce states into regulating in accordance with federal policy is an unconstitutional intrusion on the independent sovereignty of the states.[9] Therefore, even if the Proposed Rule were a permissible reading of the statutes it purports to interpret—which it is not—such a reading renders those statutes unconstitutional, and the Proposed Rule must fall with them.

**The Proposed Rule Did Not Adequately Assess the Impact on Families**

Under federal rulemaking rules, prior to proposing a new rule, HHS is required to determine whether a proposed policy or regulation could affect family well-being and, if affirmative, prepare an impact assessment. Yet, HHS determined that the Proposed Rule will not negatively impact family well-being. The commentary states that, "[i]t is unlikely that this proposed rule will negatively impact the stability of the family. . ." The commentary further states, "[i]n addition, the proposed rule has no bearing on the disposable income or poverty of families and children. . ." These statements are patently false. Interfering with a women's access to safe abortion services will adversely impact her health and correspondingly the well-being of her family. In addition, limiting health insurance coverage of abortion services will directly impact the disposable income of families, as women will be forced to pay for abortion services out-of-pocket, when other medical procedures are covered for men. Importantly, the

[6] South Dakota v. Dole, 483 U.S. 203, 204 (1987).
[7] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 577-78, 132 S. Ct. 2566, 2602 (2012) ("[W]hen pressure turns into compulsion, the legislation runs contrary to our system of federalism. The Constitution simply does not give Congress the authority to require the States to regulate." quoting New York v. United States, 505 U.S. 144, 178 (1992) internal quotations omitted).
[8] New York v. United States, 505 U.S. 144, 169, 112 S. Ct. 2408, 2424 (1992).
[9] See e.g., Sebelius, 567 U.S. at 577-85.

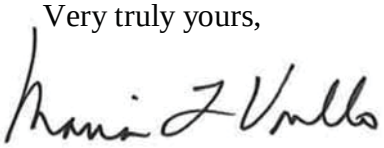
Proposed Rule would have a disparate impact on lower income women who do not have the financial means to pay for an abortion. The Proposed Rule fails for these additional reasons.

**Conclusion**

NYSDFS strongly urges HHS to reconsider adopting this unconstitutional, unlawful, unreasonable, discriminatory, and impermissible Proposed Rule. Women must have access to medical services to ensure their health, well-being, and gender equality. The federal government may not infringe on the independent sovereignty of the states and the states must be accorded their traditional and Congressionally recognized power over the regulation of health insurance business within their borders. The Proposed Rule unlawfully and impermissibly attempts to curtail women's rights and powers of the state. It should not be adopted.

We appreciate the Department's consideration of these comments.

Very truly yours,



Maria T. Vullo
Superintendent of Financial Services

# Exhibit 66

March 27, 2018

**VIA ELECTRONIC TRANSMISSION**

Secretary Alex Azar
Director Roger Severino
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F
Hubert H. Humphrey Building
Washington, DC 20201

**Re: RIN 0945-ZA03 Protecting Statutory Conscience Rights in Health Care; Delegations of Authority**

Dear Secretary Azar and Director Severino:

Planned Parenthood Federation of America (Planned Parenthood) and Planned Parenthood Action Fund (the Action Fund) submit these comments in response to the Protecting Statutory Conscience Rights in Health Care; Delegation of Authority, released by the Department of Health and Human Services (the Department) Office for Civil Rights (OCR) and Office of the Secretary on January 19, 2018 and published in the federal register on January 26, 2018. As a trusted women's health care provider and advocate, Planned Parenthood takes every opportunity to weigh in on policy proposals that impact the communities we serve across the country.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States. Each year, Planned Parenthood's more than 600 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted diseases (STDs), and other essential care to 2.4 million patients. We also provide abortion services and ensure that women have accurate information about all of their reproductive health care options. One in five women in the U.S. has visited a Planned Parenthood health center. The majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level (FPL).

As a health care provider, Planned Parenthood knows how important it is that people have access to quality health care and information they can trust. Already, too many people in this country are denied, often without realizing it, access to medically-appropriate information and care because of a health care provider's or employer's personal beliefs. Instead of protecting

patients' access to quality care, this rule -- if finalized -- would make it easier for health care workers to refuse care, disproportionately impacting women, LGBTQ people, people with low incomes, people from rural areas, and other people already experiencing barriers to care. Importantly, the proposed rule goes beyond the reach of the statutes the Department claims to be implementing, undermining the intent of the statutes and exceeding the authority given by Congress. Further, as outlined below, the proposed rule potentially conflicts with existing civil rights statutes and state laws, and it fails to adequately account for costs.

Indeed, this proposed rule is unprecedented in its reach and harm, seeking to allow almost any worker in a health care setting to refuse services and information to a patient because of personal beliefs, which notably would include "religious, moral, ethical, or other reasons."[1] This means that under this proposed rule, a pharmacist could refuse to fill a prescription for birth control or antidepressants, a woman could be denied life-saving treatment for cancer, or a transgender patient could be denied hormone therapy. And while the proposed rule purports to be protecting the conscience rights and "personal freedom" of health care workers "with a variety of moral, religious, and philosophical backgrounds," it selectively ignores the many workers who are prevented from following their conscience by *restrictions* on care imposed by their employers.

The Department has an obligation to follow parameters established by Congress and aim for equality in health care access across the country, including for women, LGBTQ people, and people living with HIV. To this end, the Department must withdraw this proposed rule.

## I. The proposed rule would endanger patients and obstruct their access to health care.

The proposed rule reflects bad public health policy. Women -- particularly women of color and women living in rural areas -- LGBTQ people, and people living with HIV already experience barriers to care, and this proposed rule would further limit health care access and result in poor health care outcomes. The proposed rule will also interfere with the ability of patients and providers to make informed medical decisions. Notably, the proposed rule does not provide any exceptions for necessary care in the case of an emergency.

### A. The proposed rule would exacerbate existing barriers to health care.

The rule would erect more barriers to reproductive health care, transition-related services, and other services, and place women, LGBTQ people, and people living with HIV at greater risk of not getting the services they need. Access to comprehensive reproductive health care, including abortion, is already limited. According to a recent report, nearly half of the women of reproductive age have to travel between 10 to 79 miles, and some women have to travel 180 miles or more, to access an abortion.[2] Importantly, the proposed rule improperly expands upon

[1] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3923 (Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88).
[2] J. Mearak, et. al., Disparities and change over time in distance women would need to travel to have an abortion in the USA; spatial analysis, The Lancet (Nov. 2017), http://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30158-5.pdf.

existing refusal laws and policies that already harm an untold number of people, who are often denied information and care.

It is already the case that women with pregnancy complications who seek care at religiously-affiliated hospitals have been denied information or abortion care, even when that information is critical to their health. An often-cited case is that of Tamesha Means, who was rushed to Mercy Health Partners in Muskegon, Michigan after her water broke at 18 weeks of pregnancy. She was sent home twice in excruciating pain despite the fact that there was no chance that her pregnancy would survive and that continuing the pregnancy posed significant risks to her health. Due to the hospital's religious affiliation, Ms. Means was not informed that terminating her pregnancy was the safest course for her condition, and therefore her health was put at risk.[3] Another woman, Mikki Kendall, went to an emergency room after experiencing a placental abruption. Even though her pregnancy would not survive and Ms. Kendall could have died due to the amount of blood loss, the doctor on call refused to perform an abortion and refused to contact another physician to perform the procedure. Fortunately, Ms. Kendall was able to receive the care she needed after several risky and agonizing hours.[4] Unfortunately, many people are not even aware that they may be denied medically-appropriate care and information, even in emergency situations. For instance, nearly 40 percent of the people who regularly visit Catholic hospitals do not know of the religious affiliation, and even patients that are aware of the affiliation frequently do not know the hospital refuses to provide certain services.[5]

Certain communities are particularly affected by denials of care. Health care refusals disproportionately impact Black women, and the expansions outlined in this proposed rule would likewise disproportionately impact Black women. For example, according to a recent report, hospitals in neighborhoods that are predominately Black are more likely to be governed by ethical and religious directives for Catholic health care services.[6] Additionally, people living in rural areas are significantly impacted if their provider refuses to provide necessary or preventive care. Women living in in rural areas already experience provider shortages and have to travel long distances for health care, resulting in significant gaps in care and low health outcomes.[7] By making it easier for providers to refuse care, the proposed rule would further restrict these options or cut off access to care altogether, which would compromise patient health still further.

The proposed rule also threatens access to transition-related services and HIV prevention and care -- including pre-exposure prophylaxis -- disproportionately impacting LGBTQ people and

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[3] ACLU, Tamesha Means v. United States of Catholic Bishops (June 30, 2015), https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops.

[4] Mikki Kendall, Abortion Saved my Life, Salon (May 26, 2011), https://www.salon.com/2011/05/26/abortion_saved_my_life/. .

[5] *Id.*

[6] K. Shepherd, et. al., Bearing Faith: The Limits of Catholic Health Care for Women of Color, Columbia Law School (January 2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf?mc_cid=51db21f500&mc_eid=780170d2f0.

[7] The American College of Obstetricians and Gynecologists, Health Disparities in Rural Women (2014, reaffirmed 2016), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20160402T0931414521.

people living with HIV. Discrimination in health care settings already prevents LGBTQ people from accessing the care they need. For instance, nearly one-third of transgender people surveyed said a doctor or health care provider refused to treat them due to their gender identity.[8] Related, people living with HIV frequently experience stigma in the health care system.[9] The proposed rule would increase this stigma and make it more likely that these communities are denied necessary health care.

**B. The proposed rule will hinder the delivery of care.**

While the Department claims that the proposed rule will "facilitat[e] open communication between providers and their patients," in fact, it would do the opposite. Specifically, the proposed rule encourages medical professionals to conceal information if they believe that information might enable a patient to seek care (even elsewhere) of which they disapprove. It also inhibits communication by increasing the risk that *patients* will conceal medically relevant information, such as sexual orientation, out of fear that their provider would refuse them care.

The proposed rule itself notes that mainstream medical groups have recognized the negative effects refusing care can have on patients and that these organizations have called for patient protections when refusals may compromise health. For example, the American Congress of Obstetricians and Gynecologists (ACOG) ethics opinion states that "in an emergency in which referral is not possible or might negatively affect patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."[10] The American Medical Association's (AMA) constitution and bylaws similarly note that physicians are required to be "moral agents" and "being a conscientious medical professional may well mean at times acting in ways contrary to one's personal ideals in order to adhere to a general professional obligation to serve patients' interests first." The constitution and bylaws further state that "having discretion to follow conscience with respect to specific interventions or services does not relieve the physician of the obligation to not abandon a patient."[11] The proposed rule would exacerbate these concerns by making it harder for medical organizations and providers to preserve existing access to reproductive health care.[12]

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[8] S. Mirza & C. Rooney, Discrimination Prevents LGBTQ people from Accessing Health Care, Ctr. for Amercian Progress (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[9] CDC, HIV Among Gay and Bisexual Men, https://www.cdc.gov/hiv/group/msm/index.htm; CDC, HIV Among African-Americans, https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-aa-508.pdf.

[10] 83 Fed. Reg. at 3888; ACOG, The Limits of Conscientious Refusal in Reproductive Medicine (Nov. 2007, reaffirmed 2016), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine.

[11] American Medical Association, Physician Exercise of Conscience: Report of the Council on Ethical and Judicial Affairs, https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/i14-ceja-physician-exercise-conscience.pdf.

[12] By ignoring these harms, the Department has failed in its obligation to acknowledge and consider the impact of a proposed rule on family well-being. *See* 83 Fed. Reg. at 3919.

### C. The proposed rule does not include exceptions for medical emergencies and potentially conflicts with existing federal law.

The proposed rule could endanger women's lives because it fails to make sure that the protections of the Emergency Medical Treatment and Active Labor Act (EMTALA) apply and take precedence when a patient is facing a medical emergency. EMTALA requires virtually every hospital to provide an examination or treatment to individuals that come into the emergency room, including care for persons in active labor, and the hospital must provide an appropriate transfer if the hospital cannot stabilize the patient.[13] The proposed rule does not address EMTALA and the potential legal conflict between that Act and the proposed rule. In particular, it is unclear if the Department or a state or local government would be considered to have engaged in prohibited "discrimination" if it penalized a hospital for failing to comply with EMTALA when a pregnant woman needs an abortion in an emergency situation.[14] There is no dispute that some pregnant women develop serious medical complications for which the standard treatment is pregnancy termination.[15] The proposed rule's silence on medical emergencies could create confusion among health care institutions or even allow them to refuse to comply with existing federal requirements to treat patients with medical emergencies and thereby endanger women's lives.[16]

## II. The proposed rule exceeds the authority granted under the underlying statutes.

While purporting to interpret long-standing statutes, the Department is expanding the requirements of the statutes beyond what Congress intended. The Department claims that it is seeking to clarify the scope and application of existing laws, but this rule would in fact drastically alter, not clarify, existing requirements. The Department both creates expansive definitions that did not exist before and reinterprets the provisions of the underlying laws in harmful ways.

### A. The proposed rule expands the definition of various terms beyond their well-settled meanings and beyond congressional intent.

The proposed rule expands the definitions of well-settled terms used in the relevant refusal laws far beyond their commonly understood meanings, defining terms so broadly as to encompass a

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[13] 42 U.S.C. § 1395dd.

[14] The government can clearly take such action under Title VII. *See* Shelton v. Univ. of Med. & Dentistry of N.J. 223 F.3d 220, 228 (3d Cir. 2000).

[15] See *e.g.*, *Planned Parenthood v. Casey*, 505 U.S. 833, 880 (1992) ("[It is undisputed that under some circumstances each of these conditions [preeclampsia, inevitable abortion, and premature rupture of membrane] could lead to an illness with substantial and irreversible consequences.").

[16] Federal abortion policy generally has recognized the need to protect women's lives. *See e.g.*, 18 U.S.C. § 1531(a) (prohibiting abortion procedure except where "necessary to save the life of a mother"); 10 U.S.C. § 1093 (banning almost all abortion services at U.S. military medical facilities, and prohibiting Department of Defense funds, which includes health insurance payments under Civilian Health and Medical Program for the Uniformed Services, from being used to perform abortions, "except where the life of the mother would be endangered if the fetus were carried to term"); Consolidated Appropriations Act, 2017, Pub. L. No. 115-131, Title V §§ 507 131 Stat. 135 (2017) (prohibiting that funds appropriated under the Act be used to pay for an abortion except where, among other narrow exceptions, "where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed").

ridiculously wide array of activities that go well beyond congressional intent. As an initial matter, although the Department purports to be bringing the refusal laws in line with other civil rights laws, the rule proposes to define "discrimination" contrary to how it is has been long understood in those laws. Under the Department's proposed rule, "discrimination" is more broadly defined to include a large number of activities, including denying a grant, employment, benefit or other privilege, as well an unspecified catch-all phrase "any activity reasonably regarded as discrimination." It also includes any laws or policies that would have the effect of defeating or substantially impairing accomplishment of a "health program or activity." The term, "health program or activity" is then defined to include, among other things, "health studies, or any other services related to health or wellness whether directly, through payments, grants contracts, or other instruments, through insurance, or otherwise."[17] The inclusion of any impairment of a "health program or activity," as defined, only adds to an unreasonably expansive definition of "discrimination" that could be applied to anything with a tangential connection to health or wellness. As set forth below, the rule's all-encompassing definition of "discrimination" fails to account for established anti-discrimination law that reflect a balancing of interests -- protecting against religious discrimination but recognizing it is not discriminatory to require an employee to perform functions that are essential to the position for which she applied and was hired.

The proposed rule also improperly stretches the definition of "refer" to include providing "any information … by any method … that could provide any assistance in a person obtaining, assisting, training in, funding, financing, or performing a particular health care service, activity or procedure."[18] This means that any health care entity, including both individuals and institutions, could refuse to provide any information that could help an individual to get the care they need, including even to provide patients with a standard pamphlet. The objecting entity would be able to refuse to provide that information even if they believe that a particular health care service is only the "possible outcome of the referral."[19] This definition would allow health care providers to deny patients full, accurate, and comprehensive information on health care options that allow people to make their own health care decisions.

The proposed rule also defines "assist in the performance of" far more broadly than its common meaning, to include participating in any program or activity with "an articulable connection" to a procedure, health service, health program, or research activity. The proposed rule specifically notes that this includes *but is not limited to* counseling, referral, training, and other arrangements.[20] Even though the Department claims to acknowledge "the rights in the statutes are not unlimited," this definition could in effect create an unlimited right to refuse services. For example, it is unclear if an employee whose task it is to mop the floors at a hospital that provides abortion would be considered to "assist in the performance" of the abortion under this proposed rule. A definition this limitless provides no functional guidance to health care providers as to what they can ask of their employees, and the refusals permitted by health care providers and non-medical staff.

The proposed rule also broadens the health care workers that can claim "discrimination," potentially allowing a range of health care workers not directly involved in delivering care to

[17] 83 Fed. Reg. at 3924.
[18] Referral is defined far more narrowly elsewhere in federal law. *See, e.g.*, 42 U.S.C. § 1395nn(h)(5); 42 C.F.R. § 411.351.
[19] 83 Fed. Reg. at 3924.
[20] 83 Fed. Reg. at 3923.

refuse to perform their duties at a health care facility. Specifically, the proposed rule seeks to expand the definition of "health care entity," "individual," and "workforce" to include a broad range of workers and organizations, including volunteers, trainees, and contractors.[21] The proposed rule notes that the workers included in the definitions are illustrative and not exhaustive, potentially creating the opportunity for non-medical personnel, such as receptionists or facilities staff, to refuse to perform job tasks. In particular, the notion that an individual who agrees to volunteer to perform a service for an entity has the right to then refuse to perform that service, but presumably without losing his or her status as "volunteer," is absurd. This nonsensical interpretation of the statutes exceed the Department's regulatory authority. In short, if this provision is finalized, a wide range of workers may be able to deny access to care - even if the worker's job is only tangentially related to that care.

The proposed rule also seeks to expand the health care providers and institutions that are subject to the rule's burdensome requirements. The proposed rule's broad definition of "entity" to include individuals as well as corporations, would greatly expand the individuals and institutions subject to the underlying laws' requirements.[22]

In general, the proposed rule's unreasonably expansive definitions could inhibit health care providers and institutions from offering a broad range of health care services to patients, and would ultimately limit patients' access to care. This is particularly so because in addition to expanding the terms used in the refusal laws beyond any possible meaning Congress intended, the Department has also expanded the substance of the refusal laws beyond their statutory text, as is discussed below. Thus, rather than clarify statutes that are as much as forty-years old, the proposed rule has stretched the meaning of key terms. This will lead to illogical, unworkable, and unlawful results.

### B. The Department broadly interprets the Church Amendments in violation of the statute.

The Department is exceeding its statutory authority by interpreting the Church Amendments far beyond what Congress intended. Each provision of the Church Amendments was enacted at a different point in time to address specific concerns. The first two provisions of the Church Amendments were enacted in 1973 during the public debate following the *Roe v. Wade* decision, and they clarify that receipt of certain federal funds does not require a health care entity to perform abortions or sterilizations or make its facilities available for abortions or sterlizations.[23] These provisions of the Church Amendments, codified at 42 U.S.C. § 300a-7(b) and (c)(1), permit individuals to refuse to perform or assist in the performance of a sterilization or abortion in certain federally funded programs if it is contrary to their religious or moral beliefs. Sections (d) and (e) of the Amendments were passed as a part of the National Research Act, which aimed at funding biomedical and behavioral research, and ensuring that research projects involving human subjects were performed in an ethical manner. [24] The Department's purported

[21] 83 Fed. Reg. at 3923–3924.
[22] 83 Fed. Reg. at 3924.
[23] The implicated funds are the Public Health Service Act [42 U.S.C. § 201 *et seq*.], the Community Mental Health Centers Act [42 U.S.C. § 2689 *et seq*.], and the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C. § 6000 *et seq*.].
[24] See 119 Cong. Rec. 2917 (1973).

interpretation of these provisions goes far beyond both the statutory text and Congressional intent in at least two ways.

First, section (b) of the Church Amendments states that courts, public officials, and public authorities are not authorized to require the performance of abortions or sterilizations, *based on the receipt of* any grant, contract, loan, or loan guarantee under the Public Health Service Act (PHSA), the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act. The proposed rule goes beyond the text of the statute and interprets it to prohibit public authorities from *requiring any individual or institution* to perform these services if they receive a grant, contract, loan or loan guarantee under the PHSA. Therefore, while the Church Amendments only make it clear that public authorities are not allowed to require the performance or assistance in the performance of abortion or sterilization based on the receipt of certain federal funding, the proposed rule imposes a blanket prohibition on any requirements related to individuals or institutions performing or assisting in the performance of abortion and sterilization if the institution or individual receives the specified funding. Combined with the expanded definition of "assist in the performance" that impacts sections (b)(1) and (b)(2)(B), the proposed rule allows for denials of services related to abortion and sterilization by both individual providers and those ancillary to the provision of health care. It could also prevent states and the federal government from requiring a hospital to provide an abortion, even if a patient's health or life is threatened.

Second, the proposed rule interprets section (d) of the Church Amendments in a way that goes well beyond the statute and that has the potential to allow any individual employed at a vast number of health care institutions to refuse to provide care that is central to the institution. Importantly, this provision was intended to apply only to individuals who work for entities that receive grants or contracts for biomedical or behavioral research. The proposed rule incorrectly claims that paragraph (d) of the Church Amendments is not based on receiving specified funding through a specific appropriation, instrument, or authorizing statute, but applies to "[a]ny entity that carries out any part of a health service program or research activity funded in whole or in part under a program administered by" the Department.[25]

The expansive definitions of "entity," "health service program" and "assist in the performance" only serve to exacerbate this unlawful expansion. As noted, "entity" is defined broadly in the proposed rule to include a "'person', as defined in 1 U.S.C. 1 or a State, political subdivision of any State, instrumentality of any State or political subdivision thereof, or any public agency, public institution, public organization, or other public entity in any State or political subdivision of any state." "Health service program" is discussed by the Department in the proposed rule as not only including programs where the Department provides care or health services directly, but programs administered by the Secretary that provide health services through grants, cooperative agreements or otherwise; programs where the Department reimburses another entity to provide care; and "health insurance programs where Federal funds are used to provide access to health coverage (e.g. CHIP, Medicaid, Medicare Advantage)." It also may include components of State or local governments.[26]

Thus, under the proposed rule, virtually any individual could refuse to provide any type of health care or any job task that has a minimal connection to the provision of health care. This provision

[25] 83 Fed. Reg. at 3925.
[26] 83 Fed. Reg. at 3894.

would not only allow individuals to refuse to provide any type of care that they object to, but could also prevent states from protecting patients by requiring the provision of health care or fulfillment of other job duties by individuals in a medical facility. This could include, for instance, enforcing a state law that requires individual pharmacists to fill all the prescriptions they receive.

Nothing in the legislative history of section (d) of the Church Amendments suggests that this provision was meant to restrict the actions of this broad range of health care related individuals and organizations, nor that it was meant to apply to these individuals and institutions in the context of such a broad range of health-related programs.[27] The Department has clearly exceeded its statutory authority by attempting to create a catch-all provision that would allow almost any health care provider in the country to refuse to provide services based on a 40-year old law that was targeted to the receipt of specific, and limited, federal funds.

### C. The Department's interpretation of the Weldon Amendment is not consistent with the plain language of the statute.

The Department has proposed a similarly broad -- and impermissible -- expansion of the Weldon Amendment. That amendment was added to the appropriations bill for the Departments of Labor, Health and Human Services, and Education in 2004 and each subsequent appropriations bill. It prohibits funds appropriated by those three agencies to be provided to a federal agency or program, or to a state or local government, if such agency, program, or government requires any institutional or individual health care entity to provide, pay for, provide coverage of, or refer for abortions.[28] While the text of the statute is limited to state and local governments and federal agencies or programs, the rule would apply the Weldon Amendment to "any entity that receives funds through a program administered by the Secretary or under an appropriations act [HHS]."[29] This interpretation of the Weldon Amendment would impermissibly turn private entities into "federal agencies or programs" by virtue of their receipt of HHS funding.

In addition to conflicting with the plain meaning of the statute, the Department's broad interpretation is also contrary to the legislative history of the Weldon Amendment. During final floor debates on the appropriations bill that included the first Weldon Amendment, one of its supporters explained: "The addition of conscience protection to the Hyde amendment remedies current gaps in Federal law and promotes the right of conscientious objection by forbidding federally funded government bodies to coerce the consciences of health care providers."[30] In other words, the Weldon Amendment's reference to "federal agency or program" was intended as a restriction on government bodies only, not on private entities that receive federal funds.

Indeed, the Department of Justice (DOJ) has taken the formal position that the receipt of federal funds does not mean that an organization is a federal agency or program. In litigation, the DOJ stated: the term "federal agency or program" does not automatically include private, individual family planning clinics that receive federal funds; the Weldon Amendment does not clearly

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[27] Indeed, section (d) of the Church Amendments does not by its terms impose any restrictions on health care providers. Rather, it is framed as an exemption to individuals from certain federal requirements that are contrary to their religious or moral beliefs. 42 U.S.C. § 300a-7(d).

[28] Weldon Amendment, Consolidated Appropriations Act 2017, Pub. L. 115-31, Div. H, Tit. V, Sec. 507(d).

[29] 83 Fed. Reg. at 3925.

[30] 150 Cong. Rec. H10095 (daily ed. Nov. 20, 2004) (statement of Rep. Smith) (emphasis added).

provide that an individual Title X clinic would constitute a "federal agency or program" covered by the statute, and "no agency responsible for the implementation or enforcement of the statute has adopted a reading to that effect."[31] If Congress intended for the Weldon Amendment to apply to virtually every private hospital, pharmacy, and outpatient care center in the country, and hundreds of thousands of private doctors and other health care practitioners, it surely would have said so more directly, either at the time the Weldon Amendment was enacted or in the 14 years that the amendment has been interpreted otherwise.

The unreasonably broad definitions of "discrimination" and "health care entity" also act to greatly expand the reach of the Weldon Amendment. By defining discrimination to include any adverse actions without any balancing of the interests of employers or patients, this provision could be used to attempt to strike down neutral state laws that protect access to health care. The term, "health care entity" is already defined in the Weldon Amendment, so a proposal to add certain entities via regulation clearly exceeds the authority of the Department. For example, the inclusion of "a plan sponsor, issuer, or third party administrator" expands the reach of the provision by allowing employers that provide health insurance (even if they have no connections to health care) to become "health care entities" for purposes of this protection from "discrimination."

Finally, the legislative history cited above makes it clear that the Weldon Amendment was intended to be limited to objections based on conscience, but under the proposed rule, the Department would allow refusal for *any* reason, including, for example, a financial one. All of these expansions are contrary to law and, more importantly, work to deny women access to information about and access to lawful medical services.

**D. The Department similarly expands the applicability of the Coats Amendment.**

The proposed rule's broad definitions of "health care entity," "refer," and "discrimination" would also expand the applicability of the Coats Amendment beyond its statutory language and intent. The Coats Amendment was adopted in 1996 in response to a new standard adopted by the Accrediting Council for Graduate Medical Education, requiring all obstetrics and gynecology residency programs to provide induced abortion training.[32] Senator Coats offered the amendment to "prevent any government, Federal or State, from discriminating against hospitals or residents that do not perform, train, or make arrangements for abortions."[33]

The amendment prohibits the federal government, or any state or local government that receives federal financial assistance, from discriminating against medical residency programs or individuals enrolled in those programs based on a refusal to undergo, require, or provide abortion training.[34] Under the Coats Amendment, the term "health care entity" is limited to "an individual physician, a postgraduate physician training program, and a participant in a program

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[31] Brief of Respondent, *NFPRHA v. Gonzales*, 391 F.Supp.2d 200 (D.D.C. 2004) (No. 04-2148).

[32] *See* 142 Cong. Rec. 5159 (March 19, 1996) (Senator Frist stating that "this amendment arose out of a controversy over accrediting standards for obstetrical and gynecological programs").

[33] 142 Cong. Rec. 4926 (March 14, 1996). *See also* 142 Cong. Rec. 5158 (March 19, 1996) (Senator Coats stating he offered the language in the bill because "it is [not] right that the Federal Government could discriminate against hospitals or ob/gyn residents simply because they choose, on a voluntary basis, not to perform abortions or receive abortion training, for whatever reason.").

[34] *See* 42 U.S.C. § 238n.

of training in the health professions."[35] However, the proposed rule's definition of health care entity would prohibit "discrimination" not just against those specified in the Coats Amendment, but also against other health care professionals, health care personnel, an applicant for training or study in the health professions, a hospital, a laboratory, an entity engaging in biomedical or behavioral research, a health insurance plan, a provider-sponsored organization, a health maintenance organization, a plan sponsor, issuer, third-party administrator, or any other kind of health care organization, facility or plan. Similar to the proposed rule's changes to the Weldon Amendment, the Department has taken a narrow statute that was enacted to address a specific concern and used the proposed rule to promote broader discrimination in health care.

## III. The proposed rule would undermine health care access in programs that Congress intended to expand care for women with low incomes and their families.

The proposed rule would impact health care programs, both domestically and internationally, that are intended to expand access and quality of care for women, people with low incomes, people living with HIV, and others. The expanded scope of the rule would reach both the Title X Family Planning Program (Title X) and the President's Emergency Plan for AIDS Relief (PEPFAR).

### A. The Department's proposal would reduce access to vital services through Title X and other programs by allowing objectors to ignore their general requirements contrary to the intent of these programs.

The Department would seemingly allow entities to apply for and receive federal funds while exempting them from the core legal and programmatic duties upon which such funds are generally conditioned. We find this particularly concerning in the context of federally supported health programs, such as Title X, which are meant to provide access to basic health services and information for people with low-incomes. When it comes to Title X, the proposed rule would not only sanction conduct at odds with pre-existing legal requirements, but could also undermine the program's fundamental objective of expanding access to reproductive health care to underserved communities.

Several of the Department's proposed provisions and definitions appear to exempt recipients of federal funds from following the rules that govern federal programs if they have an objection to doing so. As discussed above, the proposed rule's expansion of the Weldon Amendment turns private entities into "federal agencies or programs" and then bars them (as well as the Department) from "discriminating" against a "health care entity" based on its refusal to provide "referrals" for abortion.[36] "Discrimination" includes, among other things, denying federal awards or sub-awards to objectors.[37] Similarly, the proposed rule provides that the Department cannot require recipients of grants provided under the Public Health Service Act to "assist in the performance of an abortion."[38] Such "assistance" includes an unreasonably broad range of conduct, including "counseling, referral, training, and other arrangements." Also, the proposed rule provides that entities receiving Public Health Service Act grants cannot be required to

[35] 42 USC § 238n(c)(2).
[36] 83 Fed. Reg. at 3925.
[37] 83 Fed. Reg. at 3923–3924.
[38] 83 Fed. Reg. at 3925.

provide personnel for "the performance or assistance in the performance of any . . . abortion;" the overbroad definition of "assistance" again applies here.[39]

Federal agencies routinely provide financial assistance to eligible entities in the form of grants, contracts, or other agreements in exchange for the performance of a prescribed set of services or activities. The Department's approach would seem to give objectors a virtually unlimited right to ignore these generally applicable requirements and may even force the Department to fund entities that refuse to advance the fundamental goals of the programs in which they seek to participate. Nowhere in the proposed rule does the Department acknowledge that its exemptions in these areas would allow conduct that conflicts with pre-existing legal requirements. Nor does it consider how overriding these rules could undermine important health care objectives that are central to the effective administration of federally supported health programs.

The proposed rule's defects come into clear focus in the context of Title X, the nation's program for birth control and reproductive health. Title X of the Public Health Service Act empowers the Department to make grants to public and not-for-profit entities for the purpose of providing confidential family planning and related preventive services.[40] Title X gives priority to services for people with low incomes and, depending on their income and insurance status, patients may be eligible for free or discounted Title X services.[41] In 2016, Title X-funded providers served over 4 million people.[42] This total includes a disproportionate share of individuals from groups that face longstanding racial and ethnic inequities; for example, 32 percent of Title X patients identified as Hispanic or Latino, and 21 percent identified as Black in 2016.[43] Title X-funded projects offer a range of reproductive health care and information, including counseling and services related to a broad range of contraceptive methods, HIV/STI services, cancer screenings, and other care.

The Department's proposal appears to sanction conduct that would interfere with Title X's legal requirements. For example, although Title X funds are barred from going toward abortion, the program's regulations expressly require providers to offer non-directive options counseling to patients, including abortion counseling and referrals upon request.[44] Even before its codification in regulation, longstanding Departmental interpretations held that non-directive options counseling was a basic and necessary Title X service.[45] The centrality of non-directive options counseling in Title X is reinforced every year through legislative mandates in annual appropriations measures.[46] These prescriptions reflect well-settled principles of medical ethics: patients are entitled to prompt, accurate, and complete information to enable them to make informed decisions about their health. And, especially when an entity does not offer a desired

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[39] 83 Fed. Reg. at 3925.
[40] 42 U.S.C. §§ 300 - 300a-8.
[41] 42 U.S.C. § 300a–4(c).
[42] Christina Fowler, et al., RTI International, *Family Planning Annual Report: 2016 national summary* (2017), available at https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.
[43] *Id*.
[44] 42 U.S.C. § 300a-6 (prohibiting funding for abortion); 42 C.F.R. § 59.5(a)(5) (requiring non-directive options counseling and referral).
[45] *See* Comptroller General of the United States, "Restrictions on Abortion and Lobbying Activities In Family Planning Programs Need Clarification" (Sept. 1982), available at http://www.gao.gov/assets/140/138760.pdf.
[46] *See, e.g.*, Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, 131 Stat 135 (2017).

service such as abortion, health professionals have a responsibility to provide the information and referrals needed to ensure that such services are provided to patients in a timely and competent manner. Yet, under the proposal, entities that object to "assist[ing] in the performance of abortion" could claim a right to refuse to offer non-directive options counseling and referrals to Title X patients.

On top of interfering with counseling and referrals under Title X, the proposed rule could also override other program requirements. For instance, Title X requires projects to provide medical services, including "a broad range of acceptable and effective medically approved family planning methods."[47] This unquestionably includes long-acting reversible contraceptive methods such as intrauterine devices (IUDs). The central place of IUDs, which are exceptionally effective, in the family planning repertoire is cemented by the Centers for Disease Control and Prevention's (CDC) Quality Family Planning recommendations. These recommendations provide, for example, that "[c]ontraceptive services should include consideration of a full range of FDA-approved contraceptive methods," and a "broad range of methods, including long-acting reversible contraception (i.e., intrauterine devices [IUDs] and implants), should be discussed with all women and adolescents."[48] Despite these national clinical standards of care, some individuals are opposed to contraception or certain forms of contraception, and under the proposed impermissible expansion of Church (d) discussed above, any individual working for an entity participating in Title X could claim a right to refuse to provide information or services related to contraception for Title X patients.

If allowed by the Department, such exemptions not only would overtake pre-existing legal rules, but could also thwart the critical health care objectives that federal programs are meant to advance. For example, Congress's purpose in passing Title X was, in part, "to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services," and "to enable public and nonprofit private entities to plan and develop comprehensive programs of family planning services."[49] Permitting health care entities to withhold vital counseling, referrals, and services is hardly conducive to the "comprehensive" approach that was contemplated by Congress. In practical terms, such policies could cut off access to basic, preventive health care and information for the low-income and uninsured people who turn to Title X-funded providers.

Since the inception of these important public health programs, entities that do not want to provide the required services are free to decline to participate. All recipients of federal funds, however, should be bound by the same, general requirements and serve the same priorities in order to serve program beneficiaries and faithfully adhere to Congress's aims.

**B. The proposed rule would severely undermine the purpose and effectiveness of U.S. funded health programs around the world.**

The Department's global health programs include those focused on combating HIV/AIDS and malaria, improving maternal and child health, and enhancing global health security. In addition

[47] 42 C.F.R. § 59.5(a)(1).
[48] Centers for Disease Control and Prevention, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, 7, 8, (2014), available at https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.
[49] Act of Dec. 24, 1970, Pub. L. No. 91-572, § 2, 84 Stat. 1504 (1970).

to funds directly appropriated to the Department for global health, considerable funding is transferred to the Department by the State Department and USAID to administer global AIDS programs under PEPFAR.

We strongly oppose the statutory prohibition on the use of foreign aid funding for abortion as a method of family planning, known as the Helms Amendment, both as it is written and the broader manner in which it is applied, and the broad and harmful refusal provision contained within the statute governing PEPFAR, which are both cited in the proposed regulation.[50] The Helms Amendment effectively coerces women into continuing unwanted pregnancies because the health care they are able to access is provided with U.S. funding. The outcome of this harmful policy is increased unwanted pregnancies and maternal morbidity and mortality.

PEPFAR's statutory refusal provision, which applies only to organizations, already puts beneficiaries at risk and undermines the overall program. For example, this restriction allows PEPFAR-participating organizations to refuse to provide condoms (or any other service to which they object) or even information about condoms to people served by the program -- despite the fact that the purpose of the program is to combat HIV/AIDS and condom provision is proven to be an essential component of effective HIV prevention programs. Organizations may even refuse to coordinate their activities or have any other relationship with programs that provide the services or information to which they object, creating a serious barrier to ensuring that the full range of HIV prevention, care, and treatment activities are available in any one community or to any individual client.

The proposed rule would go even further than the statutory refusal provision and under the guise of paragraph (d) of the Church Amendments allow any individual working under global health funds from the Department (whether the funds are from direct appropriations or transferred from another agency and then administered by the Department) to refuse to perform or assist in any part of a health service program. As explained above, this expansion of Church (d) is contrary to Congress' intent in enacting this provision. The result is to magnify the harm of PEPFAR's refusal provision by appearing to allow individuals to refuse to treat any patient if doing so would violate his or religious beliefs or moral convictions, without concern for the needs of the patient and regardless of what type of health service the patient needs -- whether it be contraception, a blood transfusion, a vaccination, condoms to prevent HIV transmission, sexually transmitted infection screenings and treatment, or even information about health care options. The proposed rule would impact a limitless array of health services.

Moreover, individuals could potentially use this broad interpretation of section (d) of the Church Amendments to pick and choose which patients to assist, making LGBTQ individuals, adolescent girls and young women, and other marginalized populations particularly vulnerable to discrimination in the provision of services. This is particularly egregious in the context of HIV/AIDS programs where these communities face elevated risk in many parts of the world. In developing countries where health systems are especially weak, there is a shortage of available health care options and supplies, and individuals often travel long distances to obtain the services that they need; it is particularly critical that individual health care providers do not deny patients the information and services that they need. Such action undermines the purpose of the programs and the rights of those they intend to serve.

[50] 83 Fed. Reg. at 3926–3927.

Furthermore, the proposed rule does not refer or defer to any but a small set of federal provisions governing U.S. foreign policy and foreign assistance, or to the agencies entrusted to set this policy. This could create confusion or even conflict with existing laws and policies, which may differ, for example, across PEPFAR implementing agencies and departments.

Finally, we are deeply concerned that the proposed rule defines recipient and subrecipient as including foreign and international organizations, including agencies of the United Nations. There are likely unique and severe compliance and certification burdens on international recipients and subrecipients, including, but not limited to with regard to translation and conflict with local law and policy. The proposed rule may directly conflict with the laws and policies of other countries where global health programs operate, putting those implementing the global health programs in an untenable position. For example, some countries may require health care providers to provide necessary care in emergency situations or information or referral for all legal health services - requirements that would be in direct conflict with this proposed regulation. The application of these requirements to UN agencies, such as the World Health Organization (WHO) with whom the Department works on issues like measles and polio, may be wholly unworkable given their missions and structures and could completely jeopardize the ability of these agencies to partner with the Department.

## V. The proposed rule would cause chaos and confusion as it is inconsistent with federal and state laws designed to prohibit discrimination and increase people's access to care.

The Department claims that it is creating a regulatory scheme that is "comparable to the regulatory schemes implementing other civil rights laws." First, the proposal does not warrant the broad enforcement authority delegated to the newly created division within OCR. The proposed rule and underlying statutes are not civil rights laws, and the proposed rule seeks to grant OCR the authority to take enforcement actions. Further, the proposed rule is not consistent with civil rights laws as it fails to provide covered entities due process protections afforded under Title VI of the Civil Rights Act (Title VI). Finally, the proposed rule would create confusion as to the interaction with existing federal and state laws. In particular, the proposed rule does not explain how it interacts with Title VII of the Civil Rights Act (Title VII) and it undermines states' ability to require care.

### A. The proposed rule provides expanded enforcement authority to OCR, while at the same time lacking necessary due process protections, such as those provided by Title VI.

While the proposed rule purports to model itself after "the general principles . . . enshrined in Title VI of the Civil Rights Act (Title VI)," it includes draconian enforcement provisions that are wildly out of sync with those in Title VI. Title VI requires a four step process before a federal agency may deny or terminate a recipient's federal funds: 1) the recipient must be notified that it has been found not in compliance with the statutes and that it can voluntarily comply; 2) the recipient must be afforded an opportunity for a hearing on the record and the agency must make an express finding of failure to comply; 3) the Secretary or head of the agency must approve the decision to suspend or terminate funds; and 4) the Secretary of the agency must file a report with the House and Senate legislative committees with jurisdiction over the applicable programs that explains the grounds for the agency's decision, and the agency may not terminate funds

until 30 days after the report is filed.[51] The proposed rule affords no such procedural due process for those accused, investigated, or those found in violation of the underlying requirements. In particular, if the proposed rule were to become law as is, then a recipient could have its financial assistance withheld in whole or in part, have its case referred to DOJ, or face a range of other unspecified actions – all without the opportunity to explain or defend its actions.

Additionally, Title VI clearly requires that an agency must engage in a concerted effort to obtain voluntary compliance *before* it may begin enforcement proceedings against an entity found to be in violation.[52] Specifically, federal law states that "effective enforcement of Title VI requires that agencies take prompt action to achieve voluntary compliance in all instances in which noncompliance is found."[53] The proposed rule loosely states that "OCR will inform relevant parties and the matter will be resolved informally wherever possible," and notes that while attempting to obtain this informal compliance, OCR can simultaneous engage in a range of enforcement actions.[54] This is not consistent with Title VI as it does not require the Department to attempt to achieve voluntary compliance from an entity *before* enforcement actions are taken.

Further, no guidance is given about the actions that would trigger each enforcement mechanism. For instance, would failure to meet the rule's requirement to post a notice result in millions of dollars of funds being withheld? Can failure to certify intention to comply with the rule result in a referral to DOJ? This proposed rule seems to allow OCR unlimited discretion to choose its enforcement mechanism -- including withdrawal of all federal funding and/or a referral to DOJ within any assurance that the Department's actions are proportionate to the violation. The Supreme Court has found government overreach when Congress authorized the Department to utilize federal financial assistance to control recipients' actions. Specifically, in *National Federation of Independent Business v. Sebelius*, the Supreme Court held that Congress exceeded its authority when it authorized the Department to withhold federal financial assistance from a state's Medicaid program if the state failed to expand the program's eligibility.[55] The Court explained if the Department withheld all federal funding from a state for failing to comply with conditions attached to the funding, then States would not have a "genuine choice whether to accept the offer" for funding.[56] Such financial inducement was found to be akin to a "gun to the head."[57] Therefore, the Department does not have unbridled authority to withhold federal financial assistance, and the Department's actions must be proportionate to the violation.

The enforcement actions contemplated under the proposed rule resulting from a formal or informal complaint are all the more problematic given that the entity may ultimately not be found in violation of the proposed rule's requirements. Covered entities subject to a "compliance review or investigation" must inform any Department funding component of such review, investigation, or complaint, and for five years, the entity must disclose on applications for new or renewed federal financial assistance or Department funding that it has been the subject of a

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[51] 42 U.S.C. § 2000d-1.

[52] 42 U.S.C. § 2000d-1.

[53] 28 C.F.R. § 42.411(a).

[54] 83 Fed. Reg. at 3930.

[55] National Federation of Independent Business v. Sebelius, 567 U.S. 519, 588 (2012).

[56] *Id.* at 584.

[57] *Id.* at 582.

review, investigation, or complaint.[58] This disclosure must be done even if the compliance reviews or investigations are found frivolous or do not lead to a finding of violation. The Department can conduct compliance reviews "whether or not a formal complaint has been filed." The Department is also "explicitly authorized to investigate 'whistleblower' complaints, or complaints made on behalf of others, whether or not the particular complainant is a person or entity protected by" the refusal laws.

The Department's sweeping enforcement authority, coupled with the lack of specific guidance to covered entities about what the proposed rule would require, places an unwarranted burden upon covered entities. The proposed rule is not consistent with Title VI - in particular, the rule does not offer due process and affords the Department complete discretion to impose penalties disproportionate to actions or alleged actions.

### B. The proposed rule upsets the balance for religious objection long enshrined in law by Title VII.

For more than 50 years, Title VII has provided protections against religious discrimination.[59] In defining "discrimination" in a way that can be understood as both different from and far broader than it has long been understood, the Department has both exceeded its authority and caused confusion. In particular, the proposed rule does not clearly state that "discrimination" has the same limits as it does in the context of religious discrimination under Title VII and in particular that the "reasonable accommodation/undue hardship" framework for assessing if there has been "discrimination" also applies under the proposed rule. On its face, it is unclear if the proposed rule adopts Title VII's reasonable accommodation/undue hardship standard, or rather, creates a *per se* rule that allows employees' beliefs to take precedence over the needs and interests of health care providers and their patients under any circumstance.

Under Title VII and the case law interpreting it: [A]n employer, once on notice, [must] reasonably accommodate an employee whose sincerely held religious belief, practice or observance conflicts with a work requirement, *unless providing the accommodation would create an undue hardship, . . . [meaning] that the proposed accommodation in a particular case poses a "more than de minimis" cost or burden.*[60] Court cases that have addressed the issue of religious refusal have found that there are limits to what employers must do to accommodate refusals, and specifically that it is legal and appropriate for employers to prioritize maintaining patient access to care.[61] Additionally, years of case law interpreting religious accommodation

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[58] 83 Fed. Reg. at 3929–3930.

[59] 42 U.S.C. § 2000e(j).

[60] U.S. Equal Employment Opportunities Comm'n, Section 12: Religious Discrimination, Compliance Manual 46 (2008), *available at* http://eeoc.gov/policy/docs/religion.html [hereinafter EEOC Compliance Manual] (emphasis added).

[61] *See*, *e.g.*, *Walden v. Centers for Disease Control & Prevention*, 669 F.3d 1277 (11th Cir. 2012) (The plaintiff was employed as a counselor through CDC's employment assistance program, but refused to counsel people in same-sex relationships. After she was laid off, the court held that CDC "reasonably accommodated Ms. Walden when it encouraged her to obtain new employment with the company and offered her assistance in obtaining a new position"); *Bruff v. N. Miss. Health Servs.*, 244 F.3d 495, 501 (5th Cir. 2001) (the accommodation requested by plaintiff—a counselor who refused to counsel individuals on certain topics that conflicted with her religious beliefs—constituted an undue hardship

provisions of Title VII has made clear that an accommodation should not place an unfair load on co-workers.[62] Finally, case law has made it clear that "Title VII does not require an employer to reasonably accommodate an employee's religious beliefs if such accommodation would violate a federal statute."[63] The proposed rule fails to give any consideration to this binding precedent or suggest why "discrimination" should be given any different meaning in the context of the refusal laws.

By requiring a balancing of interests between the employee, the employer, and the employer's clients, Title VII ensures that accommodating the religious beliefs of an employee in the health care field does not harm patients by denying them health care and/or health care information. Title VII also avoids placing employers in the untenable position of having employees on staff who will not fulfill core job functions. The Department has ignored that balancing, undermining its stated goal to "ensure knowledge, compliance, and enforcement of the Federal health care conscience and associated antidiscrimination laws."[64] In so doing, the Department should bear in mind that a decision not to incorporate the Title VII reasonable accommodation/undue hardship balancing would lead to absurd and disastrous results. For example, a health care provider could be forced to hire employees who refuse to be involved in medical services that form the core of the medical care it offers. The Department should also bear in mind Executive Order 13563's injunction, which as the Department notes requires it to "avoid creating redundant, inconsistent, or overlapping requirements applicable to already highly-regulated industries and sectors."

The ability of health care employers to continue providing medically appropriate services and information would be significantly compromised if they are forced to operate under a rule which could be understood to compel them to hire, retain, and/or not transfer employees who refuse to provide medically necessary health services and information to patients -- or face a possible penalty of loss of all federal funding.

### C. The proposed rule limits states' authority to increase health care access for their citizens.

This rule would undermine states' ability to protect and expand health care access. States have an important role to play when addressing the harm from denials of health care. State laws that require institutions to provide information, referrals, prescriptions, or care in the event of a life or health risk are vital safeguards for individuals who might be impacted by religious refusals. The expansion of the Weldon and Church Amendments through new definitions and a

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because it would have required her co-workers to assume her counseling duties whenever she refused to do so, resulting in a disproportionate workload on co-workers); *see also Haliye v. Celestica Corp.*, 717 F. Supp. 2d 873, 880 (D. Minn. 2010) ("when an employee has a religious objection to performing one or more of her job duties, the employer may have to offer very little in the way of an accommodation—perhaps nothing more than a limited opportunity to apply for another position within the organization") (citing Bruff).

[62] *See, e.g., Tagore v. United States*, 735 F.3d 324, 330 (5th Cir. 2013) ("more than de minimis adjustments could require coworkers unfairly to perform extra work to accommodate the plaintiff"); *Harrell v. Donahue*, 638 F.3d 975, 980 (8th Cir. 2011) ("an accommodation creates an undue hardship if it causes more than a de minimis impact on co-workers").

[63] *Yeager v. First Energy Generation Corp.*, 777 F.3d 362, 363 (6th Cir. 2015).

[64] 83 Fed. Reg. at 3887.

reinterpretation of existing law could render useless any existing or future state laws that protect patients and consumers.

The Department makes it clear that there are certain types of state laws that they seek to eliminate by reinterpreting the federal refusal laws. For example, the Department clearly wants to undermine state laws that require coverage of abortion. To do so, the Department not only reverses their position on the application of the Weldon amendment, but actually changes the existing (and statutory) definition of "health care entity" so as to include plan sponsors and third party administrators. This will mean more individuals are covered under the statute. The Department has previously rejected this interpretation noting "by its plain terms, the Weldon Amendment's protections extend only to health care entities and not individuals who are patients of, or institutions, or individuals that are insured by such entities."[65]

The Department also highlights state laws that require crisis pregnancy centers to provide information or referrals, as well as state laws and previous lawsuits that seek to require the provision of health care by an institution when a patient's health or life is at risk. The Department clearly wishes to contort the federal refusal laws to address state laws that it finds objectionable. If Congress had wanted to prohibit federal, state, and local governments from ever requiring health care entities to provide, pay for, cover, or refer for abortions, it could easily have done so. The Department now reinterprets these laws to attempt to limit the reach of state laws that protect patients from harmful denials of health care, including laws that simply require referrals to another provider.

The proposed rule invites those who oppose access to reproductive health to make OCR complaints by allowing any individual to file a complaint, whether or not they are the subject of any potential violation. This may have a chilling effect on states' willingness to enforce their own laws. The uncertainty regarding whether enforcement of state laws is "discrimination," especially as to health care entities that refuse to provide medical services or insurance coverage for reasons other than moral or religious reasons, would inhibit states' ability to increase access and provide for the well-being of their citizens. The negative effects of such confusion and uncertainty in our public health care system would certainly fall disproportionately on the millions of people in this country who already experiences barriers to health care access and worse health outcomes, including but not limited to women, LGBTQ people, and people living with HIV.

## VI. The proposed rule fails to properly account for the enormous costs it would impose on providers, patients, and the public.

The Department purports to have conducted an economic analysis for the proposed rule, as required by Executive Order 12866 as well as the Regulatory Flexibility Act, but that analysis is deficient in at least two respects.[66] First, and critically, the Department's analysis ignores entirely the cost to patients of reduced access to health care, fewer health care options, less

[65] Letter from Jocelyn Samuels, Director, Office for Civil Rights to Catherine Short, Life Legal Defense Foundation et. al. re: OCR Transaction Numbers: 14-193604, 15-193782, & 15-195665 (June 21, 2016), http://www.adfmedia.org/files/CDMHCInvestigationClosureLetter.pdf.

[66] That Act requires an analysis of a rule's effects on small businesses, including non-profits. The proposed rule's analysis at 83 Fed. Reg. 3918 is inadequate because as explained below it radically underestimates costs. And while the proposed rule notes that some entities are exempted from some requirements based on cost concerns, it fails to explain why those exemptions (which at any rate would not mitigate the costs described below) were so limited.

comprehensive medical information, impeded ability for patients to make their own health care choices, and interference with provider-patient relationships.[67] Also contrary to Executive Order 12866, it fails to account for how these costs are distributed, e.g. whether they will fall disproportionately on women, rural residents, individuals with low incomes, people of color, LGBTQ people, and people living with HIV. It fails to account for the public health costs associated with reduced patient access to medical information, contraception, abortion, and other reproductive health care, or delays in accessing care due to refusals. Thus, it clearly fails multiple requirements under Executive Order 12866, including the requirement that the Department analyze "any adverse effects on the efficient functioning of the economy, private markets (including productivity, employment, and competitiveness), health, safety, and the natural environment), together with, to the extent feasible, a quantification of those costs."

Second, the Department's estimate of costs that the rule imposes on health care providers is far too low. Given the new burdensome notice and attestation policies, it is unrealistic to think that health care providers -- who as of 2015, employed more than 12 million employees -- would be able to adjust all of their policies, train all of their hiring managers, and ensure and document compliance with the proposed rules, for less than $1000 the first year and less than $900 in subsequent years.[68] Moreover, the Department's cost analysis ignores entirely the enormous cost imposed on health care providers if they were required to employ people unwilling to fulfill job functions necessary to deliver care.

Therefore, the Department's estimate that the proposed rule would cost over $812 million dollars within the first five years is inadequate.[69] But even if it would *only* cost the amount estimated by the Department (which it would not), that sum could be far better used to *provide* health care to individuals and correct inequities in the health care system. While the Department claims the rule is required to "vindicate" the religious or moral conscience of health care providers, significant portions of the proposed rule have nothing to do with the Department's purported motivation. Rather, certain sections give license to HMOs, health insurance plans, or any other kind of health care organization to refuse to pay for, or provide coverage of necessary abortion services for any reason—even financial.[70] These provisions do not protect anyone's conscience, they simply undercut providers' ability to deliver care and consumers' ability to obtain and pay for medical services. The limited resources of the Department and health care providers should be better spent.

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We strongly urge the Department to withdraw this rule. In 2011, the Department withdrew a

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[67] The Department claims that the rule provides non-quantifiable benefits, such as more diverse and inclusive workforce, improved provider patient relationships; and equity, fairness, and non-discrimination. This proposed rule would in fact lead to the exact opposite of these intended benefits. While the Department claims to be protecting the psychological, emotional, and financial well-being of health care workers who refuse to provide care, the proposed rule does not mention the psychological, emotional, or financial harms to patients of well-being associated with being denied access to care.

[68] Kaiser Family Foundation, State Facts: Total Health Care Employment (May 2015), https://www.kff.org/other/state-indicator/total-health-care-employment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[69] The economic analysis estimates the cost at $312 million dollars in year one alone and over $125 million annually in years two through five. And those estimates are based on "uncertain" assumptions that the costs would decrease after five years. 83 Fed. Reg. at 3902.

[70] 83 Fed. Reg. at 3925.

similar rule that was enacted in 2008 noting that the 2008 rule attempting to clarify existing laws had "instead led to greater confusion." This rule has the potential to cause even more confusion and, more egregiously, to reduce access to critical health care even more severely than the 2008 rule. It would jeopardize many people's health and lives. Planned Parenthood strongly urges the Department to follow the law and withdraw this dangerous rule.

Respectfully,

Dana Singiser
Vice President of Public Policy and Government Relations
Planned Parenthood Action Fund
Planned Parenthood Federation of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF NEW YORK**

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|---|---|
| STATE OF NEW YORK, et al.,<br><br>Plaintiffs,<br><br>v.<br><br>UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,<br><br>Defendants. | 19 Civ. 4676 (PAE) |

**PLAINTIFFS' NOTICE OF FILING OF CORRECTED EXHIBIT**

Plaintiffs advise the Court that Exhibit 5 to the Declaration of Matthew Colangelo (Dkt. 43-5) was inadvertently docketed without two attachments cited in the exhibit. Attached to this Notice is a complete version of Exhibit 5 with all attachments.

DATED: June 14, 2019

Respectfully submitted,

LETITIA JAMES
Attorney General of the State of New York

By: */s/ Matthew Colangelo*
Matthew Colangelo
*Chief Counsel for Federal Initiatives*
Office of the New York State Attorney General
28 Liberty Street
New York, NY 10005
Phone: (212) 416-6057
matthew.colangelo@ag.ny.gov

Attorney for the Plaintiffs

# Exhibit 5

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF NEW YORK**

| | |
|---|---|
| STATE OF NEW YORK, CITY OF NEW YORK, STATE OF COLORADO, STATE OF CONNECTICUT, STATE OF DELAWARE, DISTRICT OF COLUMBIA, STATE OF HAWAI'I, STATE OF ILLINOIS, STATE OF MARYLAND, COMMONWEALTH OF MASSACHUSETTS, STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEVADA, STATE OF NEW JERSEY, STATE OF NEW MEXICO, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, STATE OF RHODE ISLAND, STATE OF VERMONT, COMMONWEALTH OF VIRGINIA, STATE OF WISCONSIN, CITY OF CHICAGO, and COOK COUNTY, ILLINOIS,<br><br>Plaintiffs,<br><br>v.<br><br>UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, *in his official capacity as Secretary of the United States Department of Health and Human Services*; and UNITED STATES OF AMERICA,<br><br>Defendants. | CIVIL ACTION NO. 1:19-cv-04676-PAE |

**DECLARATION OF DR. MACHELLE ALLEN**

1. I, Dr. Machelle Allen, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

2. I submit this Declaration in support of the City of New York's litigation against the United States Department of Health and Human Services ("HHS"), Alex M. Azar II, in his official capacity as Secretary of the United States Department of Health and Human Services, and the United States of America regarding the recently issued rule entitled Protecting Statutory Conscience Rights in Health Care; Delegations of Authority ("Final Rule"). I have compiled the information in the statements set forth below either through personal knowledge, NYC Health + Hospitals (herein after "Health + Hospitals" or "the System") personnel who have assisted me in gathering this information from the System, or on the basis of documents that I have reviewed. I have also familiarized myself with the Final Rule in order to understand its immediate impact upon Health + Hospitals.

3. I am a Senior Vice President and the System Chief Medical Officer ("CMO") at Health + Hospitals, located in New York City. I am a graduate of Cornell University and the University of California, San Francisco, School of Medicine, and completed a residency in Obstetrics and Gynecology at Health + Hospitals/Jacobi. I have been employed as the System's CMO since April 2017. Prior to that date, I was the System's Deputy CMO since October 2013.

**Background on the NYC Health + Hospitals; Receipt and Use of HHS Funds**

4. Health + Hospitals is New York City's municipal hospital system and the largest public health care system in the United States. Health + Hospitals protects and promotes the health and well-being of 8.5 million diverse New Yorkers across all five boroughs, serving as the City's public safety net and health care system.

5. Health + Hospitals operates an integrated health care system consisting of: eleven acute care hospitals; five post-acute/long-term care facilities; "Gotham Health," a network of health clinics across the five boroughs offering primary and preventive care services; and "NYC

Health + Hospitals/At Home," a certified home health agency offering expert services in Manhattan, Queens, Brooklyn, and the Bronx.

6. Health + Hospitals offers: "MetroPlus," a low to no-cost health insurance plan serving more than 500,000 New York residents; "OneCity Health," the largest Medicaid Performing Provider System in the City composed of hundreds of health care providers, community-based organizations, and health systems; and "Health + Hospitals/Correctional Health Services," one of the largest correctional health care systems in the nation, with over 43,000 annual admissions in jails across the City.

7. In addition to this range of facilities and programs, twenty-two Health + Hospitals facilities have been designated as "Leaders in LGBT Healthcare Equality" by the Human Rights Campaign Foundation. This designation is given to entities that train staff in the provision of LGBTQ health care, have LGBTQ-responsive policies, and make those policies available to the public and staff.

8. Health + Hospitals received approximately $3.4 billion in fiscal year 2018 from HHS. In particular, Health + Hospitals received: $5,933,864 for services covered by Child Health Plus; $1,153,400,144 for services covered by Medicaid; $29,459,286 in federal grants related to HIV/AIDS, Sexually Transmitted Disease Treatment and Prevention, Substance Abuse Treatment, Public Health and Prevention, Immunization, Biomedical and Behavioral Research; $112,799,439 in other grants; $978,233,262 in Medicaid supplemental payments; and $1,114,354,374 for services covered by Medicare.

9. These federal funds allow Health + Hospitals to serve around one million patients annually and are essential to the functioning of our System and maintaining public health within our jurisdiction.

**Existing Health + Hospitals Policies Addressing Religious Objections**

10. Health + Hospitals has robust anti-discrimination policies that are tailored to comply with the existing requirements of our state and local laws on religious accommodation. Foremost among these, Health + Hospitals has an Equal Employment Opportunity ("EEO") Program and a Religious Accommodation Policy. Attached hereto as Exhibit A are true and correct copies of Operating Procedure No. 20-32, Equal Employment Opportunity Program ("EEO Policy"). Attached hereto as Exhibit B are true and correct copies of Operating Procedure No. 20-18, Corporation Policy with Respect to Requests for Religious Accommodation ("Religious Accommodation Policy").

11. The EEO Policy emphasizes its commitment to providing equal employment opportunities to all employees and applicants for employment without regard to, among other bases, their actual or perceived religion or creed. *See generally*, EEO Policy.

12. In the context of religious accommodations, Health + Hospitals "grant[s] requests by employees and prospective employees for a reasonable accommodation of the employee or prospective employee's religious beliefs, practices or observance." Religious Accommodation Policy at 1; *see also* EEO Policy at 3 (prohibiting the denial of reasonable accommodations for "sincerely held religious beliefs, observances, and practices").

13. An accommodation would not be available if it would impose an "undue hardship" on the particular facility or department. *Id.* at 7; Religious Accommodation Policy at 3. A requested accommodation may cause an "undue hardship" if it would be significantly difficult or unduly costly to implement, may affect patient care, or would fundamentally change the nature or operation of Health + Hospitals. *Id.*

14. The Religious Accommodation Policy likewise explains that,

> A request for a religious accommodation will be denied only if, after exploring reasonable alternatives, the network/facility where the employee works or has applied to work determines that granting the request will cause an undue hardship to the operation of the applicable network/facility either because it would interfere significantly with the safe and efficient operation of the network/facility (including, without limitation, its ability to care for patients in a unit or division affected by the request) or would result in significant expense in relation to the size and operating costs of the network/facility.

Religious Accommodation Policy at 1–2.

15. Requests for religious accommodations should be made in writing to a Senior Manager and be made as far in advance as possible. Religious Accommodation Policy at 2.

16. In determining whether to grant a religious accommodation request, the Senior Manager will engage in an interactive dialogue with the employee's department to discuss the effects of the accommodation on the department, and when appropriate, alternative accommodations with the employee. EEO Policy at 7–8.

17. The Religious Accommodation Policy requires the Senior Manager to give written decisions on the religious accommodation requests. The Religious Accommodation Policy also provides higher levels of review that offer additional opportunities for exploring alternatives not yet considered. Religious Accommodation Policy at 3–4.

18. Absent plain reason to believe otherwise—such as inconsistency of practice—the Senior Manager accepts the employee's assertion of the sincerity of his or her religious belief. Religious Accommodation Policy at 4.

19. Health + Hospitals's policies are modeled on a reasonable accommodation and undue hardship framework in order to balance a variety of interests, at times competing, that surface in the workplace. The desire to balance these interests is motivated in part by Health + Hospitals's fundamental mission to provide care to all as well as the need to operate a financially

sustainable public hospital system. Health + Hospitals employs tens of thousands of employees in a variety of patient care environments who utilize complex and highly-specialized skill sets. They work together to deliver care to some of the most vulnerable and underserved patients. It is therefore imperative that the System maintain planned and adequate staffing levels so that care can be delivered in a predictable and safe manner. The current model of evaluating requests for reasonable accommodations, which accounts for the burden on Health + Hospitals, allows the System to guarantee that patient safety is not negatively affected.

**Immediate Impact of the Final Rule Upon Health + Hospitals**

20. It is Health + Hospital's understanding that the Final Rule expands definitions of terms in ways that affect how we function, specifically: "assist in the performance," "discriminate or discrimination," "health care entity," and "referral or refer for."

21. There is a lack of clarity as to who or what falls under these terms, yet Health + Hospitals must prepare for compliance with the Final Rule.

22. ***Staffing costs.*** Health + Hospitals must expend time, resources, and effort by: modifying hiring practices; double or triple-staffing emergency functions in light of limits the Final Rule places on requiring advance notice of objections; and training staff on what behavior is now permissible from objectors and how to work around objections not planned in advance.

23. For example, in the context of a hysterectomy at least twelve different employees are involved in delivering direct care to the patient. This includes nurses, operating room technicians, and others. If clerical staff and housekeepers are included in that figure, the number increases to at least fifteen different people. Many of those individuals are scheduled to perform services weeks or months in advance. It may be impossible to perform the procedure when even one of them—for example, a scrub nurse or certified registered nurse anesthetist—lodges a last minute objection to providing care. In such an instance, the procedure may not be able to be

rescheduled for weeks or months. This could result in harm to the patient or could discourage the patient from coming back to have the procedure performed.

24. Hiring additional staff to act as alternate providers is impracticable for Health + Hospitals. As shown below, in fiscal year 2018, Health + Hospitals directly employed the equivalent of 35,860 full-time and part-time staff; 8,433 affiliate and temporary staff persons; and 700 staff persons who provided hourly services. These salaries amounted to over $4 billion.

| FY18 | H+H (Full Time & Part Time Staff) | Affiliate | Allowances | Overtime | Temporary Staffing | FY18 Total |
|---|---|---|---|---|---|---|
| Full Time Equivalent (FTEs) | 35,860 | 5,657 | 700 | 2,144 | 2,776 | 47,138 |
| Health + Hospital Corp ($ in 000s) | $2,588,661 | $1,208,964 | $51,931 | $155,881 | $155,529 | $4,160,966 |

25. Additional staffing would be costly. It is not clear Health + Hospitals can feasibly comply with the Rule without compromising patient care.

26. ***Emergency care.*** As a result of the Rule, and the risk that any employee may now refuse to provide patient care without advance notice to the hospital, Health + Hospitals must attempt to create contingency staffing plans to ensure that more than one of each necessary professional is available at all times in its emergency rooms.

27. Health + Hospitals operates under enormous budgetary constraints and does not have additional staff to perform essential functions required for a patient experiencing an emergency.

28. For example, a woman who arrives at a Health + Hospitals emergency room with a miscarriage or ectopic pregnancy will typically encounter at least fifteen staff members during her course of treatment.

29. These staffers include: Registration Clerks; Triage Nurses; Patient Care Associates; Laboratory Techs; ER Doctors; OR Technicians; Clerical Staff; Radiologists; Radiology Technicians; Staff Nurses; Housekeeping Staff; Scrub Nurses; Circulating Nurses; Anesthesiologists; and Certified Registered Nurse Anesthetists.

30. Just as hiring additional staff for non-emergency services would be cost prohibitive, hiring additional staff for emergency services is not realistic.

31. ***LGBTQ health care.*** In order to better meet the needs of the estimated 750,000 LGBTQ individuals living in the City of New York, Health + Hospitals began collecting sexual orientation and gender identity ("SOGI") demographic information at the System's facilities. This data—identifying when, where, and why LGBTQ individuals seek medical treatment—will help the System better allocate resources. This, in turn, creates an affirming experience for LGBTQ patients at Health + Hospitals, thus reducing barriers to equitable care and improving patient outcomes.

32. The Final Rule threatens our effort to improve patient care. It deters LGBTQ individuals from disclosing information for fear that a System employee may refuse them services. It may even cause LGTBQ individuals to delay or refuse to seek care altogether due to stigma and discrimination in the health care setting.

33. ***Contractual relationships.*** Health + Hospitals must review contractual relationships with subcontractor institutions that are used to deliver health services in order to

ensure that such institutions are in compliance with the Rule. In doing so, Health + Hospitals must devote substantial time and resources to this immense undertaking.

I declare under penalty of perjury that, to the best of my knowledge, the foregoing is true and correct.

Executed on this 7th day of June, 2019

Machelle Allen, M.D.

Senior Vice President and Chief Medical Officer NYC Health + Hospitals

# Exhibit 5
# Attachment A

NYC HEALTH + HOSPITALS

# OPERATING PROCEDURE NO. 20-32
# EQUAL EMPLOYMENT OPPORTUNITY (EEO) PROGRAM[1]

**Effective Date:** September 1, 2018 approved by Mitchell Katz, MD President and CEO

**Responsible Department:** The Office of Equal Employment Opportunity (EEO)

**Sub-Department(s):** The Office of Legal Affairs

**Regulatory Requirement(s):** Civil Rights Act of 1964; New York State Human Rights Law; New York City Human Rights Law, New York City Administrative Code; Age Discrimination in Employment Act (ADEA); Americans with Disabilities Act of 1990

**Required Date of Review:** September 30, 2020

## I. PURPOSE:

NYC Health + Hospitals (hereafter, the System) is committed to providing equal employment opportunities (EEO) to all employees and applicants for employment without regard to actual or perceived race; color; national origin; alienage or citizenship status; religion/creed; sex and/or gender (including sexual harassment and/or "gender identity" – which refers to a person's actual or perceived sex and includes self-image, appearance, behavior or expression, whether or not different from that traditionally associated with the legal sex assigned to the person at birth); disability; age; pregnancy; prior record of arrest or conviction; marital status; partnership status; familial status; caregiver status; genetic information or predisposing genetic characteristics; sexual orientation; unemployment status; salary history; credit history; status as a veteran or active military member; status as a victim or witness of domestic violence, sex offenses or stalking; and/or any other protected class covered by federal, state and/or local anti-discrimination laws.

This Operating Procedure is intended to set out the applicable policies and procedures of the System's Equal Employment Opportunity Program. Further, this Operating Procedure serves to remind all staff as to their rights and responsibilities with respect to fostering and maintaining a workplace of equal employment opportunity and to ensure compliance with all applicable federal, state and local antidiscrimination laws.

## II. SCOPE:

Everyone who works for the System, or is an applicant for employment with the System, is covered by federal, state, and/or local anti-discrimination laws as well as this Policy. This includes current employees, volunteers, temporary staff, and job applicants. Further, the System is committed to a workplace free from

[1] This Operating Procedure supersedes OP 20-32, "Equal Employment Opportunity Program and Affirmative Action Plan" dated March 21, 2012 and the NYC Health + Hospitals "Equal Opportunity Policy Statements" dated November 12, 2008.

discrimination and/or retaliation. All System employees are expected to be respectful of everyone in the System's workplace (including, but not limited to, contractors, affiliates, vendors, patients, etc.) and members of the public, and to be sensitive to the effects of their behavior on those around them. All affiliates, contractors and/or other non-System employees assigned to a System facility are required to comply with the System's EEO Policy consistent with the terms of their affiliation agreements, service contracts, and/or applicable agreements, rules, regulations, and laws.

This Policy not only protects individuals from prohibited conduct because of their own protected status (such as their own actual or perceived race, religion, national origin or disability), but also protects individuals from conduct motivated by the actual or perceived race, religion, national origin, or disability, etc., of other persons with whom they are associated. For example, this Policy applies to individuals who are subjected to adverse actions because of their marriage to, or domestic partnership or association with, persons of a particular racial, religious, or national origin group, or persons who have a disability.

The System's EEO Policy extends to conduct which occurs at any location that could be reasonably regarded as an extension of the workplace, such as any field location, work conferences/trade shows, offsite business-related or System-sponsored social functions (e.g. System sponsored holiday party), System vehicle, or facility where System business is being conducted and discussed.

## III. POLICY:

It is the policy of the System to recruit, select, train and promote, into all job levels, the most qualified individuals without regard to actual or perceived race; color; national origin; alienage or citizenship status; religion/creed; gender (including sexual harassment and/or "gender identity" – which refers to a person's actual or perceived sex and includes self-image, appearance, behavior or expression, whether or not different from that traditionally associated with the legal sex assigned to the person at birth);disability; age, pregnancy; prior record of arrest or conviction; marital status; partnership status; familial status; caregiver status; genetic information or predisposing genetic characteristics; sexual orientation; unemployment status; salary history; credit history; status as a veteran or active military member; status as a victim or witness of domestic violence, sex offenses or stalking; and/or any other protected class covered by federal, state and/or local anti-discrimination laws.

To achieve and maintain an atmosphere of opportunity and equality, the System has in place an Equal Employment Opportunity ("EEO") Office staffed by EEO personnel. The Office of Equal Employment Opportunity (EEO) is responsible for the day-to-day implementation and monitoring of the Equal Employment Opportunity Program under the supervision of the Office of Legal Affairs. However, it is the responsibility of all employees of the System to ensure compliance with the System's EEO policies and obligations, to prevent discrimination in the work place, and to ensure that all employees and applicants for employment are given the opportunity to realize their full potential.

**A. Types of Prohibited Conduct**

Decisions and practices based on an individual's protected status (e.g., race, religion, age, and/or the other previously listed categories) that unlawfully affects the terms and conditions of employment or potential employment with the System are prohibited by this Policy. This includes unlawful decisions, actions, and practices that occur in the course of recruitment, testing, hiring, work assignments, determination of salary and benefits, working conditions, performance evaluations, promotions, training opportunities, career development and advancement, transfers, discipline, discharge, or any other application or selection process relating to employment.

This Policy prohibits sexual harassment (i.e., unwelcome conduct or language of a sexual nature) and harassment based on any other protected characteristic referenced above (such as race, gender, religion, disability, or sexual orientation). In addition, this Policy prohibits conduct which unreasonably interferes with an employee's job performance or creates an intimidating, hostile, or offensive working environment based on any protected characteristic. Harassment and/or retaliation against a person who opposes or complains about prohibited conduct or participates in any way in the complaint and/or investigation of an EEO-related matter or in the reasonable accommodation process are strictly prohibited.

This Policy also prohibits the denial of reasonable accommodations for disabilities; pregnancy, childbirth, and related medical conditions; sincerely held religious beliefs, observances, and practices; and/or status as a victim of domestic violence, sex offenses, or stalking. As set forth in more detail later in this policy, all requests for a reasonable accommodation based on a disability; pregnancy, childbirth, or a related medical condition; and/or status as a victim of domestic violence, sex offenses, or stalking, must be made with and/or referred to the Office of EEO.

In addition, this Policy prohibits any employee of the System from aiding, abetting, inciting, compelling, or coercing any person present in a facility of the System, whether or not that person is an employee of the System, from engaging in any conduct prohibited by this Policy, including, but not limited to, conduct that creates a hostile work environment based on any protected characteristic.

Some offensive acts or remarks may be violations of other policies of the System concerning codes of conduct and professional behavior even if they are not so severe that they violate federal, state, or local discrimination laws. The System may discipline conduct that violates such policies even if the conduct does not violate this Policy.

**B. Specific Protections**

The following sections are provided to enable individuals to understand the unique definitions, issues, rights, and responsibilities under this Policy pertaining to sexual harassment and discrimination based on disability; genetic information; retaliation and status as a victim of domestic violence, sex

offenses, or stalking.

1. **Sexual Harassment**
   NYC Health + Hospitals is committed to maintaining a workplace free from sexual harassment. Sexual harassment is unlawful and subjects NYC Health + Hospitals to liability. The System is committed to eliminating such practices through heightened employee awareness, training, and prompt investigations of allegations. Sexual harassment is prohibited under federal, state and local antidiscrimination laws, including but not limited to Section 703 of Title VII of the Civil Rights Act of 1964 as amended, the New York State Human Rights Law, and the New York City Human Rights Law.

   Sexual harassment is any unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature in which someone's submission to or rejection of the conduct is made part of their employment, used as the basis for employment decisions affecting them, or the conduct unreasonably interferes with their work or creates an intimidating, hostile or offensive work environment. A broad range of behavior may be considered sexual harassment, including sexually suggestive remarks, pictures or gestures, verbal abuse or harassment of a sexual nature, subtle or direct propositions for sexual favors, and any unnecessary touching, patting, or pinching.

   The key word is "unwelcome" indicating that the conduct must not be wanted or solicited. This Policy is not intended to regulate social interactions in the work place. When a person makes it known that the sexual overture or conduct is unwelcome, then it must stop immediately.

   The following describes some of the types of acts that may be considered sexual harassment:
   - Physical assaults of a sexual nature, such as:
     - Rape, sexual battery, molestation, or attempts to commit these assaults. Intentional or unintentional physical conduct which is sexual in nature, such as touching, pinching, patting, grabbing, brushing against another employee's body, or poking another employees' body.
   - Unwanted sexual advances, propositions or other sexual comments, such as:
     - Requests for sexual favors accompanied by implied or overt threats concerning the victim's job performance evaluation, a promotion, or other job benefits or detriments;
     - Subtle or obvious pressure for unwelcome sexual activities;
     - Sexually oriented gestures, noises, remarks, jokes or comments about a person's sexuality or sexual experience which are sufficiently severe or pervasive to create a hostile work environment.
   - Sexual or discriminatory displays or publications anywhere in the workplace, such as:
     - Displaying pictures, posters, calendars, graffiti, objects,

promotional material, reading materials, or other materials that are sexually demeaning, pornographic.

Sexual harassment may involve individuals of the same or different gender(s) and can include a complaint by or against a manager or employees of the same rank or against a non-employee.

Any employee of NYC Health + Hospitals who believes that they have experienced sexual harassment and/or are made aware that sexual harassment occurred, even if it does not involve themselves, should contact the Office of EEO. In addition, employees are encouraged to be an ally to any person who was harassed by letting them know that they saw what happened to them and encouraging them to report the behavior to the Office of EEO. Any supervisor or manager that witnesses and/or is made aware that sexual harassment occurred must report it to the Office of EEO.

Please note that pursuant to the System's EEO Internal Complaint process whenever the Office of EEO receives a complaint of sexual harassment or otherwise knows of possible sexual harassment occurring, it will conduct an investigation. Those who are found to have engaged in sexual harassment and/or any supervisory or managerial personnel who knowingly allows such behavior to continue will be subject to appropriate sanctions, including but not limited to disciplinary and/or corrective actions as deemed appropriate. Retaliation against those who complain of sexual harassment or who testify, assist or participate in an investigation, proceeding, or hearing involving a complaint of sexual harassment is unlawful and strictly prohibited by this policy. Some examples of retaliation could include a termination or failure to hire, a demotion, a decrease in pay, a decrease in the number of hours worked, poor performance evaluation/rating, etc.

2. **Disability**

In accordance with the Americans with Disabilities Act (ADA), as well as all other federal, state and local anti-discrimination laws, it is the policy of the System to provide equal employment opportunity to persons with disabilities with respect to all personnel practices, including, but not limited to, hiring, recruitment, advertising, promotion, training, compensation and benefits. Discrimination against a person based on that person's actual or perceived disability, or relationship with a person with a disability, will not be tolerated by the System. For purposes of this Policy, a disability is: 1) a physical, medical, mental, or psychological impairment; 2) a history or record of such impairment; or 3) being regarded as having such impairment.

The System provides reasonable accommodation to its employees and applicants with disabilities to enable them to perform the essential functions of their job. The Office of EEO is responsible for overseeing and coordinating requests for reasonable accommodation received from employees or applicants for hire. In order to request an accommodation, the individual shall make a request with the Office of EEO.

3. **Genetic Information Non-Discrimination Act (GINA)**
The System, in keeping with Title II of the Genetic Information Non-Discrimination Act (GINA), hereby confirms its commitment to prevent the misuse of certain information for employment purposes.

The System respects all employees' privacy of their genetic information and enforces a strict policy of non-discrimination on the basis of genetic information. It is a violation of this Policy to discriminate, harass or retaliate on the basis of genetic information when it comes to all aspects of employment. This includes unlawful decisions, actions, and practices that occur in the course of recruitment, testing, hiring, work assignments, determination of salary and benefits, working conditions, performance evaluations, promotions, training opportunities, career development and advancement, transfers, discipline, discharge, or any other application or selection process relating to employment. Genetic information includes information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about any disease, disorder or condition of an individual's family members (i.e. family medical history).

4. **Domestic Violence, Sex Offenses, or Stalking**
The New York City Human Rights Law prohibits employment discrimination against an individual in the terms, conditions, compensation or privileges of employment because of the actual or perceived status as a victim of domestic violence, or victim of sex offenses or stalking.

The System provides reasonable accommodation to its employees and applicants for hire who are victims of domestic violence, sex offenses or stalking to enable them to perform the essential requisites of their job. The Office of EEO is responsible for overseeing and coordinating requests for reasonable accommodation received from employees or applicants for hire. In order to request an accommodation, the individual shall make a request with the Office of EEO.

5. **Retaliation**
It is a violation of this Policy to retaliate against or harass any person who asserts their rights regarding claims of employment discrimination by: 1) opposing discriminatory practices in the workplace; 2) complaining about prohibited conduct; or 3) participating in any way in the complaint and/or investigation of an EEO-related matter or in the reasonable accommodation process. It is also a violation of this Policy to retaliate against or harass someone because of their association with such an individual.

Behaviors which may be considered retaliatory include, but are not limited to, threats, reprimands, negative evaluations, harassment, refusal to hire, denial of promotion or job benefits, demotion, suspension, discharge, or other actions affecting the terms, conditions, or privileges of employment.

Examples of behavior that are protected against retaliation under this Policy

include, but are not limited to, expressing an intent to file or filing a charge or complaint alleging prohibited conduct under this Policy; participating as a witness in an EEO investigation, an EEO administrative proceeding, hearing, or trial; and/or seeking a reasonable accommodation.

## IV. PROCEDURE/GUIDELINES:

### 1. Requests for Reasonable Accommodations

The System shall provide reasonable accommodations to qualified employees or job applicants unless to do so would cause an undue hardship. Reasonable accommodation requests may be made in connection with disabilities; pregnancy, childbirth, or a related medical condition; sincerely held religious beliefs, observances, and practices; and/or status as a victim of domestic violence, sex offenses, or stalking.[2]

Whether an accommodation is reasonable will depend upon the circumstances of the particular request. Undue hardship may exist when an accommodation is significantly difficult or unduly costly, extensive, substantial, disruptive, or would fundamentally change the nature or operation of the System's business.

The Office of EEO is responsible for overseeing and coordinating requests for reasonable accommodations received from employees and job applicants for disabilities; pregnancy, childbirth, or a related medical condition; and/or status as a victim of domestic violence, sex offenses, or stalking. All requests for a reasonable accommodation for these categories must be made with and/or referred to the Office of EEO. Supervisors, managers, or human resources personnel who become aware of any employee or job applicants request for a reasonable accommodation must notify the Office of EEO.

In order to request a reasonable accommodation for a disability, the employee or job applicant shall make a request to the Office of EEO by completing a reasonable accommodation request form and providing supporting documentation (as applicable). Requests for a reasonable accommodation may also be referred to the Office of EEO through Human Resources, the Occupational Health and Safety Department (OHS) or from the employee's department. Upon receipt and/or notice of an employee's need for a reasonable accommodation, the assigned EEO personnel will engage in the interactive process to clarify the employee's functional limitations and identify the appropriate reasonable accommodation(s). In order to determine an employee's essential functions, the reasonableness of a request, and/or whether or not such a request would impose an undue hardship, the EEO personnel will engage in an interactive dialogue with the employee's department to discuss if and how the requested reasonable accommodation can be effectuated by the department without imposing an undue hardship and, when appropriate, discuss alternative accommodations with the employee. Whether an accommodation is reasonable

[2] The System treats leave requests to address medical or health care needs related to an individual's gender identity in the same manner as requests for all other medical conditions. In addition, the System provides reasonable accommodations to individuals undergoing gender transition, including medical leave for medical and counseling appointments, surgery and recovery from gender affirming procedures, surgeries and treatments as it would for any other medical condition.

will depend upon the circumstances of the particular request.

The following details the specific aspects of each type of request:

**A. Disabilities**

An employee or job applicant with a disability who requires a reasonable accommodation(s) to enable them to perform the essential functions of the job, or to enjoy the benefits and privileges of employment, are urged to promptly request an accommodation with the Office of EEO. Supervisors, managers, or human resources personnel who become aware of any employee or job applicants request for a reasonable accommodation **must** notify the Office of EEO. The EEO personnel involved in the process shall provide reasonable assistance (such as help in completing forms) to an individual requesting an accommodation. Additionally, if a reasonable accommodation is requested to facilitate an individual's ability to apply for employment, the staff supervising the application procedures may be required to assist the applicant in completing the application process. All documentation and information concerning the medical condition or history of an individual requesting a reasonable accommodation for a disability shall be collected and maintained by the Office of EEO separately and apart from the individual's personnel and labor files. Such information will be treated as confidential records, except that managers and supervisors may be informed of limitations, work restrictions and reasonable accommodations requested. Furthermore, medical information may be provided: 1) to first-aid and safety personnel if the disability might require emergency treatment; 2) to government officials investigating the System's compliance with applicable laws; 3) to workers' compensation offices in accordance with Workers' Compensation Law; and 4) for insurance purposes.

**B. Religion**

The System shall grant requests by employees and job applicants for a reasonable accommodation of the individual's sincerely-held religious beliefs, practices or observances unless granting such request will cause an undue hardship to the operation of the applicable facility. Requests for religious accommodations should be made in writing to the individual's "Senior Manager" as set forth in NYC Health + Hospitals Operating Procedure 20-18, "*Corporation Policy with Respect to Requests for Religious Accommodation.*" Please refer to Operating Procedure 20-18 for further guidance on the System's Policy regarding requests for religious accommodation.

**C. Victim of Domestic Violence, Sex Offenses, or Stalking**

Employees or job applicants who require a reasonable accommodations in connection to their status as a victim of domestic violence, sex offenses or stalking are urged to promptly request an accommodation with the Office of EEO. Supervisors, managers, or human resources personnel who become aware of any employee or job applicants request for a reasonable accommodation must notify the Office of EEO. Certification of one's status as a victim of domestic violence, sex offenses, or stalking may be requested by the EEO personnel handling the accommodation request. A person may

satisfy the certification requirement by providing documentation from an employee, agent, or volunteer of a victim services organization, an attorney, a member of the clergy, or medical or other professional service provider from whom the individual seeking a reasonable accommodation, or that individual's family or household member, has sought assistance in addressing domestic violence, sex offenses, or stalking and the effects of the violence or stalking; a police or court record; or other information consistent with the disclosure and the request for accommodation.

**D. Pregnancy, Childbirth or Related Medical Condition**

Employees or job applicants who require a reasonable accommodations on the basis of pregnancy, childbirth, or a related medical condition are urged to promptly request an accommodation with the Office of EEO. Supervisors, managers, or human resources personnel who become aware of any employee or job applicants request for a reasonable accommodation must notify the Office of EEO. The System shall provide reasonable accommodations to employees or job applicants on the basis of pregnancy, childbirth, or a related medical condition unless to do so would cause undue hardship. Such reasonable accommodations may include, but is not limited to bathroom breaks; leave for a period of disability arising from pregnancy, childbirth, or related medical conditions; breaks to facilitate increased water intake; breaks for the purpose of expressing breast milk; periodic rest for those who stand for long periods of time; and assistance with manual labor, among other things. If granted, the reasonable accommodation shall allow the individual to perform the "essential requisites" of their job.

**2. Internal Complaint Procedure**

**A. Reporting Violations of the EEO Policy**

Employees or job applicants of the System who believe that they have been subjected to any action, decision, or harassment in violation of this Policy, or who witness others being subjected to conduct covered by this Policy, are urged to promptly report the incident(s) to the Office of EEO. Supervisors, managers, or human resources personnel who become aware of any claimed violations of this Policy must notify the Office of EEO. Please note that a complaint can be filed against a non-System employee, including but not limited to, affiliates, contractors, members of the public, and/or other non-System employees assigned to a System facility. In such cases, the Office of EEO may contact the non-employee and/or issue recommendations for remedial action consistent with the terms of their affiliation agreements, service contracts, and/or applicable agreements, rules, and regulations. In certain circumstances, a joint investigation between the System's Office of EEO and the non-employees employer may be appropriate. Further, should the Office of EEO receive a complaint against a System employee from a non-employee, the Office of EEO may conduct an investigation, and/or a joint investigation with the non-employee's employer, and issue recommendations for remedial action as deemed appropriate.

Complaints must be in writing and filed within one (1) year of the most recent alleged discriminatory action. Complaint forms may be obtained from Office of EEO and/or the NYC Health + Hospitals Intranet portal. The complaint shall include the name, contact information and signature of the person filing the complaint and a detailed description of the action alleged. It may be filed by personal delivery, electronic mail, or ordinary mail, addressed to the Office of EEO.

After the submission of a written complaint to the Office of EEO, the assigned EEO personnel will review the complaint to determine if it alleges a violation of the EEO Policy. If so, the assigned EEO personnel will conduct an investigation of the complaint. If deemed necessary, as part of the investigation, separate meetings will be arranged to discuss allegations with the person who submitted the complaint, the person who is alleged to have violated the EEO Policy, potential witnesses and/or other persons who could contribute any information regarding the allegations. All internal complaints shall be responded to by the assigned EEO personnel as soon as practicable based on the unique facts and circumstances of the complaint.

After the investigation, the assigned EEO personnel will make a determination of whether a violation of this Policy has occurred. If it is determined that there is no violation of the EEO Policy, the complaint will be closed with such notice of determination sent to the Complainant and the Respondent. If it is determined that there is reasonable cause to believe that the EEO Policy was violated or that behavior inconsistent with the Policy occurred, such notice of determination will be provided to the parties. Where appropriate, remedial and corrective measures will be taken by the Office of EEO and/or the matter will be referred to Human Resources, Labor Relations and/or other department as deemed appropriate.

**B. Complaints against Senior Management Staff**

Complaints against senior management staff (President, Senior Vice Presidents, Vice Presidents, Executive Directors, and General Counsel) and/or members of the Board of Directors may be filed with the Office of EEO at Central Office. The Office of EEO and the Office of Legal Affairs, in consultation, will determine whether the investigation will be conducted by the Office of EEO or by an independent investigator, as appropriate. Where the General Counsel is named as a respondent, the complaint will be referred to the President of NYC Health + Hospitals for the assignment of an investigator. The investigative findings and recommendations of an independent investigator, before finalization, shall be shared with the Office of EEO and/or the Office of Legal Affairs, except where the General Counsel has been named as a respondent. The Office of EEO or the Office of Legal Affairs shall refer the investigative findings and recommendations to either the President or Board of Directors, as appropriate. In those instances where the General Counsel is named as a respondent, the findings will be referred directly by the investigator to the President of NYC Health + Hospitals.

**C. Cooperating in an Investigation**

All current employees, volunteers, and temporary staff, are required to cooperate fully during an investigation into an EEO complaint. All affiliates, contractors and/or other non-System employees are required to cooperate with an investigation into an EEO complainant consistent with the terms of their affiliation agreements, service contracts, and/or applicable agreements.

Failure or refusal to cooperate may result in a recommendation for disciplinary action.

**D. Confidentiality**

All EEO complaints and investigations will be handled, to the extent possible, in a manner that will protect the privacy interests of those involved. While all internal EEO investigations will be conducted in a confidential manner, certain exceptions apply. In the course of the investigation, the assigned EEO personnel may discuss EEO matters with other individuals who may have information about a complaint. In addition, it may be necessary for the assigned EEO personnel to disclose certain information on a need to know basis. The Office of EEO may disclose to persons with a legitimate need to know certain information in order to respond to the complaint allegations or to implement interim or corrective action, including but not limited to disciplinary action (e.g. certain information regarding the complaint and witness statements may be shared with Labor Relations and/or Human Resource in order to determine whether further action/s should be taken). All persons with whom the Office of EEO interacts concerning the complaint and its investigation are asked to refrain from discussing the complaint, to the extent possible, beyond their interaction with the Office of EEO.

**E. Allegations Made in Bad Faith**

If any employee knowingly makes a false accusation of discrimination or knowingly provides information in bad faith in the course of an investigation of a complaint, such conduct may be grounds for discipline. A complaint made in good faith, even if found to be unsubstantiated, will not be considered a false accusation.

**F. Contact with the EEO Office**

An employee has a right to meet privately with the Office of EEO. Such meetings may take place either during or outside of office hours. If an employee makes a request to meet with EEO personnel during office hours, the employee should obtain approval from a manager or supervisor before leaving their work assignment. An employee need not disclose to the manager/supervisor the purpose for or details of the meeting with the EEO personnel. Reasonable requests to meet with an EEO personnel during work hours should not be denied by managers or supervisors. Managers and supervisors shall allow employees to meet with EEO personnel at the earliest practical time consistent with the operational needs of their units.

At the employee's request, arrangements may also be made to hold the EEO meeting before or after office hours, or during the employee's lunch period. Should such a meeting take place entirely on the employee's own time, he or she need not advise a manager or supervisor of the meeting, or obtain the consent or approval of a manager or supervisor. If necessary, the EEO personnel will make arrangements for interpreters and other forms of communication assistance to facilitate effective communication with persons with disabilities.

**G. Right to Representation During Internal Investigation**

All internal EEO investigations will be conducted consistent with all applicable collective bargaining agreements and/or rules. In instances where Group 12 (unionized) employees are named as Respondents and/or where disciplinary action may reasonably result from the interview and/or pursuant to their rights under applicable collective bargaining agreements, the unionized employee will have the right to seek union representation during an EEO investigation at their own election and discretion.

The EEO Policy does not afford employees the right to counsel or other legal representation at an interview with an EEO personnel in connection with an investigation of an internal EEO complaint.

**H. Other Places Where Complaints May Be Filed**

All complainants shall be advised of their right to pursue an external complaint with an outside Civil Rights enforcement agency (see Appendix A) and/or to pursue a complaint through the judicial system. This right is not forfeited by using the System's internal procedure.

The following federal, state, or local agencies enforce laws against discrimination:

- United States Equal Employment Opportunity Commission (the "EEOC"): http://www.eeoc.gov/
- New York State Division of Human Rights (the "SDHR"): http://www.dhr.ny.gov/
- New York City Commission on Human Rights (the "CCHR"): http://www.nyc.gov/html/cchr/html/home/home.shtml
- United States Department of Justice: http://www.justice.gov/

When an employee or job applicant exercises their right to file a complaint with a federal, state, or local civil rights enforcement agency (known as an "external complaint") based on or related to the same facts and circumstances of an internal complaint, the Office of EEO will cooperate with the enforcement agency with respect to the ultimate resolution of the complaint. Complaints filed with the EEOC must be filed within 300 days of the act of discrimination. Complaints filed with the SDHR or the CCHR must be filed within one year of the act of discrimination (note: individuals have up to 3 years to file a sexual harassment claim with the CCHR). In such cases, the EEO Office will respond to the internal complaint through the external complaint process. Please note that if an employee or job applicant files an external complaint prior to the

completion of the investigation of an internal complaint based on the same facts and circumstances, they will not receive a written decision pursuant to the informal complaint procedure; rather, the System's response will be to the external complaint. In addition, there may be certain instances, based on the unique circumstances of the case, where an internal complaint will not be taken and instead the Complainant will be notified of their right to file a complaint externally should they wish to proceed with a complaint.

I. **Withdrawing Complaints**

A complaint of discrimination may be withdrawn at any time by the person who filed the complaint. Once a withdrawal is submitted, the assigned EEO personnel will end the investigation, with certain exceptions. In some instances, the assigned EEO personnel may continue the investigation if deemed appropriate by the Office of EEO. Investigations of complaints alleging sexual harassment will continue notwithstanding the withdrawal of a complaint.

## V. REFERENCES TO REGULATIONS AND/OR OTHER RELEVANT POLICIES:

- Title VII of the Civil Rights Act of 1964;
- New York State Human Rights Law, N.Y. Exec. L. § 290 et seq.;
- New York City Human Rights Law, New York City Administrative Code § 8-101 et seq.;
- 42 U.S.C. § 1981;
- 29 U.S.C. § 206(d)(1);
- Executive Order 11246;
- §§ 503-504 of the Rehabilitation Act of 1973;
- Age Discrimination in Employment Act (ADEA), 29, U.S.C. § 623 et seq.;
- Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.;
- NYC Health + Hospitals Operating Procedure 20-18, "Corporation Policy with Respect to Requests for Religious Accommodation.

## APPENDIX A

### FILING A COMPLAINT WITH AN EXTERNAL CIVIL RIGHTS ENFORCEMENT AGENCY

Any employee or applicant for employment who believes that they have experienced unlawful discrimination has a right to file a formal complaint with the federal, state or local agencies listed below. A person does not give up this right when they file a complaint with the NYC Health + Hospitals Office of Equal Employment Opportunity (EEO).

The following federal, state and local agencies enforce laws against discrimination:

### NEW YORK CITY COMMISSION ON HUMAN RIGHTS

40 Rector Street
New York, NY 10006
(212) 306-7450
(212) 306-7686 (TTY)
Web site: www.nyc.gov/html/cchr/home/html

### NEW YORK STATE DIVISION OF HUMAN RIGHTS

One Fordham Plaza, 4th Floor
Bronx, NY 10458
(718) 741-8400

or

163 West 125th Street, 4th Floor
New York, NY 100270
(212) 961-8650
(212) 961-8999 (TTY)

or

20 Exchange Place, 2nd Floor
New York, NY 10005
(212) 480-2522

or

55 Hanson Place, 3rd Floor
Brooklyn, NY 11217
(718) 722-2856
Web site: www.nysdhr.com

**UNITED STATES EQUAL EMPLOYMENT OPPORTUNITY COMMISSION (EEOC)**

New York District Office
33 Whitehall Street, 5th Floor
New York, NY 10004
(212) 336-3620; (212) 336-3622 (TTY)
Web site: www.eeoc.gov

In addition to filing with the aforementioned agencies, a person with a complaint alleging discrimination based on disability may file with:

**UNITED STATES DEPARTMENT OF JUSTICE CIVIL RIGHTS DIVISION**

Disability Rights Section
New York Avenue Building
950 Pennsylvania Avenue N.W.
Washington, D.C. 20530
(202) 307-0663 (voice and TDD)
Web site: www.usdoj.gov/crt/drs/drshome/htm

A person with a complaint alleging discrimination based on citizenship or immigration status may file with:

**UNITED STATES DEPARTMENT OF JUSTICE CIVIL RIGHTS DIVISION**

Office of Special Counsel for Immigration-Related Unfair Employment Practices
New York Avenue Building
950 Pennsylvania Avenue N.W.
Washington, D.C. 20530
Voice: (202) 616-5594: (202) 616-5525; 1-800-237-2515
Web site: www.usdoj.gov/crt/osc

A person who has been discriminated against by a recipient of financial assistance from the U.S. Department of Labor may file a complaint, either with the recipient or with the Civil Rights Center (CRC). Those who wish to file complaints with CRC should mail their complaints to:

**UNITED STATES DEPARTMENT OF LABOR**

Director, Civil Rights Center
Frances Perkins Building, Room N-4123 200
Constitution Avenue N.W.
Washington, D.C. 20210
(202) 693-6502 (voice)
(202) 693-6515 (TTY)
Web site: www.dol.gov/dol/oasam/crchome.htm

**Please Note**: There are statutory deadlines for filing complaints with each of these agencies. The deadline in some instances is as short as 300 days. If you wish to file a complaint with an external administrative agency, you should contact the external agencies promptly.

NYC HEALTH+ HOSPITALS

## EQUAL EMPLOYMENT OPPORTUNITY (EEO) POLICY STATEMENT

NYC Health + Hospitals is committed to providing equal employment opportunities (EEO) to all employees and applicants for employment and encouraging each one to realize their full potential. It is the policy of the System to recruit, select, train and promote, into all job levels, the most qualified individuals without regard to actual or perceived race; color; national origin; alienage or citizenship status; religion/creed; gender (including sexual harassment and/or "gender identity" – which refers to a person's actual or perceived sex and includes self-image, appearance, behavior or expression, whether or not different from that traditionally associated with the legal sex assigned to the person at birth);disability; age, pregnancy; prior record of arrest or conviction; marital status; partnership status; familial status; caregiver status; genetic information or predisposing genetic characteristics; sexual orientation; unemployment status; salary history; credit history; status as a veteran or active military member; status as a victim or witness of domestic violence, sex offenses or stalking; and/or any other protected class covered by federal, state and/or local anti-discrimination laws.

To achieve and maintain an atmosphere of opportunity and equality, the System has in place an Equal Employment Opportunity ("EEO") Office staffed by EEO personnel. The Office of Equal Employment Opportunity (EEO) is responsible for the day-to-day implementation and monitoring of the Equal Employment Opportunity Program under the supervision of the Office of Legal Affairs. However, it is the responsibility of all employees of the System to ensure compliance with the System's EEO policies and obligations, to prevent discrimination in the work place, and to ensure that all employees and applicants for employment are given the opportunity to realize their full potential.

Employees or job applicants of the System who believe that they have been subjected to any action, decision, or harassment in violation of this Policy, or who witness others being subjected to conduct covered by this Policy, are urged to promptly report the incident(s) to the Office of EEO and/or may file a complaint with an external Civil Rights Enforcement Agency. Supervisors, managers, or human resources personnel who become aware of any claimed violations of this Policy must notify the Office of EEO.

Mitchell Katz
President and CEO — Date 9/21/18

Robert F. Nolan
Chairperson, EEO Committee — Date 11/13/18

Andrea G. Cohen
Senior Vice President and General Counsel — Date 9/17/18

# Exhibit 5
# Attachment B

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
125 Worth Street, Room 514, New York, NY 10013 Tel: 212-788-3321 alan.aviles@nychhc.org
nyc.gov/hhc

Alan D. Aviles
President

# OPERATING PROCEDURE NO. 20-18[1]
# CORPORATION POLICY WITH RESPECT TO REQUESTS FOR RELIGIOUS ACCOMMODATION

September 24, 2012

TO: Distribution "D"

FROM: Alan D. Aviles, President

## I. PURPOSE

This procedure is to establish Corporate policy for providing accommodations for religious observances.

## II. SCOPE

This policy and procedure applies to all employees of the Corporation.

## III POLICY

### Religious Accommodation Policy Statement

The New York City Health and Hospitals Corporation (the "Corporation") recognizes and respects every employee's right to practice the religion of his or her choice. Both the law and the Corporation's policy prohibit discrimination against any employee or prospective employee on the basis of that individual's sincerely-held religious beliefs or practices. The Corporation and its networks and facilities will make efforts to grant requests by employees and prospective employees for a reasonable accommodation of the employee or prospective employee's religious beliefs, practices or observance. A request for a religious accommodation will be denied only if, after exploring reasonable alternatives, the network/facility where the employee works or has applied to work determines that granting the request will cause an undue hardship to the operation of the applicable network/facility either because it would interfere significantly with the safe and efficient operation of the network/facility (including, without limitation, its ability to

[1] This Operating Procedure supersedes Operating Procedure 20-18, dated February 3, 2003.

care for patients in a unit or division affected by the request[2]) or would result in significant expense in relation to the size and operating costs of the network/facility.

## IV. IMPLEMENTATION: GENERAL PROCEDURES

### A. Current Employees

1. Requests for religious accommodation should be made in writing and submitted to the employee's "Senior Manager."[3] Such requests may include, but are not limited to, scheduling changes, exceptions from dress codes and requests for early departures, time off during a work day or a day off to attend religious service or engage in private worship. Employees should be as specific as possible in describing the precise accommodation needed and the religious practice or observance with which the employee is seeking to comply. Requests for religious accommodations should be made as far in advance as possible, and employees should maintain a copy of any such request.

2. Requests for Time Off for Religious Observance in Units with 24-Hour Coverage

While the network/facility will make reasonable efforts to accommodate all requests for religious accommodation, including employees' needs for time off for religious observance, Senior Managers will take the following specific steps to attempt to accommodate requests for scheduling adjustments from employees working in units with 24-hour coverage:

(i) When an employee seeks an accommodation requiring an early departure, time off during a work day, or days off on a Sabbath or holy day, the Senior Manager will make reasonable efforts to accommodate that request consistent with the regular shift assignment system, which efforts may include use of the regular self-scheduling process and the granting of scheduling preferences based on seniority where appropriate. When such an accommodation is requested on a regular basis, the requesting employee's Senior Manager (or his/her designee) must meet with the employee to attempt to develop a reasonable accommodation plan in accordance with the following sub-paragraphs of this Paragraph 2.

(ii) If the regular assignment system does not result in a satisfactory accommodation, the Senior Manager will then undertake to identify all employees who: (a) are qualified to work in the particular unit and position and who would also have the desired shift(s) or portions thereof off during the normal shift scheduling process; and (b) are willing to voluntarily switch shift(s) or portions thereof so that the

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[2] Nothing in this policy diminishes the authority and responsibility of HHC and its hospitals and staff to make clinical and medical decisions regarding the safe and efficient operation of the HHC hospitals and their units, divisions and departments, including, without limitation, their ability to care for their patients.

[3] As used herein, the "Senior Manager" of an employee making a request for religious accommodation is the Group 11 manager who has executive authority over the operations of the department in which the requesting employee works.

religious accommodation request may be granted. The Senior Manager shall then revise work schedules to incorporate any voluntary shift changes that would allow the network/facility to provide the requested religious accommodation.

(iii) In the event that the processes set forth in the preceding sub-paragraphs of Paragraph 2 do not result in the requested accommodation, the Senior Manager shall then explore the possibility of providing the requesting employee with a shift on the requesting employee's unit that would accommodate the request for time off through some other manner. If the requesting employee's request cannot be accommodated pursuant to efforts taken in accordance with the preceding sentence, the Senior Manager shall determine if it is feasible to transfer the requesting employee to a position in another unit in the network/facility which is able to reasonably accommodate the employee's request for religious accommodation. In making such determination, the Senior Manager shall consult with the Human Resources Director and the network/facility shall make reasonable efforts to ensure that any transfer is to a position that is commensurate with the employee's experience, seniority, and professional expertise.[4]

(iv) If steps (i) through (iii) do not result in a satisfactory accommodation, the Senior Manager shall then undertake to identify: (a) all employees in the unit who voluntarily would provide overtime coverage for the requested time off; and (b) all per diem, part-time, or floating employees qualified to work in the particular position and willing to provide the necessary coverage. The supervisor shall consider the use of voluntary overtime coverage and per diem, part-time, and floating coverage, as a potential means to allow the network/facility to achieve the requested religious accommodation. In any instance in which the employee requesting the accommodation is excused from working his or her full work week due either to another employee's voluntary overtime coverage or the use of per diem, part-time or floating employees to cover such requesting employee's absence, the requesting employee's absence will be charged to his or her accrued annual leave or, if a sufficient balance does not exist, will be coded as an absence without pay. The requesting employee's sick leave balance may not be used for this purpose.

3. An employee's request for a religious accommodation may be denied if granting the request would cause undue hardship to the conduct of the network/facility's operations. A requested accommodation would pose an undue hardship if it would interfere significantly with the safe and efficient operation of the network/facility (including, without limitation, its ability to care for patients in a unit or division affected by the request) or would result in significant expense in relation to the size and operating costs of the network/facility. If a Senior Manager determines that the request cannot be accommodated pursuant to Paragraph 2 above without causing undue hardship to the conduct of the network/facility's operations, the Senior Manager must forward the

[4] As used herein, the term "Human Resources Director" means the Human Resources Director or his or her designee and/or, if applicable, the Human Resources Director or his or her Designee of the applicable network/facility.

request to the Human Resources Director of the network/facility for review. The Human Resources Director will reconsider the religious accommodation request and, after consulting with the Senior Manager and/or relevant network/facility clinical staff, determine whether he or she agrees with the decision of the Senior Manager. If the Human Resources Director concludes that granting the request would cause an undue hardship to the conduct of the network/facility's operations, the Human Resources Director will meet with the employee and other relevant staff, if any, to determine if there is any other reasonable measure, not yet explored, that can be taken to accommodate the employee.

4. As soon as is practicable, and in no case more than three weeks after the employee submits a religious accommodation request (unless the request seeks an accommodation prior to three weeks), the Senior Manager shall inform the employee in writing whether the network/facility will grant the requested accommodation, and if so, the specific terms of the accommodation. If the network/facility is unable to grant the accommodation, the supervisor will provide the employee with the reasons for the denial in writing, along with the attached Religious Accommodation Complaint Form.

5. Senior Managers receiving requests for religious accommodations shall maintain a file for each request containing the following information: (a) a copy of the written religious accommodation request; (b) the efforts undertaken by the Senior Manager to accommodate the request; and (c) a statement indicating whether the request was granted, in whole or in part, and if not, the reasons why the requested accommodation was not granted. A copy of the file shall be forwarded to the Human Resources Director.

6. If a Senior Manager is unfamiliar with the faith of the employee requesting a religious accommodation, the Senior Manager may inquire about the nature of the religious observance in order to assess the time required to accommodate the employee's participation in the observance and to determine how to accommodate the request in a manner least disruptive to the network/facility's operations. The Senior Manager shall accept the employee's assertion of the sincerity of his or her religious belief, absent plain reason to believe otherwise (such as inconsistency of practice).

7. If an employee believes that the network/facility failed to comply with the procedures detailed above, he or she may complete the Religious Accommodation Complaint Form attached hereto as Attachment A and submit it to the Human Resources Director of the applicable network/facility.

**B. <u>Prospective Employees or Employees Seeking Transfer</u>**

1. Applicants for employment or current employees applying for a transfer who wish to request a religious accommodation must submit a written request to the Human Resources Director or other Human Resources department manager managing the recruitment (the "Recruitment Manager") for the position at issue. The written request must specify the precise religious accommodation required.

2. If the applicant for employment or transfer is qualified for the position, the Recruitment Manager, working with the Senior Manager in the department at issue, shall

follow the steps outlined in Section A above to review the applicant's request. However, the Recruitment Manager may take longer than three weeks to respond to the applicant's request if circumstances warrant a longer response time. In addition, the Recruitment Manager is not required to explore alternate work areas for the applicant if an accommodation is not possible, but rather need only consider the vacant position for which hiring of the applicant is contemplated.

3. The network/facility will not consider the requested accommodation as a factor in the candidate selection process unless the network/facility determines that granting the requested accommodation would cause undue hardship to the operation of the network/facility. If the applicant's request will not pose an undue hardship, it shall be granted in the event that the applicant is hired.

4. If the applicant believes the network/facility has not complied with the procedures detailed above, the applicant may complete the Religious Accommodation Complaint Form attached hereto as Attachment A and submit it to the Human Resources Director.

## V. EFFECTIVE DATE

This policy and procedure shall be effective with respect to all employees of the Corporation working at Jacobi Medical Center as of October 29, 2012 and with respect to all other employees of the Corporation as of January 15, 2013.

# ATTACHMENT A

## Religious Accommodation Complaint Form

Please complete this form if you have requested an accommodation at work to allow you to practice your religion and you believe that your request was improperly denied. Please submit this completed form with any supporting documentation to the Human Resources Director of the applicable network/facility.

Please keep a copy for your records.

Name _____ Department _____

Tel. No.: (w) _____ (h) _____

Home Address:

_____

_____

_____

Describe the accommodation requested:

_____

_____

Reason given for refusal to accommodate:

_____

_____

I am making this complaint because I requested an employment accommodation at the Facility that I need so that I can practice my sincerely-held religious beliefs and I believe that the Facility improperly denied my request.

_____
Signed

Dated: _____

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al.,

Plaintiffs,

-v-

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

19 Civ. 4676 (PAE)
19 Civ. 5433 (PAE)
19 Civ. 5435 (PAE)

ORDER

PAUL A. ENGELMAYER, District Judge:

The Court has previously accepted as related to 19 Civ. 4676 the following two later-filed cases: (1) 19 Civ. 5433, *Planned Parenthood Federation of America, Inc., et al. v. Azar II, et al.*; and (2) 19 Civ. 5435, *National Family Planning and Reproductive Health Association, et al. v. Azar, et al.* *See* Dkt. 42. On January 12, 2019, plaintiffs in each case filed unopposed motions to consolidate each case with 19 Civ. 4676. *See* 19 Civ. 5433, Dkt. 12; 19 Civ. 5435, Dkt. 20.

Under Federal Rule of Civil Procedure 42(a)(2), "[i]f actions before the court involve a common question of law or fact, the court may . . . consolidate the actions." Here, plaintiffs in each case challenge the same rule, Protecting Statutory Conscience Rights in Health Care, 94 Fed. Reg. 23,170 (May 21, 2019). The U.S. Department of Health and Human Services, the agency that promulgated the rule at issue, is a defendant in each case. Plaintiffs in each case challenge the rule under the Administrate Procedure Act as arbitrary and capricious and contrary to law. Each case involves largely the same facts, including the identical administrative record of the rule at issue.

Accordingly, the Court grants the motions to consolidate cases 19 Civ. 5433 and 19 Civ. 5435 with 19 Civ. 4676. 19 Civ. 4676 shall serve as the lead case, and counsel are directed to

file all filings on the docket of that case. The Clerk of Court is respectfully requested to grant the motions pending at 19 Civ. 5433, Dkt. 12, and 19 Civ. 5435, Dkt. 20.

SO ORDERED.

Paul A. Engelmayer

PAUL A. ENGELMAYER
United States District Judge

Dated: June 26, 2019
New York, New York

**U.S. Department of Justice**
Civil Division
Federal Programs Branch
1100 L Street, NW
Washington, D.C. 20005

Tel: (202) 305-0878
Fax: (202) 616-8470
Bradley.Humphreys@usdoj.gov

June 26, 2019

**BY ELECTRONIC COURT FILING**

The Honorable Paul A. Engelmayer
United States District Court
Southern District of New York
Thurgood Marshall U.S. Courthouse
40 Foley Square, Room 2201
New York, NY 10007

Re: Defendants' letter motion to continue the deadline to respond to Plaintiffs' motions for preliminary injunction and to set a summary judgment briefing schedule; or, in the alternative, for enlargement of time to file Defendants' opposition to Plaintiffs' motions for preliminary injunction, No. 1:19-cv-04676-PAE (consolidated with Nos. 1:19-cv-05433-PAE & 1:19-cv-05435-PAE).

Dear Judge Engelmayer:

Defendants Alex M. Azar II, in his official capacity as Secretary of Health and Human Services, and the U.S. Department of Health and Human Services (HHS) respectfully ask that the Court continue the deadline to respond to Plaintiffs' motions for a preliminary injunction in the three consolidated cases and to set a briefing schedule for (cross) motion(s) for summary judgment. In the alternative, Defendants respectfully ask for an enlargement of time to respond to Plaintiffs' motions for preliminary injunction, until July 31, 2019. Pursuant to the Court's June 7, 2019 and June 13, 2019 Orders, ECF No. 27; ECF No. 38, Defendants' opposition to Plaintiffs' motions for preliminary injunction is currently due on June 28, 2019.

Defendants' request is warranted for several reasons. First, undersigned counsel is authorized to represent to this Court that HHS will delay enforcement of the HHS rule challenged in this case, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2018) ("Final Rule"), until *November 22, 2019*—four months after its July 22, 2019 effective date. Thus, the initial alleged emergency that prompted Plaintiffs' preliminary injunction motions no longer exists. Instead, there is now sufficient time to permit the Court's resolution on the merits of Plaintiffs' purely legal challenges to the Final Rule, before any of Plaintiffs' allegedly irreparable harms could plausibly come to pass. Proceeding to summary judgment briefing would also conserve the resources of the Court and the parties by avoiding the duplication of resolving motions for preliminary injunction and then, regardless of that result, a

later motions for summary judgment.

Accordingly, Defendants respectfully request that the Court continue the deadline to respond to Plaintiffs' motions for preliminary injunction and set the following briefing schedule for (cross) motion(s) for summary judgment, which would provide sufficient time for Defendants to prepare the Administrative Record, for Plaintiffs to review the Record (more than two months), for the parties' to thoroughly brief the merits, and for the Court to resolve this case on the merits before November 22, 2019:

- July 22, 2019: HHS lodges the administrative record.
- September 5, 2019: Defendants file their motion for summary judgment.
- September 27, 2019: Plaintiffs file their opposition to Defendants' motion for summary judgment (and cross-motions for summary judgment, if any).
- October 11, 2019: Defendants file their reply (and opposition, if any).
- October 25, 2019: Plaintiffs file their reply in support of their motions for summary judgment, if any.

If the Court is not inclined to adopt Defendants' proposed summary judgment briefing schedule, Defendants respectfully request, in the alternative, an expansion of time, until July 31, 2019, to respond to Plaintiffs' motions for preliminary injunction. Again, in light of HHS's commitment not to enforce the Final Rule until November 22, 2019 at the earliest, Plaintiffs will not be harmed by the expansion of time. Counsel for Defendants require more time to respond because they have expended a significant amount of time in the past several weeks consulting both within the government concerning the delay in enforcement and with Plaintiffs as to the best course forward. A small team of government attorneys, each of whom is also assigned to other matters in active litigation, are handling the multiple cases in various jurisdictions challenging the Final Rule. Defendants' proposed opposition deadline would allow sufficient time to resolve Plaintiffs' motions for preliminary injunction well before November 22, 2019. The longer briefing schedule would also permit Defendants to more thoroughly respond to Plaintiffs' claims, including through motions for summary judgment, which Defendants may file alongside their opposition to Plaintiffs' motions for preliminary injunction.

Counsel for Defendants have conferred with counsel for Plaintiffs, who indicated that Plaintiffs do not consent to Defendants' motion.

We appreciate your Honor's time and attention to this matter.

Sincerely,

*/s/ Bradley P. Humphreys*
BRADLEY P. HUMPHREYS
Trial Attorney
U.S. Department of Justice, Civil Division

June 27, 2019

The Honorable Paul A. Engelmayer
United States District Court for the Southern District of New York
Thurgood Marshall U.S. Courthouse
40 Foley Square, Room 2201
New York, NY 10007

RE: Plaintiffs' joint opposition to Defendants' motion to continue the deadline to respond to Plaintiffs' motions for preliminary injunction, and for other relief, in *State of New York v. U.S. Dep't of Health & Human Servs.*, 19 Civ. 4676 (PAE) (consolidated with 19 Civ. 5433 (PAE) and 19 Civ. 5435 (PAE)).

Dear Judge Engelmayer,

Plaintiffs in these consolidated cases oppose Defendants' motion to continue the deadline to respond to Plaintiffs' motions for preliminary injunction and to set a summary judgment briefing schedule. Dkt. 79. Defendants' motion represents that "HHS will delay enforcement of the HHS rule challenged in this case" until November 22, 2019. *Id.* at 1. Nonetheless, the effective date of that rule remains July 22, 2019. 84 Fed. Reg. 23,170, 23,170 (May 21, 2019).

Plaintiffs appreciate Defendants' acknowledgment that the equities here weigh decisively against enforcement of the Final Rule on July 22, 2019, and Plaintiffs are sensitive to Defendants' request for additional time to brief their position on the pending motions for preliminary injunction. With regard to that request, Plaintiffs would consent to a stipulated order that preserves the status quo to allow Defendants more time to respond to those motions. But Defendants' proposal—based on a representation through counsel of the agency's intent to delay enforcement of the Final Rule for four months following its effective date—should be rejected because it does not preserve the status quo as would a preliminary injunction, and therefore it does not protect Plaintiffs from irreparable harm upon the Final Rule's effective date. In addition, Defendants' proposed schedule for summary judgment briefing is unworkable and prejudicial, and should be rejected.

Plaintiffs therefore respectfully request that the Court (1) deny without prejudice Defendants' request to continue the deadlines for Plaintiffs' motions for preliminary injunction; (2) deny Defendants' request to set their proposed schedule for cross-motions for summary judgment briefing; and (3) as necessary, schedule a status conference at the Court's earliest convenience to discuss the most efficient way to resolve these challenges.

*1*. The deadlines for preliminary injunction briefing and argument set by the Court, Dkt. 38, should not be adjourned absent a stipulated order or other measure that fully preserves the status quo. Plaintiffs have briefed in detail the irreparable injury they will face immediately upon the effective date of the Final Rule. *See* 19 Civ. 4676, Dkt. 45, at 9-23; 19 Civ. 5433, Dkt. 20, at 42-50; 19 Civ. 5435, Dkt. 26, at 42-50. The *State of New York* Plaintiffs, for example, explained that they will be harmed through (a) the forced choice of complying with a potentially unlawful regulation or risking the loss of federal health care funds; (b) harms to Plaintiffs' health institutions and their direct delivery of care; and (c) interference with Plaintiffs' administration

of their insurance laws. *See* Dkt. 45, at 9-23. Defendants' delay of enforcement would seemingly address only one of the threats of imminent harm Plaintiffs face—namely, the risk that federal health care funds will be terminated for noncompliance with the Final Rule. But because the Final Rule will be in effect, all of the other injuries that Plaintiffs (including their affiliates, members, institutions, patients, and residents) will face—the likelihood of increased denials of care, interference with the provider-patient relationship, decreased insurance coverage, and other harms—will still accrue.

Defendants' motion and the accompanying representation from counsel provide the Court and Plaintiffs with no details regarding the contours of Defendants' proposed delay of enforcement. For example, between July 22 and November 22, 2019, it is not clear whether HHS's Office for Civil Rights ("OCR") will accept complaints under the Final Rule; whether OCR will commence complaint investigations and merely delay taking action based on such investigations; or whether HHS and OCR will take no action at all with respect to the Final Rule. In a meet-and-confer with Defendants' counsel yesterday (after Plaintiffs were first advised of Defendants' intended approach, *see* Ex. 1 at 1), Plaintiffs requested additional detail regarding what "delayed enforcement" would mean, but Defendants were unable to provide any information. And Defendants' current position is a significant departure from the representation they made to the parties last week: that HHS had decided to publish a new rule delaying the effective date of the Final Rule from July 22 to November 22, 2019. *See* Ex. 1 at 3, 6. Defendants' last-minute change in position—combined with the refusal or inability to describe what a delay of enforcement would entail—strongly suggest a substantive difference between counsel's representation that the agency will "delay enforcement," Dkt. 79, and Defendants' earlier representation that they intended to publish a rule delaying the Final Rule's effective date.

So, under Defendants' proposed approach, the Final Rule will still take effect on July 22, 2019. Accordingly, on that date, an employee at one of Plaintiffs' institutions could assert her new refusal rights under the Final Rule, and that assertion of rights would arguably be completely lawful under the rule, because it will have taken effect. Whether Defendants are prepared to *enforce* the rule seemingly affects only whether Plaintiffs face financial sanction for noncompliance with the Final Rule's requirements, but does not stem the many other irreparable injuries Plaintiffs will face.

As noted, Plaintiffs are prepared to consent to a stipulated order that *would* fully preserve the status quo. *See* Ex. 1. Defendants could, for example, consent to a temporary restraining order that would enjoin Defendants from enforcing, applying, or taking any action to implement the Final Rule until the pending motions for preliminary injunction are resolved. Defendants in fact agreed to a similar approach in a different case earlier this year. *See* Temporary Restraining Order and Scheduling Order, *DeOtte v. Azar*, No. 4:18-cv-825 (N.D. Tex. Feb. 20, 2019), Dkt. 29 (Ex. 2). In the alternative, Defendants could stipulate to entry of an order from the Court that postpones the effective date of the Final Rule under 5 U.S.C. § 705 pending judicial review. Plaintiffs proposed both of these options to Defendants, but Defendants rejected each approach.

Until a preliminary injunction, stipulated order, or other mechanism that preserves the status quo is effectuated, any adjournment of the current briefing schedule would prejudice Plaintiffs by exposing them to the very harms they are seeking a preliminary injunction to avert.

*2.* The Court should also reject Defendants' proposed schedule for summary judgment briefing because it does not allow the parties sufficient time to brief, or the Court to consider, the merits of Plaintiffs' challenges in a case of this size and complexity.

Defendants propose that they provide the Administrative Record ("A.R.") by July 22, 2019; that they move for summary judgment 45 days later, by September 5; and that Plaintiffs file their opposition to Defendants' motion for summary judgment and cross-move for summary judgment approximately three weeks after that, by September 27. These deadlines are unworkable and would prejudice Plaintiffs. First, although Defendants repeatedly stated on the parties' meet-and-confer calls that they are unable to provide Plaintiffs with the anticipated size of the A.R., Plaintiffs understand that, at minimum, it will include the more than 200,000 public comments filed during the notice-and-comment period, *see* 84 Fed. Reg. at 23,180, as well as any yet-to-be disclosed studies, reports, or economic analyses the agency considered in preparing the Final Rule. Defendants' proposed schedule allows insufficient time to digest an A.R. of that size, *and* at the same time brief the merits of Plaintiffs' summary judgment motions and opposition to Defendants' motions. All the more so given that, in the normal course, Plaintiffs could assess the A.R. before negotiating a summary judgment briefing schedule.

Second, Defendants' proposed schedule includes virtually no allowance for the possibility that Defendants will produce a deficient A.R. In at least four lawsuits challenging federal agency action in just the past eighteen months, the agency has produced a deficient record that required court-ordered completion. *See In re Nielsen*, No. 17-3345, slip op. at 2-3 (2d Cir. Dec. 27, 2017) (order denying mandamus petition) (Ex. 3); *Washington v. U.S. Dep't of State*, No. 18-cv-1115, 2019 WL 1254876, at *1-4 (W.D. Wash. Mar. 19, 2019); *New York v. U.S. Dep't of Commerce*, 351 F. Supp. 3d 502, 529 (S.D.N.Y. 2019); Minute Order, *Saget v. Trump*, No. 18-cv-1599 (WFK) (E.D.N.Y. Aug. 27, 2018) (Ex. 4). That is so even though "an agency's designation of the administrative record is generally afforded a presumption of regularity," and that "[s]upplementation of the record as designated by the agency is, thus, the exception, not the rule." *Comprehensive Cmty. Dev. Corp. v. Sebelius*, 890 F. Supp. 2d 305, 309 (S.D.N.Y. 2012) (Engelmayer, J.). Plaintiffs do not presume that the A.R. Defendants will produce will be incomplete, but the truncated schedule Defendants have proposed—with the Final Rule in effect and the end of HHS's delay of enforcement looming—would prevent any meaningful consideration of the issue by Plaintiffs or the Court.

In contrast to the prejudicial schedule that Defendants have proposed, Plaintiffs proposed a modified briefing schedule that would allow for summary judgment motions practice on a more realistic—yet still expedited—timeline. *See* Ex. 1, at 2. Defendants rejected Plaintiffs' proposal.

*3.* If the Court is inclined to adjourn the preliminary injunction briefing deadlines or set a summary judgment briefing schedule, Plaintiffs request a status conference beforehand at the Court's earliest convenience to discuss the most efficient way to resolve the merits while protecting Plaintiffs from irreparable injury in the interim.

Respectfully submitted,

LETITIA JAMES
Attorney General of the State of New York

By: */s/ Matthew Colangelo*
Matthew Colangelo
*Chief Counsel for Federal Initiatives*
Justin Deabler, *Assistant Attorney General*
Brooke Tucker, *Assistant Attorney General*
Amanda Meyer, *Assistant Attorney General*
Office of the New York State Attorney General
28 Liberty Street
New York, NY 10005
Phone: (212) 416-6057
matthew.colangelo@ag.ny.gov

Attorneys for the *State of New York* Plaintiffs

Diana Salgado (*pro hac vice*)
Planned Parenthood Federation of America, Inc.
1110 Vermont Ave., NW Ste. 300
Washington, D.C. 20005
Tel.: (202) 973-4800
Fax: (202) 296-3480
diana.salgado@ppfa.org

Hana Bajramovic
Planned Parenthood Federation of America, Inc.
123 William St., 9th Floor
New York, NY 10038
Tel.: (212) 541-7800
Fax: (212) 247-6811
hana.bajramovic@ppfa.org

Michelle Banker
Sunu Chandy*
National Women's Law Center
11 Dupont Circle, NW #800
Washington DC 20036
Tel: (202) 588-5180
Fax: (202) 588-5185
mbanker@nwlc.org
schandy@nwlc.org

Sarah Mac Dougall
Cristina Alvarez*
Covington & Burling LLP
620 Eighth Avenue
New York, NY 10018-1405
Tel: (212) 841-1000
Fax: (212) 841-1010
smacdougall@cov.com
calvarez@cov.com

Kurt G. Calia*
Marina Dalia-Hunt*
Covington & Burling LLP
3000 El Camino Real, 5 Palo Alto Square
Palo Alto, CA 94306-2112
Tel: (650) 632-4717
Fax: (650) 632-4800
kcalia@cov.com
mdaliahunt@cov.com

Ryan Weinstein*
Paulina Slagter*
Covington & Burling LLP
1999 Avenue of the Stars
Los Angeles, CA 90067-4643
Tel: (424) 332-4800

Adam Grogg*
Robin F. Thurston*
Democracy Forward Foundation
P.O. Box 34553
Washington, DC 20043
Tel: (202) 448-9090
agrogg@democracyforward.org
rthurston@democracyforward.org
* *Pro hac vice* motion forthcoming

Attorneys for the *PPFA* Plaintiffs

Alexa Kolbi-Molinas
Lindsey Kaley
Elizabeth Deutsch*
Brigitte Amiri
American Civil Liberties Union Foundation
125 Broad Street, 18th Floor
New York, NY 10004
Phone: (212) 549-2633
Fax: (212) 549-2652
akolbi-molinas@aclu.org
lkaley@aclu.org
edeutsch@aclu.org
bamiri@aclu.org

Daniel Mach**
American Civil Liberties Union Foundation
915 15th Street NW
Washington, DC 20005
Phone: (202) 675-2330
Fax: (202) 546-0738
dmach@aclu.org

* Application for admission forthcoming
**Pro hac vice* motion forthcoming

Attorneys for the *NFPRHA* Plaintiffs

Fax: (424) 332-4749
rweinstein@cov.com
pslagter@cov.com

* *Pro hac vice* motion forthcoming

Attorneys for the *PPFA* Plaintiffs

Christopher Dunn
Erin Beth Harrist
Donna Lieberman
New York Civil Liberties Union Foundation
125 Broad Street, 19th Floor
New York, NY 10004
Phone: (212) 607-2298
cdunn@nyclu.org
eharrist@nyclu.org
dlieberman@nyclu.org

Elizabeth O. Gill**
American Civil Liberties Union Foundation of Northern California, Inc.
39 Drumm Street
San Francisco, CA 94111
Phone: (415) 621-2493
Fax: (415) 255-8437
egill@aclunc.org

* Application for admission forthcoming
**Pro hac vice* motion forthcoming

Attorneys for the *NFPRHA* Plaintiffs

# Exhibit 1

**From:** Colangelo, Matthew
**Sent:** Wednesday, June 26, 2019 4:49 PM
**To:** Humphreys, Bradley (CIV); Adam Grogg; Takemoto, Benjamin (CIV); Kopplin, Rebecca M. (CIV); Meyer, Amanda; Brigitte Amiri (bamiri@aclu.org); Alexa Kolbi-Molinas (akolbi-molinas@aclu.org); Salgado, Diana (diana.salgado@ppfa.org); Deabler, Justin; Tucker, Brooke
**Subject:** RE: New York, et al. v. U.S. Department of Health & Human Services, et al., 19-cv-4676

Counsel,
Thank you for your time on the parties' meet-and-confer discussion this afternoon. Based on the information you have been able to provide regarding Defendants' nonenforcement proposal, Plaintiffs in these consolidated cases oppose your proposed summary judgment briefing schedule, and oppose your proposal to vacate the current briefing and hearing schedule for Plaintiffs' motions for preliminary injunction. If you receive additional information regarding your client's intended approach in response to the questions we raised when we spoke, we are of course happy to revisit this position.
Thank you,
Matthew

---

**From:** Humphreys, Bradley (CIV) <Bradley.Humphreys@usdoj.gov>
**Sent:** Wednesday, June 26, 2019 10:24 AM
**To:** Adam Grogg <agrogg@democracyforward.org>; Takemoto, Benjamin (CIV) <Benjamin.Takemoto@usdoj.gov>; Kopplin, Rebecca M. (CIV) <Rebecca.M.Kopplin@usdoj.gov>
**Cc:** Colangelo, Matthew <Matthew.Colangelo@ag.ny.gov>; Meyer, Amanda <Amanda.Meyer@ag.ny.gov>; Brigitte Amiri (bamiri@aclu.org) <bamiri@aclu.org>; Alexa Kolbi-Molinas (akolbi-molinas@aclu.org) <akolbi-molinas@aclu.org>; Salgado, Diana (diana.salgado@ppfa.org) <diana.salgado@ppfa.org>; Deabler, Justin <Justin.Deabler@ag.ny.gov>; Tucker, Brooke <Brooke.Tucker@ag.ny.gov>
**Subject:** RE: New York, et al. v. U.S. Department of Health & Human Services, et al., 19-cv-4676

All –

After further deliberations, HHS no longer intends to delay the effective date of the rule with a notice in the Federal Register. HHS will, however, delay any enforcement of the Rule until November 22, 2019. We intend to file a motion this afternoon asking the Court to enter the following briefing schedule (which is largely similar to our initial proposal, except the order of summary judgment motions is switched):

- July 22, 2019: HHS lodges the administrative record.
- September 5, 2019: Defendants file their motion for summary judgment.
- September 27, 2019: Plaintiff files its opposition to Defendants' motion for summary judgment (and cross-motion for summary judgment, if any).
- October 11, 2019: Defendants file their reply (and opposition, if any).
- October 25, 2019: Plaintiff files its reply in support of its motion for summary judgment, if any.

In the alternative, if the Court rejects that proposal, we will be asking for an extension of the PI opposition deadline until July 31.

Based on your earlier response, I understand that Plaintiffs opposes our request, but I wanted to let you know nonetheless about the modification to our prior representation. We plan to file later this afternoon, and, unless we hear differently from you, we'll indicate that Plaintiffs oppose our motion.

Thanks,
Brad

**From:** Adam Grogg <agrogg@democracyforward.org>
**Sent:** Friday, June 21, 2019 11:29 AM
**To:** Takemoto, Benjamin (CIV) <btakemot@CIV.USDOJ.GOV>; Humphreys, Bradley (CIV) <brhumphr@CIV.USDOJ.GOV>; Kopplin, Rebecca M. (CIV) <rkopplin@CIV.USDOJ.GOV>
**Cc:** Colangelo, Matthew <Matthew.Colangelo@ag.ny.gov>; Meyer, Amanda <Amanda.Meyer@ag.ny.gov>; Brigitte Amiri (bamiri@aclu.org) <bamiri@aclu.org>; Alexa Kolbi-Molinas (akolbi-molinas@aclu.org) <akolbi-molinas@aclu.org>; Salgado, Diana (diana.salgado@ppfa.org) <diana.salgado@ppfa.org>; Deabler, Justin <Justin.Deabler@ag.ny.gov>; Tucker, Brooke <Brooke.Tucker@ag.ny.gov>
**Subject:** Re: New York, et al. v. U.S. Department of Health & Human Services, et al., 19-cv-4676

Ben and Brad,

For all the reasons we have previously explained, including in our email yesterday, we are unable to consent to Defendants' revised proposal.

The most recent schedule you have proposed, which would require that summary judgment motions be fully briefed, argued, and decided by Nov. 22, is simply not workable and would severely prejudice Plaintiffs. The additional three weeks in your latest proposal are not sufficient; indeed, under this new proposal the government would be providing the administrative record one week later than in your previous proposal. In addition, your schedule would leave Plaintiffs only two weeks to simultaneously oppose your motion for summary judgment and file a reply in support of our own motion. We cannot agree to such an arbitrary and prejudicial schedule when preliminary injunctive relief would allow the parties -- and the Court -- a reasonable amount of time to resolve this case on the merits. As we have stated previously, we are particularly unable to agree to the truncated schedule you have proposed when we have not even seen the administrative record, but know that it is over 200,000 pages.

We are willing, however, to offer the following counter-proposal:

July 22, 2019 – Defendants produce the administrative record

Oct. 1, 2019 – Plaintiffs move for summary judgment

Nov. 1, 2019 – Defendants oppose and cross-move

Dec. 2, 2019 – Plaintiffs file their reply and opposition

Dec. 20, 2019 – Defendants file their reply

Month of Jan. 2020 or at the Court's convenience – argument on cross-motions

Feb. 15, 2020 – Rule's delayed effective date

If the above is not agreeable to Defendants, we will contest Defendants' motion to set the summary judgment briefing schedule you have proposed.

Brad, your email from yesterday stated that if the Court does not adopt Defendants' proposed summary judgment schedule, you will seek, in the alternative, an extension of time to respond to Plaintiffs' preliminary injunction motions until July 31, 2019. At present, however, the rule's effective date is July 22, 2019, and so until the delay that you indicate is forthcoming takes effect, we are not in a position to agree. However, once the rule's effective date is delayed through Nov. 22, 2019, we certainly anticipate that we will be able to agree to an extended schedule for briefing the preliminary injunction motions.

All my best,
Adam

—
Adam Grogg
Senior Counsel, Democracy Forward Foundation
agrogg@democracyforward.org | (202) 701-1790



On Thu, Jun 20, 2019 at 10:01 PM Takemoto, Benjamin (CIV) <Benjamin.Takemoto@usdoj.gov> wrote:

> Matthew,
>
> We reject your counter-proposal, but HHS is willing to delay the effective date of the rule until November 22, 2019. And, in light of the new effective date, we propose the following schedule:
>
> - HHS will provide the administrative record by July 22, 2019.
> - Plaintiffs' motion for summary judgment by September 5, 2019.
> - Defendants' oppositions and cross motions by September 27, 2019.
> - Plaintiffs' reply and opposition by October 11, 2019.
> - Defendants' reply by October 25, 2019.
>
> Regarding your question about authority, HHS will issue the notice pursuant to section 553(b)(3)(B); there is good cause to waive the normal rulemaking requirements in light of the imminent PI briefing schedule and the attendant difficulty in implementing the Rule.

And last, we reject your proposed stipulation to delay implementation of the rule pending judicial review.

Ben

--

Benjamin T. Takemoto

Trial Attorney

U.S. Department of Justice, Civil Division, Federal Programs Branch

P.O. Box 883, Ben Franklin Station, Washington, DC 20044

Tel: (202) 532-4252 / Fax: (202) 616-8460



---

**From:** Colangelo, Matthew <Matthew.Colangelo@ag.ny.gov>
**Sent:** Thursday, June 20, 2019 5:09 PM
**To:** Humphreys, Bradley (CIV) <brhumphr@CIV.USDOJ.GOV>; Meyer, Amanda <Amanda.Meyer@ag.ny.gov>; Brigitte Amiri (bamiri@aclu.org) <bamiri@aclu.org>; Alexa Kolbi-Molinas (akolbi-molinas@aclu.org) <akolbi-molinas@aclu.org>; Salgado, Diana (diana.salgado@ppfa.org) <diana.salgado@ppfa.org>; Adam Grogg (agrogg@democracyforward.org) <agrogg@democracyforward.org>; Deabler, Justin <Justin.Deabler@ag.ny.gov>; Tucker, Brooke <Brooke.Tucker@ag.ny.gov>; Takemoto, Benjamin (CIV) <btakemot@CIV.USDOJ.GOV>; Kopplin, Rebecca M. (CIV) <rkopplin@CIV.USDOJ.GOV>
**Subject:** RE: New York, et al. v. U.S. Department of Health & Human Services, et al., 19-cv-4676

Brad,

We take it this moots your colleague Rebecca's request this morning that we provide our alternative proposed schedule, but in the event that assumption is incorrect, following is a proposed schedule that we think is a more reasonable timeline for briefing cross-motions for summary judgment in a case of this size and complexity:

July 15, 2019 - HHS produces the administrative record

Oct. 15, 2019 – Plaintiffs file the Motion for Summary Judgment

Nov. 26, 2019 – Defendants file their Opposition and Cross-motion for Summary Judgment

Jan. 7, 2020 – Plaintiffs file their Reply and Opposition

Jan. 28, 2020 – Defendants file their Reply

Month of February or March at the Court's convenience – argument on cross-motions

Mar. 31, 2020 – Delayed effective date

Given the different messages we have heard from DOJ on this question in the past few hours, we'd appreciate confirmation that you are now saying there is no room to negotiate any proposed schedule other than the one set out in your original message. As we explained this morning, we think an October 31 effective date does not give the parties or the Court sufficient time to brief summary judgment and consider the large administrative record here, which we understand includes, at a minimum, more than 200,000 comments. Plaintiffs' proposal more reasonably allows for that review. In the normal course, we would agree on a reasonable summary judgment schedule *after* reviewing the AR. In light of the uncertainty given that we haven't seen the AR here, we believe this would be a more reasonable schedule—and, in any event, that October 31 is not.

We also asked your colleagues this morning what additional information your client could provide regarding the authority for the delay you intend to announce. Your message below does not answer that question. As we discussed on our call, the Plaintiffs can't assess whether our interests will be adequately protected by an agency delay notice absent a preliminary injunction, including in the event your delay notice is challenged by third parties. Rebecca told us this morning she would convey our request for additional information to your client. Has that request been conveyed, and are you authorized to communicate the basis for the intended delay?

We separately asked your colleagues this morning if your client would instead consider presenting the Court with a joint stipulation to postpone the effective date of the Final Rule under 5 U.S.C. 705 pending judicial review. Are you rejecting that request?

We can better assess and respond to your new questions below if you are able to answer the questions we discussed with your colleagues on the phone earlier today.

Thank you,

Matthew

**From:** Humphreys, Bradley (CIV) <Bradley.Humphreys@usdoj.gov>
**Sent:** Thursday, June 20, 2019 4:13 PM
**To:** Colangelo, Matthew <Matthew.Colangelo@ag.ny.gov>; Meyer, Amanda <Amanda.Meyer@ag.ny.gov>; Brigitte Amiri (bamiri@aclu.org) <bamiri@aclu.org>; Alexa Kolbi-Molinas (akolbi-molinas@aclu.org) <akolbi-molinas@aclu.org>; Salgado, Diana (diana.salgado@ppfa.org) <diana.salgado@ppfa.org>; Adam Grogg (agrogg@democracyforward.org) <agrogg@democracyforward.org>; Deabler, Justin <Justin.Deabler@ag.ny.gov>; Tucker, Brooke <Brooke.Tucker@ag.ny.gov>; Takemoto, Benjamin (CIV) <Benjamin.Takemoto@usdoj.gov>; Kopplin, Rebecca M. (CIV) <Rebecca.M.Kopplin@usdoj.gov>
**Subject:** RE: New York, et al. v. U.S. Department of Health & Human Services, et al., 19-cv-4676

All –

Thanks for taking the time to talk through our proposal this afternoon, and I'm sorry I wasn't able to make the call. I understand Plaintiffs are concerned about the timing. The government, however, is not willing to delay the effective date of the Rule beyond October 31. I suspect that means we're at an impasse, but we'd ask that you give us your definitive position on our initial proposal by noon tomorrow.

Regardless of Plaintiffs' position, HHS intends to file a notice in the Federal Register delaying the effective date of the Rule until October 31.

If Plaintiffs do not consent to Defendants' proposal, Defendants intend to file a contested motion requesting that the Court deny Plaintiffs' motion for a preliminary injunction without prejudice in light of the delayed effective date and set briefing for cross motions for summary judgment according to the schedule we proposed in our email from Monday, with the view that this will permit the Court to rule on those motions before the new effective date.

If the Court does not adopt the requested MSJ schedule, Defendants will seek, in the alternative, an extension of time to respond to the preliminary injunction motion until July 31, 2019, at which point Defendants may also move for summary judgment. If Plaintiffs do not consent to the proposed summary judgment briefing schedule, would you please let us know Plaintiffs' position regarding this alternative request for an extension of the preliminary injunction opposition deadline by noon this Friday as well? We would hope that, in light of Defendants' extension of the effective date of the Rule, Plaintiffs would have no objection to our request for an extension of that deadline.

Thank you,

Brad

# Exhibit 2

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE NORTHERN DISTRICT OF TEXAS**
**FORT WORTH DIVISION**

| | | |
|---|---|---|
| **RICHARD W. DEOTTE et al.,** | § | |
| | § | |
| | § | |
| **Plaintiffs,** | § | |
| | § | |
| **v.** | § | **Civil Action No. 4:18-cv-00825-O** |
| | § | |
| **ALEX M. AZAR II et al.,** | § | |
| | § | |
| **Defendants.** | § | |

**TEMPORARY RESTRAINING ORDER AND SCHEDULING ORDER**

Before the Court are Plaintiffs' Motion for Preliminary Injunction, (ECF No. 20), and Motion for Class Certification, (ECF No. 21), each filed on February 5, 2019. On February 7, 2019, the Court ordered the parties to confer on a briefing schedule for each motion. *See* Feb. 7, 2019 Order, ECF No. 24. After conferring, the parties have put before the Court a Joint Status Report with a proposed initial briefing schedule, (ECF No. 27), and an Unopposed Motion for Temporary Restraining Order, (ECF No. 28).

The parties' joint proposed briefing schedule is "joint" only insofar as a temporary restraining order is granted. Plaintiff Braidwood seeks a prompt ruling on its request for a preliminary injunction to avoid fines for conduct it claims is within its rights under the Religious Freedom Restoration Act. *See* Joint Status Report 2, ECF No. 27. And because Braidwood's tax returns for the 2018 calendar year are due on March 15, 2018, Braidwood is generally unwilling to agree to a briefing schedule that would push resolution of its request for an injunction past that date. But as the Court has alluded, "the scope of any injunction would inevitably turn on whether and what kind of class is certified." Feb. 7, 2019 Order, ECF No. 24. And for the same reason,

Defendants are generally unwilling to agree to a briefing schedule that would put the injunction cart before the class-certification horse. *See* Joint Status Report 3, ECF No. 25.

To alleviate this impasse, the parties have agreed to a combination of an unopposed motion for a temporary restraining order and a briefing schedule that will allow resolution of the class issue before the Court and the parties turn to the preliminary injunction. *See generally* Joint Status Report, ECF No. 27. Defendants therefore do not oppose Plaintiffs' Motion for Temporary Restraining Order, (ECF No. 28), which is to apply only to Plaintiff Braidwood and only until such time as the Court rules on the motion for a preliminary injunction.

Having considered the parties' status reports, motion, and briefing, the Court finds that the motion, (ECF No. 28), should be and is hereby **GRANTED**.

It is therefore **ORDERED** that:

Defendants Alex M. Azar II, Steven T. Mnuchin, and R. Alexander Acosta, and their officers, agents, servants, employees, attorneys, designees, and subordinates, as well as any person acting in concert or participation with them, are **ENJOINED** from enforcing the Contraceptive Mandate, codified at 42 U.S.C. § 300gg-13(a)(4), 45 C.F.R. § 147.130(a)(1)(iv), 29 C.F.R. § 2590.715–2713(a)(1)(iv), and 26 C.F.R. § 54.9815–2713(a)(1)(iv), **only** against any group health plan, and any health insurance coverage provided in connection with a group health plan, that is **sponsored by Braidwood Management Inc.**, and they are **ENJOINED** from enforcing 26 U.S.C. § 4980D against **Braidwood Management Inc.** for its failure to provide contraceptive coverage in its self-insured health plan from December 1, 2018, **until** the date on which this Court rules on Plaintiffs' motion for a preliminary injunction.

This order, which is **limited to Plaintiff Braidwood Management Inc.**, shall be incorporated into the final judgment or consent decree issued in this case.

Additionally, it is **ORDERED** that Defendants file a response to Plaintiffs' Motion for Class Certification, (ECF No. 21), on or before **March 8, 2019**, that Plaintiffs file a reply thereto on or before **March 15, 2019**, and that the parties meet and confer on a briefing schedule for the Motion for Preliminary Injunction, (ECF No. 20), with **seven days** of the Court's entry of an order on the Motion for Class Certification.

**SO ORDERED** on this **20th day** of **February, 2019**.

Reed O'Connor
UNITED STATES DISTRICT JUDGE

# Exhibit 3

E.D.N.Y.-Bklyn
16-cv-4756
17-cv-5228
Garaufis, J.
Orenstein, M.J.

# United States Court of Appeals
FOR THE
SECOND CIRCUIT

At a stated term of the United States Court of Appeals for the Second Circuit, held at the Thurgood Marshall United States Courthouse, 40 Foley Square, in the City of New York, on the 27th day of December, two thousand seventeen.

Present:

Barrington D. Parker,
Gerard E. Lynch,
Christopher F. Droney,
*Circuit Judges*.

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In re Kirstjen M. Nielsen, Secretary of Homeland Security,

17-3345

*Petitioner*.*

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Petitioner Kirstjen M. Nielsen, the Secretary of the Department of Homeland Security, seeks a writ of mandamus to stay discovery orders entered by the District Court that required the Government (1) to supplement the administrative record it filed with the District Court and (2) to file a privilege log, in litigation challenging the decision to rescind the Deferred Action for Childhood Arrivals ("DACA") program.

Upon due consideration, it is hereby ORDERED that the mandamus petition is DENIED, and the stay of the District Court's discovery orders is LIFTED. Mandamus is "a drastic and extraordinary remedy reserved for really extraordinary causes." *Balintulo v. Daimler AG*, 727 F.3d 174, 186 (2d Cir. 2013) (quoting *Cheney v. U.S. Dist. Ct. for D.C.*, 542 U.S. 367, 380 (2004)). To be entitled to mandamus relief, a petitioner must show (1) that it has "no other adequate means to obtain the relief [it] desires," (2) that "the writ is appropriate under the circumstances," and (3) that the "right to issuance of the writ is clear and undisputable." *In re Roman Catholic Diocese of Albany, Inc.*, 745 F.3d 30, 35 (2d Cir. 2014) (quoting *Cheney*, 542 U.S. at 380–81). We have "expressed reluctance to issue writs of mandamus to overturn discovery rulings," and will do so only "when a discovery question is of extraordinary significance or there is an extreme need for reversal of the district court's mandate before the case goes to judgment." *In re City of New York*, 607 F.3d 923, 939 (2d Cir. 2010) (internal quotation marks omitted). "Because the writ of mandamus is such an extraordinary remedy, our analysis of whether the petitioning party has a

* In accordance with Fed. R. App. P. 43(c)(2), the Clerk of Court is directed to amend the caption as set forth above.

clear and indisputable right to the writ is necessarily more deferential to the district court than our review on direct appeal," *Linde v. Arab Bank, PLC*, 706 F.3d 92, 108–09 (2d Cir. 2013) (internal quotation marks omitted), and the writ will not issue absent a showing of "a judicial usurpation of power or a clear abuse of discretion," *In re City of New York*, 607 F.3d at 943 (emphasis omitted) (internal quotation marks omitted).

The Government argues that it cannot be ordered (1) to supplement its administrative record or (2) to produce a privilege log for materials withheld from the record. With respect to the Government's first argument, the Government's position appears to be that in evaluating agency action, a court may only consider materials that the Government unilaterally decides to present to the court, rather than the record upon which the agency made its decision. To the contrary, judicial review of administrative action is to be based upon "the full administrative record that was before the Secretary at the time [s]he made [her] decision." *Citizens to Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 420 (1971), *abrogated on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977). "The [Administrative Procedure Act ("APA")] specifically contemplates judicial review on the basis of the agency record compiled in the course of informal agency action in which a hearing has not occurred." *Fla. Power & Light Co. v. Lorion*, 470 U.S. 729, 744 (1985) Allowing the Government to determine which portions of the administrative record the reviewing court may consider would impede the court from conducting the "thorough, probing, in-depth review" of the agency action with which it is tasked. *Overton Park*, 401 U.S. at 415.[1]

We have previously held that whether the complete record is before the reviewing court "may itself present a disputed issue of fact when there has been no formal administrative proceeding." *Dopico v. Goldschmidt*, 687 F.2d 644, 654 (2d Cir. 1982). This is particularly true in a case like the one before us "where there is a strong suggestion that the record before the Court was not complete." *Id.* In such a situation, a court must "permit[] plaintiffs some limited discovery to explore whether some portions of the full record were not supplied to the Court." *Id.*

Plaintiffs in the District Court have identified specific materials that appear to be missing from the record. For example, in her memorandum terminating DACA, then-Acting Secretary Elaine C. Duke indicated that "[United States Citizenship and Immigration Services] has not been able to identify specific denial cases where an applicant appeared to satisfy the programmatic categorical criteria as outlined in the [original DACA] memorandum, but still had his or her application denied based solely upon discretion." Elaine C. Duke, *Memorandum on Rescission of Deferred Action for Childhood Arrivals (DACA)*, Dep't of Homeland Security (Sept. 5, 2017), https://www.dhs.gov/news/2017/09/05/memorandum-rescission-daca. Presumably, then-Acting Secretary Duke based this factual assertion upon evidence, yet that evidence is not in the record filed in the District Court. Additionally, in parallel litigation challenging the repeal of DACA in

[1] In arguing for a different rule, the Government cites language from *Florida Power* indicating that the "task of the reviewing court is to apply the appropriate APA standard of review to the agency decision based on the record the agency presents to the reviewing court." 470 U.S. at 743–44 (citation omitted). However, the Government takes this language out of context. The *Florida Power* Court used this language in explaining that, ordinarily, additional factfinding in the District Court is inappropriate; the Court did not suggest that the Government may prevent a reviewing court from considering evidence that the agency considered by not filing that evidence as part of the administrative record in the reviewing court. *Id.* at 743–45.

the Northern District of California in which the Government filed the same administrative record, the District Court—following *in camera* review of documents considered during the repeal of DACA but not included in the record filed with the court—concluded that 48 of those documents were not subject to privilege. *See* Statement of District Court in Response to Application for a Stay at 3, *In re United States*, 583 U.S. ___, 2017 WL 6505860 (Dec. 20, 2017) (No. 17-801); *see also Regents of Univ. of Cal. v. U.S. Dep't of Homeland Sec.*, Nos. C 17-05211, C 17-05235, C 17-05329, C 17-05380, 2017 WL 4642324, at *8 (N.D. Cal. Oct. 17, 2017). Also, as the Supreme Court pointed out, nearly 200 pages of the 256 page record submitted to the District Court consist of published opinions from various federal courts. *In re United States*, 2017 WL 6505860, at *1. It is difficult to imagine that a decision as important as whether to repeal DACA would be made based upon a factual record of little more than 56 pages, even accepting that litigation risk was the reason for repeal. Accordingly, "there is a strong suggestion that the record before the [District Court] was not complete," entitling the plaintiffs to discovery regarding the completeness of the record. *Dopico*, 687 F.2d at 654.

The Government also argues that it should not be required to produce a privilege log of documents that it withheld from the record on the basis of privilege because disclosure would "'probe the mental processes' of the agency." Full Pet. For Mandamus 22 (quoting *United States v. Morgan*, 304 U.S 1, 18 (1938)). First, while it is true that "review of deliberative memoranda reflecting an agency's mental process . . . is usually frowned upon, in the absence of formal administrative findings"—*e.g.*, in the case of "[a] nonadjudicatory, nonrulemaking agency decision"—"they may be considered by the court to determine the reasons for the decision-maker's choice." *Suffolk v. Sec'y of the Interior*, 562 F.2d 1368, 1384 (2d Cir. 1977) (citations omitted). Thus, the possibility that some documents not included in the record may be deliberative does not necessarily mean that they were properly excluded. Second, without a privilege log, the District Court would be unable to evaluate the Government's assertions of privilege. *See Nat'l Nutritional Foods Ass'n v. Mathews*, 557 F.2d 325, 333 (2d Cir. 1977) (finding no abuse of discretion in District Court refusal to compel disclosure *after* it reviewed documents *in camera* and concluded they were protected by deliberative privilege).[2]

We are unpersuaded by the Government's argument that compliance with the orders would be overly burdensome due to the scope of the documents that it must review to comply with the District Court's order and the protracted timeline allowed for compliance. Administrative records, particularly those involving an agency action as significant as the repeal of DACA, are often quite voluminous. *See, e.g.*, *Georgia ex. rel. Olens v. McCarthy*, 833 F.3d 1317, 1320 (11th

[2] We express no opinion at this juncture as to whether discovery is appropriate in connection with plaintiffs' non-APA claims. We note, however, that even if the Government were correct that a deliberative privilege prevents discovery with respect to the APA claims, the Government could not rely on such privilege to avoid all discovery with respect to plaintiffs' constitutional claims. *See Webster v. Doe*, 486 U.S. 592, 604 (1988) (holding that in the context of a suit against the Central Intelligence Agency, "the District Court has the latitude to control any discovery process which may be instituted so as to balance respondent's need for access to proof which would support a colorable constitutional claim against the extraordinary needs of the CIA for confidentiality and the protection of its methods, sources, and mission."); *In re Subpoena Duces Tecum Served on Office of Comptroller of Currency*, 145 F.3d 1422, 1424 (D.C. Cir. 1998) ("If the plaintiff's cause of action is directed at the government's intent, however, it makes no sense to permit the government to use the [deliberative process] privilege as a shield.").

Cir. 2016) (noting that the administrative record "is more than a million pages long"); *Chem. Mfrs. Ass'n v. U.S. EPA*, 870 F.2d 177, 184 (5th Cir. 1989) (noting that the administrative record was 600,000 pages). Moreover, in order to accommodate the Government's concerns, the District Court three times modified the magistrate judge's discovery order, the first time by extending the deadline, the second time by limiting the order's scope to documents before the Department of Justice and the Department of Homeland Security, and the third time by limiting it to documents considered by then-Acting Secretary Duke or Attorney General Jefferson B. Sessions or their "first-tier subordinates—i.e., anyone who advised them on the decision to terminate the DACA program." *Batalla Vidal v. Duke***,** Nos. 16 CV 4756, 17 CV 5228, 2017 WL 4737280, at *5 (E.D.N.Y. Oct. 19, 2017). At oral argument, the Government conceded that the number of documents covered by the order, as modified, is approximately 20,000, a far smaller number than the Government's papers led this Court to believe. We are satisfied that under the circumstances, compliance with the District Court's order would not be an undue burden on the Government.

We have been particularly attentive to the Supreme Court's recent opinion granting certiorari and remanding to the District Court in parallel litigation in the Northern District of California. *See In re United States*, 2017 WL 6505860. Contrary to the Government's argument, however, we conclude that that decision does not strengthen the Government's position in the matter before this Court, because the posture of this case in the District Court here, and the orders issued by the District Court in this matter, are significantly distinguishable from those in the California case. Further, the Supreme Court did not decide the merits of the discovery dispute, instead remanding to the District Court to first resolve the Government's threshold arguments "that the Acting Secretary's determination to rescind DACA is unreviewable because it is 'committed to agency discretion,' 5 U.S.C. § 701(a)(2), and that the Immigration and Nationality Act deprives the District Court of jurisdiction." *Id.* at *2. In the case before this court, the District Court has already considered and rejected these threshold arguments. *Batalla Vidal v. Duke*, No. 16 CV 4756, 2017 WL 5201116, at *9, 13 (E.D.N.Y. Nov. 9, 2017). Of course, as the Supreme Court pointed out, the Government has the right to ask the District Court to certify its ruling for interlocutory appeal under 28 U.S.C. § 1292(b), and has announced its intention to do so. While we decline to reserve decision on this petition while the Government pursues an interlocutory appeal, it may be prudent for the District Court to stay discovery pending the resolution of such proceedings. *See In re United States*, 2017 WL 6505860, at *2.

We acknowledge that the Supreme Court noted that "[t]he Government makes serious arguments that at least some portions of the District Court's order are overly broad." *Id*. However, in the case pending in the Northern District of California, the District Court's discovery order applied to documents considered by persons "anywhere in the government," *id.*, which appears to include White House documents, creating possible separation of powers issues not at issue in this case, *see Cheney*, 542 U.S. at 382 ("[S]eparation-of-powers considerations should inform a court of appeals' evaluation of a mandamus petition involving the President or the Vice President.") The California order also appears to cover a far larger universe of documents than the contested orders before this Court. In contrast, here, the District Court's order covers only documents considered by then-Acting Secretary Duke and Attorney General Sessions, as well as their first-tier subordinates. The order thus does not encompass White House documents, and, as noted above,

the number of officials whose files would be reviewed, and the number of documents that would be involved in that review, would be dramatically fewer than in the case before the Supreme Court.

The Supreme Court also indicated that "the District Court may not compel the Government to disclose any document that the Government believes is privileged without first providing the Government with the opportunity to argue the issue." *In re United States*, 2017 WL 6505860, at *2. The District Court here has required only a privilege log, and has not ordered the production of any documents over which the Government asserts privilege. The order thus plainly contemplates an orderly resolution of any claims of privilege, and we are confident that the District Court will provide the Government with an opportunity to be heard on any claims of privilege it may assert.

We have considered Petitioner's additional arguments and find no basis for the extraordinary remedy of mandamus relief. Accordingly, the petition is DENIED, and the stay of the District Court's discovery orders is LIFTED.

FOR THE COURT:
Catherine O'Hagan Wolfe, Clerk of Court

# Exhibit 4

# CIVIL MINUTE ENTRY

| | |
|---|---|
| **BEFORE:** | Magistrate Judge Steven L. Tiscione |
| **DATE:** | August 21, 2018 |
| **TIME:** | 11:00 A.M. |
| **DOCKET NUMBER(S):** | CV-18-1599 (WFK) |
| **NAME OF CASE(S):** | **SAGET ET AL. V. TRUMP ET AL.** |
| **FOR PLAINTIFF(S):** | Pipoly |
| **FOR DEFENDANT(S):** | Marutollo |
| **NEXT CONFERENCE(S):** | **See rulings below** |
| **FTR/COURT REPORTER:** | 11:10 - 11:47 |

**RULINGS FROM MOTION HEARING:**

For the reasons discussed on the record, Plaintiffs' Motion to Supplement the Administrative Record and for Extra-Record Discovery [31] is granted in part and denied in part. Defendants are ordered to supplement the administrative record to include "all documents and materials that the agency directly or indirectly considered," including all materials that are already being produced in discovery in parallel cases. Plaintiffs' Motion for Extra-Record Discovery is denied at this time, with leave to renew following a determination on pending Defendants' Motion to Dismiss.

June 27, 2019

The Honorable Paul A. Engelmayer
United States District Court for the Southern District of New York
Thurgood Marshall U.S. Courthouse
40 Foley Square, Room 2201
New York, NY 10007

RE: Supplemental authority regarding Defendants' motion to continue the deadline to respond to Plaintiffs' motions for preliminary injunction in *State of New York v. U.S. Dep't of Health & Human Servs.*, 19 Civ. 4676 (PAE) (consolidated with 19 Civ. 5433 (PAE) and 19 Civ. 5435 (PAE)).

Dear Judge Engelmayer,

Plaintiffs write to bring to the Court's attention the attached order in *City and County of San Francisco v. Azar*, No. 19-cv-2405-WHA (N.D. Cal. June 27, 2019), which was issued this morning after Plaintiffs filed their opposition to Defendants' motion to continue the preliminary injunction deadlines. *Cf.* Fed. R. App. P. 28(j). In the attached order, Judge Alsup of the U.S. District Court for the Northern District of California denied Defendants' request for virtually identical relief in three consolidated challenges to the same Final Rule at issue in these cases. Ex. 1. The order holds that "a mere indication HHS 'will delay' enforcement of the rule until November 22 is not the same as an official postponement of the Rule" and "[u]ntil there is an official postponement, counsel's and the agency's indications are too uncertain to rely on." *Id.* at 1.

Accordingly, as it stands, Defendants must litigate the preliminary injunction in the Northern District of California cases prior to the July 22, 2019 effective date, or otherwise effectuate an official postponement of the Final Rule. For that reason, and for all the other reasons Plaintiffs have put forward, Plaintiffs respectfully submit that at present Defendants have not established good cause for deviating from the Court-ordered schedule. *See* Dkt. 38. Of course, Plaintiffs remain willing to consent to a stipulated order that would fully preserve the status quo while permitting Defendants additional time to litigate the preliminary injunction motions. *See* Dkt. 80 at 2.

Respectfully submitted,

LETITIA JAMES
Attorney General of the State of New York

By: */s/ Matthew Colangelo*
Matthew Colangelo
*Chief Counsel for Federal Initiatives*
Justin Deabler, *Assistant Attorney General*
Brooke Tucker, *Assistant Attorney General*
Amanda Meyer, *Assistant Attorney General*
Office of the New York State Attorney General

28 Liberty Street
New York, NY 10005
Phone: (212) 416-6057
matthew.colangelo@ag.ny.gov

Attorneys for the *State of New York* Plaintiffs

Diana Salgado (*pro hac vice*)
Planned Parenthood Federation of America, Inc.
1110 Vermont Ave., NW Ste. 300
Washington, D.C. 20005
Tel.: (202) 973-4800
Fax: (202) 296-3480
diana.salgado@ppfa.org

Hana Bajramovic
Planned Parenthood Federation of America, Inc.
123 William St., 9th Floor
New York, NY 10038
Tel.: (212) 541-7800
Fax: (212) 247-6811
hana.bajramovic@ppfa.org

Michelle Banker
Sunu Chandy
National Women's Law Center
11 Dupont Circle, NW #800
Washington DC 20036
Tel: (202) 588-5180
Fax: (202) 588-5185
mbanker@nwlc.org
schandy@nwlc.org

Adam Grogg*
Robin F. Thurston*
Democracy Forward Foundation
P.O. Box 34553
Washington, DC 20043
Tel: (202) 448-9090
agrogg@democracyforward.org
rthurston@democracyforward.org
* *Pro hac vice* motion forthcoming

Attorneys for the *PPFA* Plaintiffs

Sarah Mac Dougall
Cristina Alvarez*
Covington & Burling LLP
620 Eighth Avenue
New York, NY 10018-1405
Tel: (212) 841-1000
Fax: (212) 841-1010
smacdougall@cov.com
calvarez@cov.com

Kurt G. Calia*
Marina Dalia-Hunt*
Covington & Burling LLP
3000 El Camino Real, 5 Palo Alto Square
Palo Alto, CA 94306-2112
Tel: (650) 632-4717
Fax: (650) 632-4800
kcalia@cov.com
mdaliahunt@cov.com

Ryan Weinstein*
Paulina Slagter*
Covington & Burling LLP
1999 Avenue of the Stars
Los Angeles, CA 90067-4643
Tel: (424) 332-4800
Fax: (424) 332-4749
rweinstein@cov.com
pslagter@cov.com

* *Pro hac vice* motion forthcoming

Attorneys for the *PPFA* Plaintiffs

Alexa Kolbi-Molinas
Lindsey Kaley
Elizabeth Deutsch*
Brigitte Amiri
American Civil Liberties Union Foundation
125 Broad Street, 18th Floor
New York, NY 10004
Phone: (212) 549-2633
Fax: (212) 549-2652
akolbi-molinas@aclu.org
lkaley@aclu.org
edeutsch@aclu.org
bamiri@aclu.org

Daniel Mach**
American Civil Liberties Union Foundation
915 15th Street NW
Washington, DC 20005
Phone: (202) 675-2330
Fax: (202) 546-0738
dmach@aclu.org

* Application for admission forthcoming
**_Pro hac vice_ motion forthcoming

Attorneys for the *NFPRHA* Plaintiffs

Christopher Dunn
Erin Beth Harrist
Donna Lieberman
New York Civil Liberties Union Foundation
125 Broad Street, 19th Floor
New York, NY 10004
Phone: (212) 607-2298
cdunn@nyclu.org
eharrist@nyclu.org
dlieberman@nyclu.org

Elizabeth O. Gill**
American Civil Liberties Union Foundation of Northern California, Inc.
39 Drumm Street
San Francisco, CA 94111
Phone: (415) 621-2493
Fax: (415) 255-8437
egill@aclunc.org

* Application for admission forthcoming
**_Pro hac vice_ motion forthcoming

Attorneys for the *NFPRHA* Plaintiffs

# Exhibit 1

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff,

v.

ALEX M. AZAR II, Secretary of U.S. Department of Health and Human Services; ROGER SERVERINO, Director, Office for Civil Rights, Department of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; and DOES 1-25,

Defendants.
_____/

No. C 19-02405 WHA
*Related to*
No. C 19-02769 WHA
No. C 19-02916 WHA

**ORDER RE DEFENDANTS' ADMINISTRATIVE MOTION TO ADJUST SCHEDULE**

The Court has received defendants' request to hold in abeyance plaintiffs' motion for preliminary injunction and to set a briefing schedule for cross motions for summary judgment (Dkt. No. 50). The motion is principally based on defense counsel's representation to the Court that "HHS will delay enforcement of the HHS rule challenged in this case, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23, 170 (May 21, 2018) [hereinafter Final Rule], until November 22, 2010" (Br. at 2).

In support, defense counsel swears, "The Department of Health and Human Services (HHS) has indicated to the undersigned that it will delay enforcement of the Final Rule until November 22, 2019" (Takemoto Decl. at ¶ 4).

The problem is that a mere indication HHS "will delay" enforcement of the rule until November 22 is not the same as an official postponement of the rule. Until there is an official postponement, counsel's and the agency's "indications" are too uncertain to rely on.

Accordingly, we will proceed with the motion for preliminary injunction until there is an official postponement.

Defendants are already in default with the existing briefing schedule. As such, this order gives defendants until **JULY 1, 2019 AT NOON** to file their opposition to the pending motion. The reply will be due **JULY 8, 2019 AT NOON.** The hearing will remain on **JULY 17, 2019 AT 8:00 A.M.**

Unfortunately, this extra time for the defendants will come out of the time the Court needs to review the materials. Counsel should have taken this into account before filing this half-baked administrative motion.

Defendants are admonished that nothing short of an official postponement of the final revised rule until a later fixed date will be sufficient to reactivate defendants' request for relief from the existing briefing schedule. Defendants should not gamble again on this possibility. Defendants must file their opposition. The administrative motion is **DENIED**.

**IT IS SO ORDERED.**

Dated: June 27, 2019.

WILLIAM ALSUP
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al.,

Plaintiffs,

-v-

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

19 Civ. 4676 (PAE)
19 Civ. 5433 (PAE)
19 Civ. 5435 (PAE)

ORDER

PAUL A. ENGELMAYER, District Judge:

The Court has received defendants' request to continue the deadline to respond to plaintiffs' motions for a preliminary injunction and to set a briefing schedule for cross motions on summary judgment. Dkt. 79. Defendants "represent to this Court that HHS will delay enforcement of the HHS rule challenged in this case, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2018) ("Final Rule"), until *November 22, 2019*—four months after its July 22, 2019 effective date." *Id.* at 1. Defendants argue, therefore, that "the initial alleged emergency that prompted Plaintiffs' preliminary injunction motions no longer exists." *Id.* Plaintiffs counter that such a representation is inadequate and does not fully preserve the status quo. *See* Dkt. 80 at 1–2.

The Court denies defendants' request in its entirety. Unless and until defendants either (1) supply conclusive evidence that the *effective date* of the Final Rule has been officially postponed; or (2) consent to a Court order that would enjoin defendants from enforcing,

applying, or taking any action to implement the Final Rule until resolution of the preliminary injunction motions, the existing briefing and argument schedule remains in effect.[1]

For avoidance of doubt, defendants' opposition to plaintiffs' motions for a preliminary injunction remain due **tomorrow, June 28, 2019**. The Court will construe a failure to file opposition submissions on this date as signifying that defendants do not oppose plaintiffs' application for preliminary relief.

SO ORDERED.

Paul A. Engelmayer

PAUL A. ENGELMAYER
United States District Judge

Dated: June 27, 2019
New York, New York

[1] The Court notes that a district court in the Northern District of California today denied similar relief requested by defendants in a case challenging the same HHS rule. *See City and Cty. of San Francisco v. Azar*, No. C 19-2405 WHA (N.D. Cal.) at Dkt. 54.

**U.S. Department of Justice**
Civil Division
Federal Programs Branch
1100 L Street, NW
Washington, D.C. 20005

Tel: (202) 305-0878
Fax: (202) 616-8470
Bradley.Humphreys@usdoj.gov

June 27, 2019

**BY ELECTRONIC COURT FILING**

The Honorable Paul A. Engelmayer
United States District Court
Southern District of New York
Thurgood Marshall U.S. Courthouse
40 Foley Square, Room 2201
New York, NY 10007

Re: Defendants' letter motion for extension of time until Monday, July 1, 2019 to Oppose Plaintiffs' Motions for Preliminary Injunction , No. 1:19-cv-04676-PAE (consolidated with Nos. 1:19-cv-05433-PAE & 1:19-cv-05435-PAE).

Dear Judge Engelmayer:

Defendants Alex M. Azar II, in his official capacity as Secretary of Health and Human Services, and the U.S. Department of Health and Human Services (HHS) respectfully ask that the Court extend the current deadline to oppose Plaintiffs' motions for preliminary injunction by three calendar days, from Friday, June 28, 2019 to Monday, July 1, 2019 (by midnight). Defendants make this modest request in light of the Court's denial of Defendants' earlier motion to continue the deadline to oppose Plaintiffs' motions for preliminary injunction and to set a summary judgment briefing schedule; or, in the alternative, for enlargement of time to file Defendants' opposition to Plaintiffs' motions for preliminary injunctions, ECF No. 79.

Over the course of the past several weeks, Defendants have been working diligently to attempt to maintain the status quo in this litigation for a period of time that would allow this case to be decided on the merits and without the need to consider a request for extraordinary injunctive relief, and in hopes of conserving the resources of the Court and the parties. Doing so has required Defendants and the undersigned to expend significant time in internal discussions and in discussions with counsel for Plaintiffs and other litigants challenging the same HHS Final Rule in other cases. Defendants appreciate that neither Plaintiffs nor the Court are satisfied that Defendants' proposal to delay any enforcement of the Final Rule would, in fact, accomplish those goals. However, Defendants' efforts were in good faith, and they have, regrettably, taken away from Defendants' time to draft an opposition to Plaintiffs' motions for preliminary injunction. Defendants also note that they are also required to file oppositions to motions for preliminary injunctions in three similar cases in the Northern District of California by 3:00 PM Eastern on July 1, 2019, and in one case

in the District of Maryland by 4:30 PM Eastern, also on July 1, 2019, and those additional deadlines have stretched the resources of the attorneys working on these matters.

Defendants, therefore, respectfully ask that the Court grant Defendants a modest extension of three calendar days, until midnight on July 1, 2019, for Defendants to file their opposition to Plaintiffs' motions for preliminary injunction. These three additional calendar days will allow Defendants to better respond to Plaintiffs' arguments, which, in turn, should assist the Court in considering Plaintiffs' challenge to the Final Rule. The requested delay also will not prejudice Plaintiffs, given that the effective date of the Final Rule is still nearly one-month away. Defendants respectfully submit that the short requested extension is warranted and ask for the Court's understanding.

Counsel for Defendants have conferred with counsel for Plaintiffs, who indicated that Plaintiffs do not consent to Defendants' motion. This is Defendants' second request for an extension of time; however, Defendants' prior request was denied, and here Defendants seek a much more limited extension.

We appreciate your Honor's time and attention to this request.

Sincerely,

*/s/ Bradley P. Humphreys*
BRADLEY P. HUMPHREYS
Trial Attorney
U.S. Department of Justice, Civil Division

**U.S. Department of Justice**
Civil Division
Federal Programs Branch
1100 L Street, NW
Washington, D.C. 20005

Tel: (202) 305-0878
Fax: (202) 616-8470
Bradley.Humphreys@usdoj.gov

June 27, 2019

**BY ELECTRONIC COURT FILING**

The Honorable Paul A. Engelmayer
United States District Court
Southern District of New York
Thurgood Marshall U.S. Courthouse
40 Foley Square, Room 2201
New York, NY 10007



Re: Defendants' letter motion for extension of time until Monday, July 1, 2019 to Oppose Plaintiffs' Motions for Preliminary Injunction , No. 1:19-cv-04676-PAE (consolidated with Nos. 1:19-cv-05433-PAE & 1:19-cv-05435-PAE).

Dear Judge Engelmayer:

Defendants Alex M. Azar II, in his official capacity as Secretary of Health and Human Services, and the U.S. Department of Health and Human Services (HHS) respectfully ask that the Court extend the current deadline to oppose Plaintiffs' motions for preliminary injunction by three calendar days, from Friday, June 28, 2019 to Monday, July 1, 2019 (by midnight). Defendants make this modest request in light of the Court's denial of Defendants' earlier motion to continue the deadline to oppose Plaintiffs' motions for preliminary injunction and to set a summary judgment briefing schedule; or, in the alternative, for enlargement of time to file Defendants' opposition to Plaintiffs' motions for preliminary injunctions, ECF No. 79.

Over the course of the past several weeks, Defendants have been working diligently to attempt to maintain the status quo in this litigation for a period of time that would allow this case to be decided on the merits and without the need to consider a request for extraordinary injunctive relief, and in hopes of conserving the resources of the Court and the parties. Doing so has required Defendants and the undersigned to expend significant time in internal discussions and in discussions with counsel for Plaintiffs and other litigants challenging the same HHS Final Rule in other cases. Defendants appreciate that neither Plaintiffs nor the Court are satisfied that Defendants' proposal to delay any enforcement of the Final Rule would, in fact, accomplish those goals. However, Defendants' efforts were in good faith, and they have, regrettably, taken away from Defendants' time to draft an opposition to Plaintiffs' motions for preliminary injunction. Defendants also note that they are also required to file oppositions to motions for preliminary injunctions in three similar cases in the Northern District of California by 3:00 PM Eastern on July 1, 2019, and in one case

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Counsel for Defendants have conferred with counsel for Plaintiffs, who indicated that Plaintiffs do not consent to Defendants' motion. This is Defendants' second request for an extension of time; however, Defendants' prior request was denied, and here Defendants seek a much more limited extension.

We appreciate your Honor's time and attention to this request.

Sincerely,

*/s/ Bradley P. Humphreys*
BRADLEY P. HUMPHREYS
Trial Attorney
U.S. Department of Justice, Civil Division

Denied. The Court set this schedule over a month ago on June 13, 2019. *See* Dkt. 38. Plaintiffs' reply is due July 5, 2019. *See id.* Extending defendants' time to respond at this late juncture would require plaintiffs to spend the entirety of the week of the July 4 holiday drafting a reply brief, without the benefit of a weekend. The Court carefully considered the schedule it set on June 13, 2019 and declines to modify it at this late stage.

SO ORDERED. Paul A. Engelmayer 6/27/19

PAUL A. ENGELMAYER
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al.,

Plaintiffs,

-v-

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

19 Civ. 4676 (PAE)
19 Civ. 5433 (PAE)
19 Civ. 5435 (PAE)

ORDER

PAUL A. ENGELMAYER, District Judge:

The Court late yesterday denied, by memo endorsement, a letter motion in which defendants sought to extend today's deadline to file an opposition to plaintiffs' motions for a preliminary injunction until July 1, 2019. Dkt. 84. That ruling stands and the deadline for defendants' opposition to plaintiffs' motions for a preliminary injunction remains today.

The Court, however, wishes to correct a factual error in yesterday's memo endorsement. The Court erroneously recited the date of the Order in which it set a briefing schedule on the preliminary injunction motion. That Order issued on June 7, 2019, Dkt. 27, and gave defendants two weeks, *i.e.*, until June 28, 2019, to respond to plaintiffs' motions for a preliminary injunction, which under the Order was due, and which was timely filed, on June 14, 2019, Dkt. 41.

The Court is mindful of counsels' understandable desire for additional time to brief the significant issues raised by the pending motions and shares all counsels' view that the process of reliable adjudication benefits from a measured briefing process. The Court is further mindful that counsel for the U.S. Department of Health and Human Services ("HHS") earlier this week sought additional time based on a representation by counsel that HHS will delay enforcement of

the HHS rule at issue until November 22, 2019. Dkt. 79. The Court denied that request because HHS had not postponed the rule's effective date, Dkt. 82, and, without such a postponement, plaintiffs viably claimed a risk of harm, *see* Dkt. 80. For avoidance of doubt, the Court clarifies that, in the event of an official postponement of the effective date of the rule to November 22, 2019, the Court would suspend today's deadline for an opposition brief, set a new and more protracted schedule for submission of the remaining briefs on plaintiffs' preliminary injunction motions, and thereafter entertain applications to litigate this case instead, as defendants have proposed, via cross-motions for summary judgment. Absent an official postponement of the effective date, however, the present briefing schedule stands.

SO ORDERED.

Paul A. Engelmayer

PAUL A. ENGELMAYER
United States District Judge

Dated: June 28, 2019
New York, New York

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF NEW YORK**

| | |
|---|---|
| STATE OF NEW YORK, *et al.*<br><br>*Plaintiffs*,<br><br>v.<br><br>UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, *in his official capacity as Secretary of the United States Department of Health and Human Services*; and UNITED STATES OF AMERICA,<br><br>*Defendants*. | No. 1:19-cv-04676-PAE<br>(consolidated with 1:19-cv-05433-PAE; 1:19-cv-05435-PAE)<br><br>**STIPULATED REQUEST FOR AN ORDER TO POSTPONE RULE'S EFFECTIVE DATE; TO SUSPEND DEFENDANTS' DEADLINE TO RESPOND TO PLAINTIFFS' PRELIMINARY INJUNCTION MOTIONS; AND TO VACATE THE CURRENT BRIEFING SCHEDULE AND HEARING DATE**<br>**[5 U.S.C. § 705]** |
| PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.,<br><br>*Plaintiffs*,<br><br>v.<br><br>ALEX M. AZAR II, in his official capacity as Secretary, United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, United States Department of Health and Human Services; and OFFICE FOR CIVIL RIGHTS, United States Department of Health and Human Services,<br><br>*Defendants*. | No. 1:19-cv-05433-PAE<br>(consolidated with 1:19-cv-0476-PAE; 1:19-cv-05435-PAE) |

| | |
|---|---|
| NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; and PUBLIC HEALTH SOLUTIONS,<br><br>*Plaintiffs*,<br><br>v.<br><br>ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director of the Office for Civil Rights of the U.S. Department of Health and Human Services; OFFICE FOR CIVIL RIGHTS of the U.S. Department of Health and Human Services,<br><br>*Defendants*. | No. 1:19-cv-05435-PAE<br>(consolidated with 1:19-cv-0476-PAE; 1:19-cv-05433-PAE) |

Subject to the Court's approval, the parties through their undersigned counsel of record HEREBY STIPULATE as follows:

1. At present, Defendants' opposition to Plaintiffs' motions for a preliminary injunction is due on June 28, 2019, Plaintiffs' reply is due on July 5, 2019, and a hearing is scheduled on July 12, 2019.

2. The U.S. Department of Health and Human Services ("HHS") agrees to postpone the effective date of the rule titled Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019) ("Final Rule"), until November 22, 2019. HHS stipulates to this postponement because it is the most efficient way to adjudicate the Final Rule on the merits. HHS does not concede that Plaintiffs are "likely to succeed on the merits,

that [they are] likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [their] favor, [or] that an injunction is in the public interest." *See Winter v. NRDC*, 555 U.S. 7, 20 (2008).

3. Plaintiffs maintain that—for the reasons expressed in their motions for a preliminary injunction and their opposition to Defendants' motion to continue the deadline to respond to Plaintiffs' motions—Plaintiffs would suffer various irreparable injuries were the Final Rule's effective date not postponed.

4. The parties request that the Court issue an order, pursuant to 5 U.S.C. § 705, that the effective date of the Final Rule is postponed until November 22, 2019.

5. The parties further request, in light of this postponement, that the Court suspend the June 28, 2019 deadline for Defendants' opposition brief and set a new and more protracted schedule for submission of the remaining briefs on Plaintiffs' preliminary injunction motions.

6. The parties agree to meet and confer to determine whether they can reach an agreement on a proposed schedule to resolve this case through cross-motions for summary judgment prior to the Final Rule's new November 22, 2019 effective date.

Dated: June 28, 2019

LETITIA JAMES
Attorney General of the State of New York

By: */s/ Matthew Colangelo*
Matthew Colangelo
*Chief Counsel for Federal Initiatives*
Justin Deabler, *Assistant Attorney General*
Brooke Tucker, *Assistant Attorney General*
Amanda Meyer, *Assistant Attorney General*
Office of the New York State Attorney General
28 Liberty Street
New York, NY 10005
Phone: (212) 416-6057

Respectfully submitted,

JOSEPH H. HUNT
Assistant Attorney General

MICHELLE R. BENNETT
Assistant Branch Director

matthew.colangelo@ag.ny.gov

Attorneys for the *State of New York* Plaintiffs

*/s/ Bradley P. Humphreys*
BRADLEY P. HUMPHREYS
(D.C. Bar No. 988057)
Trial Attorney, U.S. Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, N.W.
Washington, D.C. 20005
Phone: (202) 305-0878
E-mail: Bradley.Humphreys@usdoj.gov

*Counsel for Defendants*

Diana Salgado (*pro hac vice*)
Planned Parenthood Federation of America, Inc.
1110 Vermont Ave., NW Ste. 300
Washington, D.C. 20005
Tel.: (202) 973-4800
Fax: (202) 296-3480
diana.salgado@ppfa.org

Hana Bajramovic
Planned Parenthood Federation of America, Inc.
123 William St., 9th Floor
New York, NY 10038
Tel.: (212) 541-7800
Fax: (212) 247-6811
hana.bajramovic@ppfa.org

Michelle Banker
Sunu Chandy
National Women's Law Center
11 Dupont Circle, NW #800
Washington DC 20036
Tel: (202) 588-5180
Fax: (202) 588-5185
mbanker@nwlc.org
schandy@nwlc.org

Adam Grogg*
Robin F. Thurston*
Democracy Forward Foundation
P.O. Box 34553
Washington, DC 20043
Tel: (202) 448-9090
agrogg@democracyforward.org
rthurston@democracyforward.org

* *Pro hac vice* motion forthcoming

Attorneys for the *PPFA* Plaintiffs

Alexa Kolbi-Molinas
Lindsey Kaley
Elizabeth Deutsch*
Brigitte Amiri

Sarah Mac Dougall
Cristina Alvarez*
Covington & Burling LLP
620 Eighth Avenue
New York, NY 10018-1405
Tel: (212) 841-1000
Fax: (212) 841-1010
smacdougall@cov.com
calvarez@cov.com

Kurt G. Calia*
Marina Dalia-Hunt*
Covington & Burling LLP
3000 El Camino Real, 5 Palo Alto Square
Palo Alto, CA 94306-2112
Tel: (650) 632-4717
Fax: (650) 632-4800
kcalia@cov.com
mdaliahunt@cov.com

Ryan Weinstein*
Paulina Slagter*
Covington & Burling LLP
1999 Avenue of the Stars
Los Angeles, CA 90067-4643
Tel: (424) 332-4800
Fax: (424) 332-4749
rweinstein@cov.com
pslagter@cov.com

* *Pro hac vice* motion forthcoming

Attorneys for the *PPFA* Plaintiffs

Christopher Dunn
Erin Beth Harrist
Donna Lieberman
New York Civil Liberties Union Foundation

American Civil Liberties Union Foundation
125 Broad Street, 18th Floor
New York, NY 10004
Phone: (212) 549-2633
Fax: (212) 549-2652
akolbi-molinas@aclu.org
lkaley@aclu.org
edeutsch@aclu.org
bamiri@aclu.org

Daniel Mach**
American Civil Liberties Union Foundation
915 15th Street NW
Washington, DC 20005
Phone: (202) 675-2330
Fax: (202) 546-0738
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* Application for admission forthcoming
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Attorneys for the *NFPRHA* Plaintiffs

125 Broad Street, 19th Floor
New York, NY 10004
Phone: (212) 607-2298
cdunn@nyclu.org
eharrist@nyclu.org
dlieberman@nyclu.org

Elizabeth O. Gill**
American Civil Liberties Union Foundation
of Northern California, Inc.
39 Drumm Street
San Francisco, CA 94111
Phone: (415) 621-2493
Fax: (415) 255-8437
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* Application for admission forthcoming
**_Pro hac vice_ motion forthcoming

Attorneys for the *NFPRHA* Plaintiffs

**~~[PROPOSED]~~ ORDER**

PURSUANT TO STIPULATION, IT IS SO ORDERED. The effective date of the Final Rule is postponed until November 22, 2019. *See* 5 U.S.C. § 705. Defendants' June 28, 2019 deadline to respond to Plaintiffs' preliminary injunction motions is suspended, and the preliminary injunction briefing schedule and hearing date set forth in the Court's June 7, 2019 and June 13, 2019 Orders is vacated. This order is without prejudice to the merits.

Dated: June 28, 2019

Paul A. Engelmayer
PAUL A. ENGELMAYER
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF COLORADO, STATE OF CONNECTICUT, STATE OF DELAWARE, DISTRICT OF COLUMBIA, STATE OF HAWAI'I, STATE OF ILLINOIS, STATE OF MARYLAND, COMMONWEALTH OF MASSACHUSETTS, STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEVADA, STATE OF NEW JERSEY, STATE OF NEW MEXICO, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, STATE OF RHODE ISLAND, STATE OF VERMONT, COMMONWEALTH OF VIRGINIA, STATE OF WISCONSIN, CITY OF CHICAGO, and COOK COUNTY, ILLINOIS,

Plaintiffs,

-v-

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX M. AZAR II, *in his official capacity as Secretary of the United States Department of Health and Human Services*, and UNITED STATES OF AMERICA,

Defendants.

19 Civ. 4676 (PAE)



PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.,

Plaintiffs,

-v-

ALEX M. AZAR II, *in his official capacity as Secretary, United States Department of Health and Human Services,* UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROGER SEVERINO, *in his capacity as Director, Office for Civil Rights, United States Department of Health and Human Services*, and OFFICE FOR CIVIL RIGHTS, *United States Department of Health and Human Services*,

Defendants.

19 Civ. 5433 (PAE)

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, and PUBLIC HEALTH SOLUTIONS, INC.,

Plaintiffs,

-v-

ALEX M. AZAR, II, *in his official capacity as Secretary of the U.S. Department of Health and Human Services*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROGER SEVERINO, *in his official capacity as Director of the Office for Civil Rights of the U.S. Department of Health and Human Services*, and OFFICE FOR CIVIL RIGHTS OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendants.

19 Civ. 5435 (PAE)

**OPINION & ORDER**

PAUL A. ENGELMAYER, District Judge:

These consolidated actions concern a challenge to a final rule issued by the U.S. Department of Health and Human Services ("HHS") on May 21, 2019. The rule is entitled "Protecting Statutory Conscience Rights in Health Care," 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88) (the "Rule"). Before the Court is a motion by Dr. Regina Frost and the Christian Medical and Dental Association ("CMDA") (together, the "Proposed Intervenors") to intervene as defendants. Plaintiffs in all three cases have opposed the motion. Defendants (collectively, "HHS") have neither consented to intervention nor conveyed to the Court their reasons for declining consent. For the following reasons, the Court grants the Proposed Intervenors' motion to intervene.

## I. Background

The Rule at issue interprets a number of federal conscience and anti-discrimination laws to allow health care providers, including individual medical personnel and affiliated employees,

the right broadly to abstain from providing medical services that conflict with their beliefs. The Rule also strengthens HHS's investigative and enforcement tools to ensure that such providers may abstain free from discrimination by their employers.

There are two sets of plaintiffs in these consolidated cases. One consists of state and local governments that are concerned about the impact of the Rule's enforcement mechanisms on states and localities and on their regions' health care plans. The other consists of non-profit organizations or associations which, or whose members, provide health care services of a nature—e.g., relating to family planning and reproductive rights—anticipated to produce abstentions by health care providers under the Rule based on personal beliefs. Plaintiffs argue that the Rule, in various respects, violates the Administrative Procedure Act ("APA"). *See, e.g.*, Dkt. 1[1] ¶¶ 159–82. The governmental plaintiffs also argue that the Rule unconstitutionally encroaches on state sovereignty and reaches beyond the limits of Executive power. *See id.* ¶¶ 183–201.

The Proposed Intervenors represent that they are health care providers whose interests in conscience-based abstention the Rule aims to protect. CMDA states that it seeks to "educate and equip its nearly 20,000 members to glorify God by serving with professional excellence as witnesses of Christ's love and compassion to all people." Dkt. 65 ("CMDA Mem.") at 2–3. CMDA represents that its members believe that certain medical procedures, including abortion and euthanasia, are incompatible with the Christian faith; and that some CMDA members object, on religious grounds, to other medical procedures, such as sterilization and artificial contraception. *Id.* at 3–4. CMDA explains that it "has long advocated for legislative and regulatory action that would protect conscience rights." *Id.* at 4. During the Rule's review

[1] Unless otherwise specified, references to the docket in this Opinion refer to the docket of No. 19 Civ. 4676, the lead case.

period, CMDA submitted comments to HHS in support of the Rule. *Id.* at 9. As for Dr. Frost, she represents that she is an OBGYN who has helped lead Women Physicians in Christ, a ministry of CMDA, since 2014. *Id.* She states that she has religious objections to performing certain procedures, including abortion and "sex reassignment surgery."[2] *Id.* at 5. If Dr. Frost's employer ever required her to perform a procedure to which she has a religious objection, Dr. Frost states, she would resign. *Id.*

## II. Procedural History

On May 21, 2019, plaintiffs in 19 Civ. 4676, consisting of state and local governments, filed their Complaint. Dkt. 1. On June 6, 2019, the Court set a schedule for an anticipated motion for a preliminary injunction to enjoin the Rule from taking effect. Dkt. 27.

On June 11, 2019, plaintiffs in 19 Civ. 5433 and 19 Civ. 5435, consisting of health care organizations or associations, filed their complaints. *See* 19 Civ. 5433, Dkt. 1; 19 Civ. 5435, Dkt. 1. On June 12, 2019, plaintiffs in the latter two cases filed motions to consolidate with 19 Civ. 4676. *See* 19 Civ. 5433, Dkt. 12; 19 Civ. 5435, Dkt. 20.

On June 13, 2019, the Court set a schedule on the anticipated preliminary injunction motion in the two newly-filed cases. Dkt. 38. The schedule was keyed to the effective date of the Rule, which was then July 22, 2019.

[2] The Court here quotes the term used by the Proposed Intervenors, while noting that the American Medical Association uses different terms—"gender confirmation surgery" or "gender-affirming surgery"—to capture the range of surgical interventions at issue. *See, e.g.*, American Medical Association, Issue Brief: Health Insurance Coverage for Gender-Affirming Care of Transgender Patients (2019), https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf; American Medical Association, Patient Reported Outcomes in Gender Confirmation Surgery H-460.893 (2018).

On June 14, 2019, plaintiffs in 19 Civ. 4676 filed a motion for a preliminary injunction. Dkts. 41–45. On June 17, 2019, plaintiffs in 19 Civ. 5433 and 19 Civ. 5435 filed a consolidated motion for a preliminary injunction. *See* 19 Civ. 5433, Dkts. 19–21.

On June 25, 2019, the Proposed Intervenors filed a motion to intervene as defendants, Dkt. 64, a memorandum of law in support, Dkt. 65, and declarations from Dr. Frost, M.D., Dkt. 66 ("Frost Decl."), and Dr. David Stevens, M.D., M.A., Dkt. 67 ("Stevens Decl."). The Proposed Intervenors also answered plaintiffs' Complaint. Dkt. 60. On June 26, 2019, plaintiffs filed a letter indicating their intention to respond to the motion to intervene on the schedule set by Local Civil Rule 6.1(b), which would require a response by July 9, 2019. *See* Dkt. 62.

Also on June 26, 2019, the Court granted the motions to consolidate the three actions and directed that 19 Civ. 4676 serve as the lead case. Dkt. 70. The Court also set a briefing schedule on the motion to intervene. However, given the condensed preliminary injunction schedule, the Court did not permit a party submission from the Proposed Intervenors on the preliminary injunction motions. The Court instead authorized the Proposed Intervenors to submit a brief as *amicus curiae*. *Id.*

Later on June 26, 2019, HHS filed a motion to continue the deadline to respond to plaintiffs' motions for a preliminary injunction and set a summary judgment schedule. Dkt. 79. On June 27, 2019, plaintiffs filed a letter in opposition. Dkt. 80. On June 27, 2019, the Court denied HHS's request. Dkt. 82.

On July 1, 2019, the Court entered a stipulation between the parties that postponed the Rule's effective date to November 22, 2019 and vacated the preliminary injunction schedule. Dkt. 90. The Court scheduled a conference to discuss, in light of the Rule's deferred effective date, a new schedule for preliminary injunction and/or summary judgment motions and solicited the parties' views as to such a schedule. Dkt. 91.

On July 9, 2019, plaintiffs in all three consolidated cases filed a memorandum of law in opposition to the Proposed Intervenors' motion to intervene. Dkt. 109 ("Pl. Mem.").

On July 12, 2019, the Court held a conference to discuss a revised schedule. On July 16, 2019, the Court issued a new schedule, which contemplated the prompt production by HHS of the administrative record, contemporaneous briefing during August and September 2019 of the motions for a preliminary injunction and for summary judgment, and oral argument on Friday, October 18, 2019. Dkt. 121.

Also on July 16, 2019, the Proposed Intervenors filed a reply memorandum of law in support of their motion to intervene. Dkt. 127 ("CMDA Reply").

On July 22, 2019, as directed by the schedule set by the Court, HHS produced the administrative record. *See* Dkt. 132.

## III. Discussion

### A. Applicable Legal Standards

Intervention of right under Federal Rule of Civil Procedure 24(a)(2) is proper when "all four of the following conditions are met: (1) the motion is timely; (2) the applicant asserts an interest relating to the property or transaction that is the subject of the action; (3) the applicant is so situated that without intervention, disposition of the action may, as a practical matter, impair or impede the applicant's ability to protect its interest; and (4) the applicant's interest is not adequately represented by the other parties." *MasterCard Int'l Inc. v. Visa Int'l Serv. Ass'n, Inc.*, 471 F.3d 377, 389 (2d Cir. 2006) (citing *United States v. Pitney Bowes, Inc.*, 25 F.3d 66, 70 (2d Cir. 1994)).

Independently, a court also has discretion to permit intervention if (1) a motion is timely, and (2) the proposed intervenor "has a claim or defense that shares with the main action a common question of law or fact." Fed. R. Civ. P. 24(b)(1). A court weighing permissive

intervention "must consider whether the intervention will unduly delay or prejudice the adjudication of the original parties' rights." *Id.* 24(b)(3).

**B. Analysis**

**1. Intervention of Right**

Plaintiffs do not dispute that the Proposed Intervenors' motion is timely. The Proposed Intervenors first learned of this lawsuit on May 21, 2019, and moved to intervene promptly after retaining counsel, on June 25, 2019. CMDA Mem. at 12. The Court's analysis therefore focuses on the remaining three requirements of Rule 24(a)(2): whether the Proposed Intervenors have an interest in the subject of this action; whether the Proposed Intervenors would be unable to protect that interest absent intervention; and whether that interest is inadequately represented by the other parties.

For an interest to be cognizable under Rule 24 it must be "direct, substantial, and legally protectable." *Wash. Elec. Coop., Inc. v. Mass. Mun. Wholesale Elec. Co.*, 922 F.2d 92, 97 (2d Cir. 1990) (citations omitted). The Proposed Intervenors argue that, as intended beneficiaries of the Rule, they have a legally protectable interest in "ensuring that federal conscience protections are enforceable and effective." CMDA Reply at 4. Citing CMDA's formal comments submitted to HHS during the agency's consideration of the Rule, the Proposed Intervenors state that, without the conscience protections contained in the Rule, "many CMDA members may be compelled to leave the practice of medicine." CMDA Mem. at 13–14. Plaintiffs counter that the Proposed Intervenors have not sufficiently alleged harm from the potential invalidation of the Rule. Plaintiffs argue that an exodus from medicine has not occurred "in the decades in which the federal government enforced the underlying refusal statutes without the . . . Rule in effect," and doubt, as to Dr. Frost, that, as a physician at a faith-based healthcare organization, she would be personally impacted by the Rule or its invalidation. Pl. Mem. at 6.

The Court holds that the Proposed Intervenors have asserted a cognizable interest in this action. The Proposed Intervenors are correct that "[w]hile Plaintiffs are entities *subject* to the rule, and Defendants are responsible for *enforcing* the rule, Doctor Frost—and CMDA's nearly 20,000 other members—are the ones *protected* by the rule." CMDA Mem. at 16.

Plaintiffs' arguments are more germane to Rule 24(a)(2)'s third requirement: that, absent intervention, the disposition of this action would impair or impede the Proposed Intervenors' ability to protect their interests. The Proposed Intervenors note that the Rule "describes numerous recent cases in which religious healthcare professionals have been targeted for their beliefs or disciplined for refusing to perform or assist in the performance of procedures that violate their consciences." CMDA Reply at 3.

*California ex rel. Lockyer v. United States*, 450 F.3d 436 (9th Cir. 2006), is apposite authority on this issue. At issue in *Lockyer* was the Weldon Amendment, enacted by Congress in 2004, which prevented federal, state, and local governments from receiving certain federal funds if they discriminated against health care providers that refused to provide abortions. *Id.* at 439. A California statute compelled emergency health care providers to deliver medical services for any condition in which a person was in danger of loss of life, and therefore was potentially implicated in situations when an abortion was necessary to preserve the life or health of a patient. The State of California brought suit to invalidate the Weldon Amendment as unconstitutional. The Ninth Circuit held that the proposed intervenors in that suit—healthcare providers with religious objections to performing abortions—had a significant protectable interest that would be affected by the lawsuit's disposition. The Ninth Circuit explained that "[s]hould California prevail in this lawsuit, it will be free to prosecute health care providers for failure to provide emergency abortion services." *Id.* at 442. And, the Ninth Circuit noted, the proposed

intervenors lacked an "alternative forum where they [could] mount a robust defense of the Weldon Amendment." *Id.*

*Lockyer* is persuasive authority on Rule 24(a)(2)'s third requirement. Here, as in *Lockyer*, invalidation of the Rule would leave the Proposed Intervenors with fewer legal protections for their exercise of moral or religious objections to certain medical procedures. The Court thus holds that the disposition of this case may, as a practical matter, affect the Proposed Intervenors.

The Court finally turns to Rule 24(a)(2)'s fourth requirement: whether the Proposed Intervenors' interests are adequately represented by the existing parties. This question is close. Although "the burden to demonstrate inadequacy of representation is generally speaking 'minimal,'" *Butler, Fitzgerald & Potter v. Sequa Corp.*, 250 F.3d 171, 179 (2d Cir. 2001) (quoting *Trbovich v. United Mine Workers*, 404 U.S. 528, 538 n.10 (1972)), "[w]here there is an identity of interest" among a proposed intervenor and the party whose position it supports, "the movant to intervene must rebut the presumption of adequate representation by the party already in the action," *id.* at 179–80 (citing *USPS v. Brennan*, 579 F.2d 188, 191 (2d Cir. 1978)). Additionally, "[t]he proponent of intervention must make a particularly strong showing of inadequacy in a case where the government is acting as *parens patriae*." *United States v. City of New York*, 198 F.3d 360, 367 (2d Cir. 1999) (citing *United States v. Hooker Chems. & Plastics Corp.*, 749 F.2d 968, 985 (2d Cir. 1984)). As the Ninth Circuit in *Lockyer* put the point: "[T]here is . . . an assumption of adequacy when the government is acting on behalf of a constituency that it represents. In the absence of a very compelling showing to the contrary, it will be presumed that a state adequately represents its citizens when the applicant shares the same interest." 450 F.3d at 443 (internal quotation marks and citations omitted),

Here, defendant HHS and the Proposed Intervenors share the same goal: upholding the Rule. *See* Pl. Mem. at 8; CMDA Mem. at 16. The Proposed Intervenors therefore must rebut the presumption of adequate representation by HHS. They make three arguments why HHS's representation will not adequately represent their interests.

First, the Proposed Intervenors argue that they "are uniquely situated to provide the Court with the perspective of physicians and medical professionals who advocated for the Rule and rely on it to protect their conscience rights." CMDA Mem. at 16. Plaintiffs counter that this perspective is already contained within the administrative record on which their APA claims will be litigated, insofar as the CMDA submitted comments supporting the Rule. Pl. Mem. at 11. Plaintiffs further argue that evidence outside the administrative record would not be properly considered on their APA claims, which will turn on "whether the agency's action is reasonable and reasonably justified in light of" that record. *Id.*

Plaintiffs are largely but not wholly correct on this point. Insofar as this case turns on an APA challenge to HHS's rulemaking, extra-record evidence from the Proposed Intervenors would have no place. However, the case includes other claims. In particular, the governmental plaintiffs also bring constitutional claims based on the Spending Clause, separation of powers, and the Establishment Clause. *See* Dkt. 1 ¶¶ 183–201. It is possible that evidence outside the administrative record may bear on these claims. Further, in the event that circumstances prevent a reliable resolution of summary judgment motions by the Rule's effective date, the Court would then be obliged to resolve plaintiffs' preliminary injunction motions. As part of that inquiry, the Court would expect to consider the balance of hardships, including the impact of staying the Rule on persons and entities, like the Proposed Intervenors, whose interests the Rule benefits. In this inquiry, too, extra-record evidence may have a proper place. The Proposed Intervenors, however, have not given the Court a compelling reason to believe that, in defending the Rule,

HHS would inadequately articulate the perspective of, and the Rule's impact upon, intended beneficiaries of the Rule, such as the Proposed Intervenors. The Court finds, therefore, that this first argument does not overcome the presumption of HHS's adequacy.

Second, the Proposed Intervenors argue, HHS would not adequately represent their interests because, they claim, HHS's interests are not coterminous with theirs. The Proposed Intervenors argue that, to enhance the likelihood that the Rule would be upheld, HHS may endorse a more limited construction of the Rule than favored by the Proposed Intervenors. *Cf. Lockyer*, 450 F.3d at 444–45 (holding that Government's proposed limiting construction to the Weldon Amendment created irreconcilable conflict with proposed intervenors' expansive construction). The Proposed Intervenors further argue that the CMDA has a strong interest in defending the CMDA surveys, which they state formed an evidentiary basis for the Rule, but that HHS may give short shrift to these surveys. Finally, the Proposed Intervenors argue that HHS's recent decision to stipulate to an extension of the Rule's effective date did not respect their interests in an earlier effective date. Plaintiffs dispute that the Proposed Intervenors' interests and HHS's are inconsistent.

On this point, too, the Court holds with plaintiffs. The Court finds the interests of the Proposed Intervenors broadly coterminous with those of HHS. "A putative intervenor does not have an interest not adequately represented by a party to a lawsuit simply because it has a motive to litigate that is different from the motive of an existing party." *NRDC, Inc. v. N.Y. State Dep't of Envtl. Conservation*, 834 F.2d 60, 62–63 (2d Cir. 1987). "So long as the party has demonstrated sufficient motivation to litigate vigorously and to present all colorable contentions, a district judge does not exceed the bounds of discretion by concluding that the interests of the intervenor are adequately represented." *Id.* at 62. To date, HHS has not indicated any intent to argue for a limited construction of the Rule, let alone a construction at odds with one that the

Proposed Intervenors may articulate. The Proposed Intervenors' concern that HHS may mount such a tactical retreat is entirely speculative. The possibility that the Proposed Intervenors may emphasize different evidence in support of a common outcome also does not make HHS's representation of the Proposed Intervenors' interests inadequate. Finally, HHS's agreement to defer the Rule's effective date, a decision uniquely within the executive prerogative and eminently justifiable as a means to assure orderly and measured resolution of the issues in this important case, does not signify that the agency has interests adverse to those of the Rule's beneficiaries.

Third, the Proposed Intervenors argue that because, historically, HHS has changed its position as to the construction of statutes underlying the Rule, in particular, upon changes of Administration, HHS may change course again. The timetable of this litigation makes this concern entirely theoretical. The Court hopes to resolve the parties' anticipated cross-motions for summary judgment by the November 22, 2019, effective date of the Rule. If not, the Court will rule promptly thereafter. And the Proposed Intervenors' argument based on the possibility of a change in policy by a future Administration—an argument available in every case in which the federal Government defends a rule or statute—conflicts with the presumption that the defense by the federal government of its regulations is adequate. *See Sagebrush Rebellion, Inc. v. Watt*, 713 F.2d 525, 528 (9th Cir. 1983) ("In allowing intervention in this case we are mindful that the mere change from one presidential administration to another, a recurrent event in our system of government, should not give rise to intervention as of right in ongoing lawsuits.").

The Court therefore holds that the Proposed Intervenors have not overcome the presumption of HHS's adequate representation of their interests. Accordingly, the Proposed Intervenors have not met the fourth condition of Rule 24(a)(2). They therefore are not entitled to intervention of right.

**2. Permissive Intervention**

A separate question, however, is presented by the Proposed Intervenors' motion for permissive intervention. A "district court's discretion under Rule 24(b) is broad." *Restor-A-Dent Dental Labs., Inc. v. Certified Alloy Prods., Inc.*, 725 F.2d 871, 876 (2d Cir. 1984) (citing *S.E.C. v. Everest Mgmt. Corp.*, 475 F.2d 1236, 1240 (2d Cir. 1972)). And, to grant permissive intervention, Rule 24(b) does not require a finding that party representation be inadequate. *United States v. Columbia Pictures Indus., Inc.*, 88 F.R.D. 186, 189 (S.D.N.Y. 1980) (adequacy of party representation is "a minor factor at most" under Rule 24(b)). Rather, "while existing adequate representation may militate against allowing permissive intervention, such intervention may still be appropriate if the addition of the intervenors will assist in the just and equitable adjudication of any of the issues between the parties." *United States v. N.Y.C. Housing Auth.*, 326 F.R.D. 411, 418 (S.D.N.Y. 2018) (internal quotation marks and citations omitted); *see also Oneida Grp. Inc. v. Steelite Int'l U.S.A. Inc.*, No. 17 Civ. 957 (ADS) (AKT), 2017 WL 6459464, at *13 (E.D.N.Y Dec. 15, 2017) (collecting cases finding permissive intervention warranted even where party representation was found adequate).

Here, while the question of permissible intervention can be fairly argued either way, and while the alternative to intervention in which CMDA and Dr. Frost participated together as an *amicus curiae* would equally result in the Court's receipt of the legal analysis that CDMA and Dr. Frost seek to present, the Court's judgment, on balance, is that permitting CMDA and Dr. Frost thus to intervene will assist the Court in resolving issues before it. In particular, the Court is mindful that, should the need arise to resolve a motion for preliminary relief in advance of the resolution of a motion for summary judgment, the Court's close attention to factual issues will be required, particularly as to the balance of hardships occasioned by staying, or not staying, the Rule's effective date. In this inquiry, the Court would benefit from concrete factual submissions

from the Proposed Intervenors as to the hardships occasioned by the absence of the Rule on CMDA members and Dr. Frost, much as the Court would benefit from factual submissions by plaintiffs as to the hardships occasioned by the Rule. The Proposed Intervenors, in fact, submitted declarations to this effect in opposition to the earlier preliminary injunction motion. *See* Dkts. 88-2 (declaration of Dr. David Stevens), 88-3 (declaration of Dr. Regina Frost).

On the opposite side of the equation, there is no palpable harm in permitting this participation. The Proposed Intervenors' motion to intervene is timely. Intervention will not unduly delay, or prejudice, the adjudication of the original parties' rights. It will not occasion any revision of the existing schedule. The Proposed Intervenors' submissions will be due on the same dates as HHS's. And intervention comports with Rule 24(b)(1), insofar as the Proposed Intervenors will litigate common questions of law and fact with those to be litigated by the parties. *See* Fed. R. Civ. P. 24(b)(1). Finally, plaintiffs cannot claim an appreciable burden from having to respond to the legal arguments by Proposed Intervenors, whose submission as *amicus curiae* the Court otherwise assuredly would have received.

In recognition of HHS's lead role in the defense of this case, the Court will impose tighter page limits on the Proposed Intervenors' submissions than on HHS's, as set forth below. In the event that plaintiffs determine that the need to respond to the intervenors' briefs necessitates additional space for plaintiffs' responsive briefs, the Court will be receptive to an application for an enlargement of plaintiffs' page limits.

## CONCLUSION

For the reasons reviewed above, the Court denies CMDA and Dr. Frost's motion for intervention of right but grants their motion for permissive intervention. The Clerk of Court is respectfully requested to terminate the motion pending at Dkt. 64 and to add Dr. Regina Frost and the Christian Medical and Dental Association to the caption of this case as defendants.

The Court authorizes CMDA and Dr. Frost to file a single consolidated brief, not to exceed 30 pages, in opposition to plaintiffs' motions for a preliminary injunction by August 14, 2019. They are also at liberty, within that single brief and that page limit, to move for summary judgment. In the event that CMDA and Dr. Frost do so move, their reply in support of the motion for summary judgment, not to exceed 15 pages, is due September 19, 2019. The Court will permit CMDA and Dr. Frost's counsel to participate in argument on October 18, 2019.

SO ORDERED.

Paul A. Engelmayer

Paul A. Engelmayer
United States District Judge

Dated: August 2, 2019
New York, New York

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF NEW YORK**

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| STATE OF NEW YORK, *et al.*<br><br>Plaintiffs,<br><br>v.<br><br>UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, *in his official capacity as Secretary of the United States Department of Health and Human Services*; and UNITED STATES OF AMERICA,<br><br>Defendants. | No. 1:19-cv-04676-PAE (rel. 1:19-cv-05433-PAE; 1:19-cv-05435-PAE)<br><br>**DEFENDANTS' CONSOLIDATED MOTION TO DISMISS OR, IN THE ALTERNATIVE, MOTION FOR SUMMARY JUDGMENT** |
| PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.,<br><br>Plaintiffs,<br><br>v.<br><br>ALEX M. AZAR II, in his official capacity as Secretary, United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, United States Department of Health and Human Services; and OFFICE FOR CIVIL RIGHTS, United States Department of Health and Human Services,<br><br>Defendants. | No. 1:19-cv-05433-PAE (rel. 1:19-cv-0476-PAE; 1:19-cv-05435-PAE) |

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| NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; and PUBLIC HEALTH SOLUTIONS,<br><br>Plaintiffs,<br><br>v.<br><br>ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director of the Office for Civil Rights of the U.S. Department of Health and Human Services; OFFICE FOR CIVIL RIGHTS of the U.S. Department of Health and Human Services,<br><br>Defendants. | ) | No. 1:19-cv-05435-PAE<br>(rel. 1:19-cv-0476-PAE; 1:19-cv-05433-PAE) |

Pursuant to Rule 12(b)(1), Rule 12(b)(6), and Rule 56 of the Federal Rules of Civil Procedure, and this Court's July 16, 2019 Order, Defendants move to dismiss Plaintiffs' complaints in these related cases or, in the alternative, move for summary judgment. Although Defendants do not believe it is necessary for the Court to rule on Plaintiffs' pending motions for a preliminary injunction, Defendants also oppose those motions.

Included with this motion are Defendants' memorandum of law, the portions of the administrative record cited therein (excluding citations to the Federal Register), and a proposed order. Because this case arises under the Administrative Procdure Act (APA), Defendants have not included a Rule 56.1 Statement of Undisputed Material Facts. *See Glara Fashion, Inc. v. Holder*, No. 11 Civ. 889(PAE), 2012 WL 352309, at *1 n.1 (S.D.N.Y. Feb. 3, 2012) ("Because this case arises under the APA, the Court's decision is based on the administrative record.

Accordingly, no Rule 56.1 Statement was required to be submitted by the parties." (citations omitted)).

Dated: August 14, 2019

Respectfully submitted,

JOSEPH H. HUNT
Assistant Attorney General

JAMES M. BURNHAM
Deputy Assistant Attorney General

CHRISTOPHER A. BATES
Senior Counsel to the Assistant Attorney General

MICHELLE R. BENNETT
Assistant Branch Director

*/s/ Bradley P. Humphreys*
BRADLEY P. HUMPHREYS
(D.C. Bar No. 988057)
Trial Attorney, U.S. Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, N.W.
Washington, D.C. 20005
Phone: (202) 305-0878
E-mail: Bradley.Humphreys@usdoj.gov

*Counsel for Defendants*

# Exhibit 1

Form Approved: OMB No. 0945-0002
Expiration Date: 04/30/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

# Civil Rights Discrimination Complaint

| YOUR FIRST NAME | YOUR LAST NAME |
|---|---|
| [redacted] | N/A |
| HOME PHONE (*Please include area code*) | WORK PHONE (*Please include area code*) |
| | [redacted] |
| STREET ADDRESS | CITY |
| [redacted] | |
| STATE / ZIP | E-MAIL ADDRESS (*If available*) |
| [redacted] | |

**Are you filing this complaint for someone else?** ☑ Yes ☐ No

If Yes, whose civil rights do you believe were violated?

| FIRST NAME | LAST NAME |
|---|---|
| American Association of ProLife Ob-Gyn | |

**I believe that I have been (or someone else has been) discriminated against on the basis of:**

☐ Race / Color / National Origin ☐ Age ■ Religion / Conscience ☐ Sex
☐ Disability ☐ Other (specify):

**Who or what agency or organization do you believe discriminated ag**

PERSON / AGENCY / ORGANIZATION: [redacted]

| STREET ADDRESS | |
|---|---|
| 409 12th Street SW | Washington |
| STATE / ZIP | PHONE (*Please include area code*) |
| D.C. 20024 | (202) 638-5277 |

**When do you believe that the occurred?**

LIST DATE(S)

Starting November 2007 to present

**Describe briefly what happened. How and why do you believe you have been discriminated against? Please be as specific as possible.**
(Attach additional pages as needed)

Please see letter attached stating specifics

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

SIGNATURE DATE 3/23/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

HHS-700 (10/17) (FRONT)

**The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.**

**Do you need special accommodations for OCR to communicate with you about this complaint?** (*Check all that apply*)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| FIRST NAME | LAST NAME |
|---|---|
| HOME PHONE (*Please include area code*) | WORK PHONE (*Please include area code*) |
| STREET ADDRESS | CITY |
| STATE / ZIP | E-MAIL ADDRESS (If available) |

**Have you filed your complaint anywhere else? If so, please provide the following.** (*Attach additional pages as needed*)

PERSON / AGENCY / ORGANIZATION / COURT NAME(S)

| DATE(S) FILED | CASE NUMBER(S) (If known) |
|---|---|

**To help us better serve the public; please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).**

ETHNICITY (*select one*)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (*select one or more*)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other than English):

**How did you learn about the Office for Civil Rights?**

■ HHS Website /Internet Search ☐ Family / Friend /Associate ☐ Religious /Community Org ☐ Lawyer /Legal Org ☐ Phone Directory ☐ Employer

☐ Fed /State/Local Gov ☐ Healthcare Provider /Health Plan ☐ Conference /OCR Brochure ☐ Other(*specify*):

**To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.**

## U.S. Department of Health and Human Services

Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail this complaint form to this address.**

HHS-700 (10/17) (BACK)

# COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights and Protecting Personal Information in Complaint Investigations for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

**In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.**

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

☒ **CONSENT**: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☐ **CONSENT DENIED**: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: Date: 3/23/2018

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Pl[redacted]

Address:

Telephon

# NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

**Privacy Act**

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

**Freedom of Information Act**
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

**Fraud and False Statements**
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

# PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

## HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

## CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

## CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

**CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?**

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

*OR*

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

THOMAS MORE SOCIETY
*A National Public Interest Law Firm*

March 23, 2018

*Via US Mail & email: ocrmail@hhs.gov*

U.S. Department of Health and Human Services
Office of Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201

Re: Violations of Conscience Rights of Physicians

Dear members of the Office of Civil Rights for the Department:

We write on behalf of our client, American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG") and its Executive Director, [redacted] M.D., seeking the assistance of the Office of Civil Rights to investigate ongoing efforts by the American College of Obstetricians and Gynecologists ("ACOG") and its lobbying sister organization American Congress of Obstetrics and Gynecology ("The Congress") to stifle and countermand conscience rights of pro-life physicians to decline to perform, participate in, or assist in the performance of abortion practices because of their conscience and/or religious opposition to such practices.

AAPLOG is a nonprofit professional medical organization consisting of approximately 4,000 obstetrician-gynecologist members and associates practicing medicine in the United States and in several foreign countries. Its mission is to encourage the practice of medicine consistent with scientific truth and the Hippocratic oath, both of which it views as orienting medicine, as a healing art, toward the well-being and flourishing of all human life. ACOG is another membership organization of obstetricians and gynecologists. It purports to represent 58,000 physicians and partners. The Congress, ACOG's sister organization, a 501(c)(4) organization under the Internal Revenue Code, exists "to promote policy positions" of ACOG, in other words, to lobby. All members of ACOG are automatically members of The Congress regardless of the desire of the member to abstain from the Congress's pro-abortion lobbying.

In November 2007 ACOG issued Ethics Statement #385. **Exhibit One.** ACOG in this statement declares to be "unethical" any physician refusing to perform or refer for elective abortions. This statement was promptly and vigorously called into

19 S. LaSalle | Suite 603 | Chicago, IL 60603 | | P: 312.782.1680 | F: 312.782.1887
501 Scoular | 2027 Dodge | Omaha, NE 68102 | | P: 402-346-5010 | F: 402 345 8853
www.thomasmoresociety.org

*"Injustice anywhere is a threat to justice everywhere." – Rev. Dr. Martin Luther King*

question by AAPLOG, other medical associations, and speakers before the President's Council on Bioethics. See, e.g., **Exhibit Two** (AAPLOG Response of Feb. 6, 2008); **Exhibit Three** (Letter from Catholic Medical Association, February 28, 2008); **Exhibit Four** (Joint Letter of Protest by various medical organizations, Dec. 7, 2007); **Exhibit Five** (Letter by 16 Members of Congress, March 14, 2008). These and other objectors requested that ACOG retract the Ethics Statement #385 as being unsupported and discriminatory. At the same time, the Department of Health and Human Services ("HHS") sent a letter to the American Board of Obstetrics and Gynecology ("ABOG"), which is the certifying body for obstetricians and gynecologists in the U.S., objecting to the ACOG policy and questioning its influence on ob-gyn certification procedures. See **Exhibit Six** (March 14, 2008 Letter to [redacted], M.D., Executive Director ABOG). ABOG responded with a letter protesting its innocence. See **Exhibit Seven** (March 19, 2008 Letter of [redacted], M.D. to [redacted], Secretary HHS). ACOG itself responded to the criticism by promising its members to revisit Ethics Statement #385, see **Exhibit Eight** (Letter to [redacted] March 26, 2008), but it never changed the policy, instead reconfirming it, most recently in 2016.[1]

ABOG's letter (Exhibit Seven) as a disclaimer carries no legal weight, since it is not an affirmative policy statement of ABOG itself. It thus gives no assurance to a pro-life ob-gyn against accusation of unethical conduct under Ethics Statement #385 upon a conscience-based refusal to perform or refer for abortion. What is needed is an affirmative statement from ABOG declaring that a conscience-based refusal to perform or refer for abortion does *not* constitute an ethical violation. But that has not been forthcoming. Without it an ob-gyn remains vulnerable to the possibility that his or her conscience-based refusal to participate in abortion could be considered unethical, prompting a loss of board certification, loss of employment, and other professional and personal adverse consequences. In that respect, the threat posed by Ethics Statement #385 is neither imaginary nor inflated. Under ABOG's current rules, an accusation of unethical professional behavior can lead to rescission of board certification, loss of licensure, and loss of hospital privileges.[2] Indeed, the very existence of Ethics Statement #385 is a

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[1] See https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine (last visited, March 21, 2018).

[2] See 2018 Bulletin for the Certifying Examination in Obstetrics and Gynecology, accessible at https://www.abog.org/bulletins/2018%20Certifying%20Examination%20in%20Obstetrics%20and%20Gynecology.pdf (last visited March 21, 2018). The Bulletin states, at p.7: "If a candidate is involved in an investigation by a health care organization regarding practice

sword of Damocles hanging over Hippocratic oath physicians, and exerts a continuing chilling effect on their conscientious performance of ob-gyn services.

This ongoing state of affairs -- in which a licensed and board certified obstetrician-gynecologist can potentially be denied certification solely on the basis of refusal to perform or refer for abortions -- is also undesirable and counterproductive from the standpoint of public policy. As is well known, the United States suffers from a critical shortage of physicians, particularly in rural and other underserved areas of the country. To qualify and certify a single ob-gyn takes eight years of training, including four years of medical school and four years in an approved ob-gyn residency program. Qualified, dedicated ob-gyns provide desperately needed obstetric and gynecological services throughout the United States, including in rural and underserved areas of our country where their professional services often constitute the primary care for women of reproductive age. To deny certification to a fully trained ob-gyn solely because of ideological disagreement with a conscience-based objection to perform or refer for abortion would disserve all women who depend on such physicians, and exacerbate the already critical shortage of health care professionals in rural and other underserved communities, which desperately require such services. This makes no sense as sound public policy.

The 4,000 members of AAPLOG and countless other physicians consider ACOG Ethics Statement #385 to pose an intentional and systematic threat to the right of Hippocratic physicians in this country to follow, on the basis of conscience, time-honored Hippocratic principles of medicine. The very existence of this policy violates the conscience rights of all AAPLOG members, whom Dr. Harrison represents as Executive Director of AAPLOG, and the conscience rights of all pro-life physicians in this country.

For these reasons, AAPLOG hereby petitions the OCR for an investigation into:

1. The systematic and continued violation of conscience rights of Hippocratic physicians authorized by ACOG's adoption and continued advancement of Ethics Statement #385.

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activities or for ethical or moral issues, the individual will not be scheduled for examination, and a decision to approve or disapprove the application will be deferred until either the candidate has been cleared or until ABOG has received sufficient information to make a final decision." See also, at p. 8: "This means that each such medical license must not be restricted, suspended, on probation, revoked, nor include conditions of practice. The terms 'restricted' and 'conditions' include any and all limitations, terms or requirements imposed on a physician's license regardless of whether they deal directly with patient care."

2. The relationship between ABOG with ACOG, an abortion advocacy organization, and the use by ABOG of ACOG Ethics Statement #385 as a criteria for board certification.

3. The unlawful use by covered entities of ABOG board certification or ACOG Ethics Statement #385 to intimidate and discriminate against individuals in violation of federal laws protecting conscience rights.

We respectfully request your office, after investigating these issues, to take appropriate action to prevent -- both now and for the future -- ACOG's political views favoring abortion, and its policy statements arising from those views, from interfering with, curtailing, or punishing the rights of conscience of pro-life physicians and service providers. In this regard, we respectfully request that HHS issue regulations that: (1) Require covered entities to provide a clear statement that covered entities cannot discriminate against individuals or healthcare entities because they refuse to perform, refer for, or train to perform, elective abortions; and (2) Require covered entities to post notices informing all healthcare providers of their conscience rights as well as that government offices individuals or healthcare entities can contact to request assistance in the event their rights are violated.

AAPLOG believes that HHS should take these and other steps necessary to prevent ABOG and ACOG from the current cat-and-mouse strategy that is being used to intimidate and harass pro-life physicians and service providers in a manner wholly inconsistent with the letter and spirit of the federal laws protecting conscience.

Thank you for considering this complaint. Please contact the undersigned in the event additional information is needed to bring your investigation to conclusion.

Respectfully,

[redacted]

Counsel, Thomas More Society

[redacted]

Enclosures

# EXHIBIT ONE

# The Limits of Conscientious Refusal in Reproductive Medicine



## ACOG COMMITTEE OPINION

Number 385, November 2007 *Reaffirmed 2016*

Committee on Ethics

PDF Format

## The Limits of Conscientious Refusal in Reproductive Medicine

ABSTRACT: Health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. In resource-poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

Physicians and other providers may not always agree with the decisions patients make about their own health and health care. Such differences are expected—and, indeed, underlie the American model of informed consent and respect for patient autonomy. Occasionally, however, providers anticipate that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience. In such cases, some providers claim a right to refuse to provide certain services, refuse to refer patients to another provider for these services, or even decline to inform patients of their existing options (1).

Conscientious refusals have been particularly widespread in the arena of reproductive medicine, in which there are deep divisions regarding the moral acceptability of pregnancy termination and contraception. In Texas, for example, a pharmacist rejected a rape victim's prescription for emergency contraception, arguing that dispensing the medication was a "violation of morals" (2). In Virginia, a 42-year-old mother of two was refused a prescription for emergency contraception, became pregnant, and ultimately underwent an abortion she tried to prevent by requesting emergency contraception (3). In California, a physician refused to perform intrauterine insemination for a lesbian couple, prompted by religious beliefs and disapproval of lesbians having children (4). In Nebraska, a 19-year-old woman with a life-threatening pulmonary embolism at 10 weeks of gestation was refused a first-trimester pregnancy termination when admitted to a religiously affiliated hospital and was ultimately transferred by ambulance to another facility to undergo the procedure (5). At the heart of each of these examples of refusal is a claim of conscience—a claim that to provide certain services would compromise the moral integrity of a provider or institution.

In this opinion, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics considers the issues raised by conscientious refusals in reproductive medicine and outlines a framework for defining the ethically appropriate limits of conscientious refusal in reproductive health contexts. The committee begins by offering a definition of conscience and describing what might constitute an authentic claim of conscience. Next, it discusses the limits of conscientious refusals, describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care. It then outlines options for public policy regarding conscientious refusals in reproductive medicine. Finally, the committee proposes a series of recommendations that maximize accommodation of an individual's religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.

### Defining Conscience

In this effort to reconcile the sometimes competing demands of religious or moral freedom and reproductive rights, it is important to characterize what is meant by conscience. Conscience has been defined as the private, constant, ethically

attuned part of the human character. It operates as an internal sanction that comes into play through critical reflection about a certain action or inaction (6). An appeal to conscience would express a sentiment such as "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night." According to this definition, not to act in accordance with one's conscience is to betray oneself—to risk personal wholeness or identity. Thus, what is taken seriously and is the specific focus of this document is not simply a broad claim to provider autonomy (7), but rather the particular claim to a provider's right to protect his or her moral integrity—to uphold the "soundness, reliability, wholeness and integration of [one's] moral character" (8).

Personal conscience, so conceived, is not merely a source of potential conflict. Rather, it has a critical and useful place in the practice of medicine. In many cases, it can foster thoughtful, effective, and humane care. Ethical decision making in medicine often touches on individuals' deepest identity-conferring beliefs about the nature and meaning of creating and sustaining life (9). Yet, conscience also may conflict with professional and ethical standards and result in inefficiency, adverse outcomes, violation of patients' rights, and erosion of trust if, for example, one's conscience limits the information or care provided to a patient. Finding a balance between respect for conscience and other important values is critical to the ethical practice of medicine.

In some circumstances, respect for conscience must be weighed against respect for particular social values. Challenges to a health care professional's integrity may occur when a practitioner feels that actions required by an external authority violate the goals of medicine and his or her fiduciary obligations to the patient. Established clinical norms may come into conflict with guidelines imposed by law, regulation, or public policy. For example, policies that mandate physician reporting of undocumented patients to immigration authorities conflict with norms such as privacy and confidentiality and the primary principle of nonmaleficence that govern the provider–patient relationship (10). Such challenges to integrity can result in considerable moral distress for providers and are best met through organized advocacy on the part of professional organizations (11, 12). When threats to patient well-being and the health care professional's integrity are at issue, some individual providers find a conscience-based refusal to comply with policies and acceptance of any associated professional and personal consequences to be the only morally tenable course of action (10).

Claims of conscience are not always genuine. They may mask distaste for certain procedures, discriminatory attitudes, or other self-interested motives (13). Providers who decide not to perform abortions primarily because they find the procedure unpleasant or because they fear criticism from those in society who advocate against it do not have a genuine claim of conscience. Nor do providers who refuse to provide care for individuals because of fear of disease transmission to themselves or other patients. Positions that are merely self-protective do not constitute the basis for a genuine claim of conscience. Furthermore, the logic of conscience, as a form of self-reflection on and judgment about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say "I would have a guilty conscience if she did 'x.'" Although some have raised concerns about complicity in the context of referral to another provider for requested medical care, the logic of conscience entails that to act in accordance with conscience, the provider need not rebuke other providers or obstruct them from performing an act (8). Finally, referral to another provider need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees (14).

The authenticity of conscience can be assessed through inquiry into 1) the extent to which the underlying values asserted constitute a core component of a provider's identity, 2) the depth of the provider's reflection on the issue at hand, and 3) the likelihood that the provider will experience guilt, shame, or loss of self-respect by performing the act in question (9). It is the genuine claim of conscience that is considered next, in the context of the values that guide ethical health care.

## Defining Limits for Conscientious Refusal

Even when appeals to conscience are genuine, when a provider's moral integrity is truly at stake, there are clearly limits to the degree to which appeals to conscience may justifiably guide decision making. Although respect for conscience is a value, it is only a prima facie value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance. Professional ethics requires that health be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and nondiscriminatory. By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice (15). Thus, with professional privileges come professional responsibilities to patients, which must precede a provider's personal interests (16). When conscientious refusals conflict with moral obligations that are central to the ethical practice of medicine, ethical care requires either that the physician provide care despite reservations or that there be resources in place to allow the patient to gain access to care in the presence of conscientious refusal. In the following sections, four criteria are highlighted as important in determining appropriate limits for conscientious refusal in reproductive health contexts.

### 1. Potential for Imposition

The first important consideration in defining limits for conscientious refusal is the degree to which a refusal constitutes an imposition on patients who do not share the objector's beliefs. One of the guiding principles in the practice of medicine is respect for patient autonomy, a principle that holds that persons should be free to choose and act without controlling constraints imposed by others. To respect a patient's autonomy is to respect her capacities and perspectives, including her right to hold certain views, make certain choices, and take certain actions based on personal values and beliefs (17). Respect involves acknowledging decision-making rights and acting in a way that enables patients to make choices for themselves. Respect for autonomy has particular importance in reproductive decision making, which involves private, personal, often pivotal decisions about sexuality and childbearing.

It is not uncommon for conscientious refusals to result in imposition of religious or moral beliefs on a patient who may not share these beliefs, which may undermine respect for patient autonomy. Women's informed requests for contraception or sterilization, for example, are an important expression of autonomous choice regarding reproductive decision making. Refusals to dispense contraception may constitute a failure to respect women's capacity to decide for themselves whether and under what circumstances to become pregnant.

Similar issues arise when patients are unable to obtain medication that has been prescribed by a physician. Although pharmacist conduct is beyond the scope of this document, refusals by other professionals can have an important impact on a physician's efforts to provide appropriate reproductive health care. Providing complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine. Providers refusing to provide such information on the grounds of moral or religious objection fail in their fundamental duty to enable patients to make decisions for themselves. When the potential for imposition and breach of autonomy is high due either to controlling constraints on medication or procedures or to the provider's withholding of information critical to reproductive decision making, conscientious refusal cannot be justified.

**2. Effect on Patient Health**

A second important consideration in evaluating conscientious refusal is the impact such a refusal might have on well-being as the patient perceives it—in particular, the potential for harm. For the purpose of this discussion, harm refers to significant bodily harm, such as pain, disability, or death or a patient's conception of well-being. Those who choose the profession of medicine (like those who choose the profession of law or who are trustees) are bound by special fiduciary duties, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest (16). Although conscientious refusals stem in part from the commitment to "first, do no harm," their result can be just the opposite. For example, religiously based refusals to perform tubal sterilization at the time of cesarean delivery can place a woman in harm's way—either by putting her at risk for an undesired or unsafe pregnancy or by necessitating an additional, separate sterilization procedure with its attendant and additional risks.

Some experts have argued that in the context of pregnancy, a moral obligation to promote fetal well-being also should justifiably guide care. But even though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients. Indeed, in the vast majority of cases, the interests of the pregnant woman and fetus converge. For situations in which their interests diverge, the pregnant woman's autonomous decisions should be respected (18). Furthermore, in situations "in which maternal competence for medical decision making is impaired, health care providers should act in the best interests of the woman first and her fetus second" (19).

**3. Scientific Integrity**

The third criterion for evaluating authentic conscientious refusal is the scientific integrity of the facts supporting the objector's claim. Core to the practice of medicine is a commitment to science and evidence-based practice. Patients rightly expect care guided by best evidence as well as information based on rigorous science. When conscientious refusals reflect a misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part, by the strength or weakness of the science on which refusals are based. In other words, claims of conscientious refusal should be considered invalid when the rationale for a refusal contradicts the body of scientific evidence.

The broad debate about refusals to dispense emergency contraception, for example, has been complicated by misinformation and a prevalent belief that emergency contraception acts primarily by preventing implantation (20). However, a large body of published evidence supports a different primary mechanism of action, namely the prevention of fertilization. A review of the literature indicates that Plan B can interfere with sperm migration and that preovulatory use of Plan B suppresses the luteinizing hormone surge, which prevents ovulation or leads to the release of ova that are resistant to fertilization. Studies do not support a major postfertilization mechanism of action (21). Although even a slight possibility of postfertilization events may be relevant to some women's decisions about whether to use contraception, provider refusals to dispense emergency contraception based on unsupported beliefs about its primary mechanism of action should not be justified.

In the context of the morally difficult and highly contentious debate about pregnancy termination, scientific integrity is one of several important considerations. For example, some have argued against providing access to abortion based on claims that induced abortion is associated with an increase in breast cancer risk; however, a 2003 U.S. National Cancer Institute panel concluded that there is well-established epidemiologic evidence that induced abortion and breast cancer are not associated (22). Refusals to provide abortion should not be justified on the basis of unsubstantiated health risks to women.

Scientific integrity is particularly important at the level of public policy, where unsound appeals to science may have masked an agenda based on religious beliefs. Delays in granting over-the-counter status for emergency contraception are one such example. Critics of the U.S. Food and Drug Administration's delay cited deep flaws in the science and evidence used to justify the delay. Flaws these critics argued were indicative of unspoken and misplaced value judgments (23). Thus, the scientific integrity of a claim of refusal is an important metric in determining the acceptability of conscience-based practices or policies.

**4. Potential for Discrimination**

Finally, conscientious refusals should be evaluated on the basis of their potential for discrimination. Justice is a complex and important concept that requires medical professionals and policy makers to treat individuals fairly and to provide medical services in a nondiscriminatory manner. One conception of justice, sometimes referred to as the distributive paradigm, calls for fair allocation of society's benefits and burdens. Persons intending conscientious refusal should consider the degree to which they create or reinforce an unfair distribution of the benefits of reproductive technology. For instance, refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not realistically available to her. She thus may experience loss of control of her reproductive fate and quality of life for herself and her children. Refusals that unduly burden the most vulnerable of society violate the core commitment to justice in the distribution of health resources.

Another conception of justice is concerned with matters of oppression as well as distribution (24). Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well. Consider, for instance, refusals to provide infertility services to same-sex couples. It is likely that such couples would be able to obtain infertility services from another provider and would not have their health jeopardized, per se. Nevertheless, allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult, namely reinforcing the scientifically unfounded idea that fitness to parent is based on sexual orientation, and, thus, reinforcing the oppressed status of same-sex couples. The concept of oppression raises the implications of all conscientious refusals for gender justice in general. Legitimizing refusals in reproductive contexts may reinforce the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally. As the place of conscience in reproductive medicine is considered, the impact of permissive policies toward conscientious refusals on the status of women must be considered seriously as well.

Some might say that it is not the job of a physician to "fix" social inequities. However, it is the responsibility, whenever possible, of physicians as advocates for patients' needs and rights not to create or reinforce racial or socioeconomic inequalities in society. Thus, refusals that create or reinforce such inequalities should raise significant caution.

## Institutional and Organizational Responsibilities

Given these limits, individual practitioners may face difficult decisions about adherence to conscience in the context of professional responsibilities. Some have offered, however, that "accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences" (1). Rather, institutions and professional organizations should work to create and maintain organizational structures that ensure nondiscriminatory access to all professional services and minimize the need for individual practitioners to act in opposition to their deeply held beliefs. This requires at the very least that systems be in place for counseling and referral, particularly in resource-poor areas where conscientious refusals have significant potential to limit patient choice, and that individuals and institutions "act affirmatively to protect patients from unexpected and disruptive denials of service" (13). Individuals and institutions should support staffing that does not place practitioners or facilities in situations in which the harms and thus conflicts from conscientious refusals are likely to arise. For example, those who feel it improper to prescribe emergency contraception should not staff sites, such as emergency rooms, in which such requests are likely to arise, and prompt disposition of emergency contraception is required and often integral to professional practice. Similarly, institutions that uphold doctrinal objections should not position themselves as primary providers of emergency care for victims of sexual assault; when such patients do present for care, they should be given prophylaxis. Institutions should work toward structures that reduce the impact on patients of professionals' refusals to provide standard reproductive services.

## Recommendations

Respect for conscience is one of many values important to the ethical practice of reproductive medicine. Given this framework for analysis, the ACOG Committee on Ethics proposes the following recommendations, which it believes maximize respect for health care professionals' consciences without compromising the health and well-being of the women they serve.

1. In the provision of reproductive services, the patient's well-being must be paramount. Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled.
2. Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.
3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.
5. In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections.
6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients' rights to health care services.
7. Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.

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# EXHIBIT TWO

**AAPLOG - AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS**
**EXECUTIVE OFFICE: AAPLOG 339 River Ave, Holland, MI 49423 Website: www.aaplog.org**
**Telephone: (616) 546-2639 E-Mail: prolifeob@aol.com**
**February 6, 2008**

# AAPLOG RESPONSE TO THE ACOG ETHICS COMMITTEE OPINION #385, TITLED "THE LIMITS OFCONSCIENTIOUS REFUSAL IN REPRODUCTIVE MEDICINE"

The American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), one of the largest Special Interest Groups of the American College of Obstetricians and Gynecologists (ACOG), strongly objects to the November 2007 release of ACOG Committee Opinion, Number 385, titled "The Limits of Conscientious Refusal in Reproductive Medicine."

We find it unethical and unacceptable that a small committee of ACOG members would pretend to provide the moral compass for 49,000 other members on one of the most ethically controversial issues in our society and within our medical specialty—and that without ever consulting the full membership.

ACOG Committee Opinion #385 is in opposition to 2500 years of accepted Hippocratic ethical medical tradition. Legal elective abortion made a unique arrival in the late 1960s in the United States as part of a legal-societal initiative, rather than as the culmination of a scientific process in biomedicine. The acceptance of elective abortion in American medical practice was contrary to the historic ethical position of Western medicine with regard to abortion.

Therefore it is of great concern that this committee opinion repeatedly describes elective abortion, and other controversial reproductive medical procedures and services as "standard." The term "standard," as used in the document, is never defined. Ideally, a care "standard" would involve a balanced and thorough consideration of the existing medical literature for the effect on the patient's health and well being, both in the short term and in the long term. There is scant evidence regarding the outcomes of elective abortion, other than its decided effectiveness at ending a pregnancy. In general, the long term safety of abortion, and its "benefit" for women, has been either assumed, or accepted on the basis of inadequate follow-up studies.

On the contrary, there are poor reproductive and other health outcomes associated with elective abortion in methodologically sound scientific studies. The data from nations with extensive computer based health registries, where linkage with subsequent health outcomes is a practical reality, show that elective

abortion has significant adverse association with subsequent preterm birth,[1] depression,[2] suicide,[3] placenta previa.[4] and breast cancer.[5] ("Although it remains uncertain whether elective abortion increases subsequent breast cancer, it is clear that a decision to abort and delay pregnancy culminates in a loss of protection with the net effect being an increased risk.")[4]

While there may be conflicting data with regard to these issues, ACOG documents have summarily denied the significance of any literature demonstrating an association. We are aware of no current ACOG educational materials providing balance to this extreme position.

In this regard, we also find the Opinion statement, "Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care," to be at odds with the actual practice of informed consent in elective abortion. The College has allowed the development of a procedure (elective abortion) in its specialty area for which record keeping is inadequate and meaningful tracking of complications is virtually impossible. There is a relative absence of data collected on abortion and subsequent health status in the United States. ACOG has colluded in this state of affairs by not insisting on adequate record keeping and reporting for this procedure. Since accurate risk and complication rates are unavailable, it is vacuous to make reference to "accurate and unbiased information" for making "informed" decisions.

Further, in most instances, the abortion practitioner is not responsible to care for "complications" of his or her work, and often may not even be aware that a complication has occurred. Rather, the emergency room physician, or the obstetrician/gynecologist on call for the emergency department, inherits untoward fallout of abortion. Therefore the physician performing the procedure cannot even accurately reference his or her own experience with regard to complications in informed consent conversations. This is the only instance in American medicine where the operating physician is not the primary physician responsible for the initial oversight of complications of their surgical procedure. Perhaps the ACOG

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[1] National Academy of Science's Institute of Medicine report " Preterm Birth: Causes, Consequences, and Prevention." July 2006, Appendix, page 518-19; Calhoun, B, Rooney, B; "Induced Abortion and Risk of Later Premature Birth," Journal of American Physicians and Surgeons, Volt 8, #2, 2003.

[2] David M. Fergusson, et al; "Abortion In Young Women And Subsequent Mental Health," J. of Child Psychology and Psychiatry, Vol 47:1 2006.

[3] Gissler, M, et.al., "Pregnancy associated deaths in Finland 1987-1994, Acta Obsetricia et Gynecologica Scandinavica 76:651-657, 1997.

[4] Thorp, et al, "Long Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence," OB GYN Survey, Vol 58, No. 1, 2002.

[5] MacMahon, et al, Bull. "Age at First Birth and Breast Cancer Risk", WHO 43:209-221, 1970; Trichopolous D, Hsieh C, MacMahon B, Lin T, et al, Age at any Birth and Breast Cancer Risk, International J Cancer, 31:70l-704, 1983.

Committee on Ethics should address the strange ethics of this "prevailing standard" of reproductive health service.

Dr. Allan Sawyer, who is an AAPLOG member and current Chairman of the ACOG Committee on Coding and Nomenclature, as well as chairman of a hospital ethics committee, has stated in a prior letter to ACOG, "It is a foundational principle of ethics that autonomy must be balanced by the other principles of ethics. Any one principle of ethics cannot trump all of the others, otherwise there is distortion of truth and the dominant principle ends up skewing the analysis. The end result often is anything but ethical. ACOG's Committee Opinion #385 is an excellent example of the collapse of ethical decision-making when patient autonomy is allowed to dominate over every other principle of ethics. This is not so much an ethics committee opinion as it is a document that promotes the right-to-abortion-on-demand stance of ACOG."[6] Dr. Sawyer's comments accurately reflect AAPLOG's position on this issue.

The idea that physicians are obligated to provide or refer for elective abortion services simply on the basis of "patient request" is antithetical to the practice of modern medicine. It is to make patient autonomy rule over physician conscience. It is to make the physician the corner vendor. A more balanced approach would be to accept that where opinions vary, the patient is free to seek a second opinion, but not to impose her will on the attending physician.

The Ethics Committee directive that those who oppose elective abortion on conscience grounds should locate their practice in proximity to an abortionist for patient convenience is patently absurd. Quite apart from our conscience convictions, this is a completely unrealistic idea. Conformity with this recommendation would result in large swathes of the United States being without any obstetric or gynecologic care (the large majority of abortion clinics are located in the inner city).

The Committee Opinion informs us that conscience based refusals should be evaluated on the basis of their potential for discrimination. For years a glaring example of systematic discrimination has been implicitly accepted within the current provision of abortion services nationwide. Year after year, African-American women have their unborn children aborted at a per capita rate three times that of Caucasian women. There has never been a protest from ACOG against this extreme disproportion in the actual distribution of abortion services. What would the Ethics Committee advise to rectify this inequity? Should the abortion rate be increased for Caucasian women, or should the abortion rate be decreased for African-American women, in order to meet the standards of justice and equitable distribution of reproductive health services?

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[6] Used with Dr. Sawyer's permission

Finally, it seems that the Ethics Committee does not understand the strength and depth of a conscience conviction against the elective, deliberate taking of an unborn human life. This is not a negotiable issue for those who hold this conviction. The United States Supreme Court allowed elective abortion to be a legal right. The U.S. Supreme Court is not an infallible moral guide for a person's conscience, as evidenced by a previous similar egregious ruling.[7]

For these reasons, we, the AAPLOG board of directors, find this Committee Opinion to be neither scientifically nor ethically sound. We strongly urge that Committee Opinion #385 be rescinded at the earliest opportunity.

Sincerely,

Joseph L. DeCook, MD, FACOG, Vice-President, AAPLOG, for the Executive Committee and the Board of AAPLOG

[7] We reference the infamous Dred Scott vs Sanford case of 1857, in which the Supreme Court of the United States found, by a 7-2 majority, that no person of African descent could claim U.S. Citizenship. (Africans, according to the Court, were "beings of an inferior order, and altogether unfit to associate with the white race,… so far inferior that they had no rights which the white man was bound to respect.") Since slaves had no claim to citizenship, they could not bring suit in court. We find the status of the unborn under Roe to be strikingly similar to the plight of the African slaves under Dred Scott: Both are human beings, but neither had/has basic human rights: neither had/has the legal right to appeal to the courts for justice or protection when they were/are victims of inhumane treatment or purposeful killing.

# EXHIBIT THREE

[redacted]D.
Board President
American College of Obstetricians and Gynecologists
409 12th St., S.W.
Washington, D.C. 20090-6920
February 28, 2008

Dear [redacted]:

On November 7, 2007, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics released an Opinion, "The Limits of Conscientious Refusal in Reproductive Medicine" (the "Opinion"), which attempts to resolve the issue of ethically appropriate limits of conscientious judgments in reproductive medicine. This is an issue that demands serious attention and sustained dialogue. Unfortunately, however, the Opinion not only fails to provide helpful guidance, but is so flawed that it threatens the reputation of ACOG itself. The Catholic Medical Association urges ACOG to rescind this opinion immediately.

The Committee on Ethics' Opinion exhibits three fatal flaws: (1) it is woefully inadequate in basic ethical theory and analysis; (2) the "considerations" advanced to limit conscientious judgments are so vague and contentious that they cannot meaningfully function as ethical or professional guidelines; and (3) the solutions proposed are unjust, unworkable, and harmful to the profession of medicine. We elaborate on these points briefly below.

1. Flaws in Ethical Analysis. The Opinion contains a seriously flawed and gratuitously condescending approach to conscience. The Opinion describes conscience in limited, negative, emotional terms, emphasizing such terms as "private," "sanction," "sentiment," and emotions such as self-hatred. At best, the Opinion notes, "Personal conscience, so conceived, is not merely a source of potential conflict." In fact, however, while conscience is a personal, subjective judgment, it is not merely "private" or relativistic. Conscientious judgments provide guidance both for good actions that should be done and unethical actions that should be refused. It is true that conscientious judgments are at times accompanied by emotion, particularly in conflict cases. Still, conscience is not a matter of feeling, as the Opinion suggests, but a judgment about moral truth.

In addition to providing an inadequate description of the nature and role of conscience, the Opinion fails to do justice to the ethical issue of cooperation in evil raised by providing referrals for abortion and, indeed, dismisses concerns about complicity in gravely immoral actions.

This disregard for the harm caused by complicity in moral evil is particularly hard to understand given the painful lessons the medical profession learned from physicians' silent tolerance of, or complicity in, the crimes against humanity in Nazi Germany. Here in the United States, in the infamous Tuskegee Syphilis Study, U.S. Public Health Service physicians denied treatment to patients with syphilis so they could study the late stages of the disease. Moreover, physicians participated or acquiesced in involuntary sterilizations under color of law in more than 30 more states between 1907 and the early 1970s. All agree now that these practices were unethical and a violation of patients' rights and that physicians were wrong to cooperate, even tacitly, or to remain silent, even when they were not direct participants.

The Opinion mentions, but fails to describe, what it means by the "set of moral values – and duties – that are central to medical practice." Since the Opinion goes on to list four "criteria" that ostensibly trump physicians' ethical convictions, it appears that these are the moral values and duties the Ethics Committee has in mind. Inexplicably missing in this section of the Opinion is any mention of respect for human life, which *has* been recognized by most physicians across centuries and cultures as a fundamental value and duty that *is* central to the practice of medicine.

Finally, the Opinion attempts, in several ways, to legitimize a moral duty to provide any requested "reproductive service." The Opinion appeals to terminology such as "standard care," "standard reproductive services," and "standard practices" without ever defining who or what has established these standards. The Opinion attempts to conflate the duty to provide treatment in an emergency with a new obligation – to provide "medically indicated and requested care" where failure to do so "might" negatively affect a patient's "mental health." This so-called obligation is unnecessary and completely unfounded. Our position is that elective abortion is not healthcare, nor does it qualify as an emergency. In a true emergency, where a pregnant woman's life is in danger, physicians can and should strive to save the lives of the mother and her unborn child.

2. Considerations Limiting Conscientious Refusal. The "considerations" that the Opinion claims limit conscientious judgments are so vague and contentious that they cannot meaningfully function as ethical guidelines. For example, the Opinion cites the "degree of imposition" as a criterion for overriding the ethical and professional judgment of physicians. It is

not clear at all what kinds or degrees of "imposition" will trump ethical judgment, much less why they should. In appealing to the criterion of "effect on patient health," the Opinion unfairly assumes that all requested reproductive interventions (including abortion or egg harvesting) are in fact good for the patient's health. Moreover, it unfairly implies that physicians with ethical objections to such practices are not motivated precisely by concern for the patient's short and long term health. In appealing to the category of scientific integrity, the Opinion overstates the certainty that current science can provide about the mechanism of drugs (such as those used in Plan B). And it fails to recognize that the real "possibility of postfertilization events" inherent in the use of such drugs *is* a valid matter for a professional's clinical and ethical judgment. Finally, in appealing to "matters of oppression," the Opinion injects a dubious political criterion into the heart of medical decision-making.

3. Solutions Proposed. The Opinion proposes solutions that are unjust, unworkable, and harmful to the profession of medicine. The Opinion unfairly dictates that only physicians who oppose a specific set of medical "services" should be required to provide patients with "prior notice of their personal moral commitments." We think that *all* physicians should be ready to explain, whenever appropriate, their ethical convictions with regard to medical practice and care. To suggest that providers with pro-life ethical convictions "practice in proximity to individuals who do not share their views" is unworkable.

The solutions proposed in the Opinion are not only unjust and unworkable, but harmful to the profession of medicine. First, by negatively and narrowly defining conscience and by suggesting that judgments of conscience are best left to "organized advocacy" groups, the Opinion tacitly discourages physicians from thinking and acting in accordance with their judgment of what is ethical or unethical. The demand that physicians provide "professionally accepted characterizations of reproductive health services" shows distrust of professionals and of the quality of the medical profession as a whole. Second, in appealing to the vague criterion of past discrimination allegedly suffered by some people, the Opinion allows values and considerations extraneous to the practice and profession of medicine to dictate treatment modalities.

Third, the Opinion invites lawmakers to enforce compliance with these vague and contentious notions. This would run counter to AMA Code of Ethics Opinion E-10.05: "[I]t may be ethically permissible for physicians to decline a potential patient when . . . [a] specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs." Moreover, this expressly contradicts ACOG's own Statement of Policy on Abortion: "The intervention of legislative bodies into medical decision making is inappropriate, ill-advised and dangerous."

Such legislation could not help but undermine the freedom and integrity of the profession of medicine and invite additional litigation and legislation that have nothing to do with promoting the health of women. Indeed, ACOG should be aware that legislation attempting to enforce this Opinion would violate constitutional and statutory protections of physicians' freedom of religion and conscience rights at federal and state levels. Finally, driving out physicians who respect the value of every human life – born and unborn – from the profession of obstetrics and gynecology would harm the profession and the health of many women and children.

There is a great deal of work to be done in assisting members of ACOG to practice medicine conscientiously, and to educate patients on what this means and why it is important. We stand ready to assist in this task. However, to be valid, any effort will have to be based on sound ethical analysis, undertaken in a spirit of dialogue, with respect for diversity in beliefs. The Committee on Ethics Opinion No. 385 falls significantly short in all these respects. Therefore, it should be rescinded immediately.

Respectfully,

[redacted]
President, Catholic Medical Association

[redacted]
Executive Director, Catholic Medical Association

cc.:

[redacted]
Chair, ACOG Committee on Ethics

[redacted]
c/o ACOG Ethics Committee

[redacted]
c/o ACOG Ethics Committee

# EXHIBIT FOUR

Project Logo **Protection of Conscience Project**

***www.consciencelaws.org***

**Service, not Servitude**

# Joint Letter of Protest

## Christian Medical Association *et al*

*Reproduced with permission*

December 7, 2007

American College of Obstetricians and Gynecology
Douglas W. Laube, MD, President
PO Box 96920
Washington, D.C. 20090-6920

Dear [redacted]:

The undersigned individuals and organizations urge the repudiation and withdrawal of the recently published position statement of The Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG), "The Limits of Conscientious Refusal in Reproductive Medicine."

The ACOG statement suggests a profound misunderstanding of the nature and exercise of conscience, an underlying bias against persons of faith and an apparent attempt to disenfranchise physicians who oppose ACOG's political activism on abortion.

The paper indicates that ACOG views the exercise of conscience and faith not so much as a cornerstone right in a democracy or as a historic hallmark of medicine, but rather as an inconvenient obstacle to abortion access.

A few excerpts from ACOG's paper illustrate these concerns:

> 1. "An appeal to conscience would express a sentiment such as 'If I were to do 'x,' I could not live with myself / I would hate myself, I wouldn't be able to sleep at night."

By caricaturing conscience as a pitifully self-centered, subjective feeling, ACOG denigrates the objective sources of conviction. Physicians of faith base decisions of conscience not on personal whims and feelings but on the objective teachings of Scripture--the same Scriptures that have provided the foundation for the laws of much of civilization. A physician's conscience may also be informed by time-honored ethical standards such as the Hippocratic Oath, which for centuries provided a foundation for medical ethics until abortion advocacy censored its teachings.

> 2. Physicians may not exercise their right of conscience if that might "constitute an imposition of religious or moral beliefs on patients."

is tantamount to "imposing religious or moral beliefs on patients."

> 3. "Physiciansâ€¦have the duty to refer patients in a timely manner to other providers if they do not feel they can in conscience provide the standard reproductive service that patients request."

This assertion contradicts a basic corollary of conscience. The same life-honoring, objective principles- "Thou shalt not kill," and "first, do no harm"--that persuade many conscientious physicians not to perform abortions also persuade them not to recommend someone else to do the deed.

> 4. "All healthcare providers must provide accurate and unbiased information so that patients can make informed decisions."

Normally no one would question this principle, but in this case, context is everything. Since ACOG has gone to court to fight laws requiring abortion doctors to offer informed consent information to patients on the risks and alternatives to abortion,[1] clearly ACOG intends to selectively apply this requirement only to pro-life physicians to force them to offer abortion as an option.

> 5. "Providers with moral or religious objections should â€¦ practice in proximity to individuals who do not share their viewsâ€¦"

It is incredible that ACOG would actually require a pro-life physician to relocate his or her practice to be close to an abortion facility. Besides the fact that this drastic requirement is selectively invoked only against pro-life doctors, it would also have the negative practical impact of removing desperately needed doctors from underserved areas.

ACOG's misguided and uninformed public statement on conscience limits is bound to have the effect, whether unintended or actually intended, of discouraging persons of faith from practicing or choosing obstetrics and gynecology as a profession. At a time when many communities are already suffering the loss of obstetricians and gynecologists forced out of their practices for economic reasons, it seems especially unwise to send such a message of ideological intolerance and religious discrimination.

ACOG's aggressive political advocacy for abortion has significantly impaired its ability to speak for all physicians and to judge matters of medical ethics without bias. We urge ACOG to reconsider and withdraw this statement as a step toward remedying that lamentable loss of respectability and credibility.

Sincerely,

[redacted]

[redacted]

**Notes**

1. American College of Obstetricians v. Thornburgh, 737 F.2d 283, 297-98 (3d Cir.1984).

cc: ACOG Executive Board Affairs
ACOG Government Relations
ACOG Clinical Practice

# EXHIBIT FIVE

# Congress of the United States
Washington, DC 20515

March 14, 2008

[redacted] MD, MS, President
The American College of Obstetricians and Gynecology
409 12th Street, SW
Washington, DC 20090-6920

Dear [redacted],

We are deeply concerned to learn of The American College of Obstetricians and Gynecology (ACOG) Committee Opinion #385 which could destroy the rights of conscience for pro-life obstetricians and gynecologists across our nation. Conforming to this guideline would force pro-life OB-GYNs to violate their moral and ethical beliefs regarding controversial issues like abortion. Furthermore, when paired with newly revised certification policies of the American Board of Obstetrics and Gynecology that condition board certification on compliance with ACOG ethics guidelines, we are concerned that the views represented in Opinion #385 can be used to force valuable pro-life OB-GYNs out of the practice of medicine for exercising their rights of conscience. *If used as a basis for decertifying physicians, these physicians* would most likely lose hospital privileges and effectively be put out of business, denying the physician's right to practice his or her profession. Moreover, pro-life women would lose the right to choose OB-GYNs who share their moral convictions.

As you know, Opinion #385 entitled "The Limits of Conscientious Refusal in Reproductive Medicine," contains seven recommendations that we believe jeopardize the rights of conscience of OB/GYNs. This report calls on OB-GYNs to disregard their moral, ethical or religious objections to abortion and instructs them to perform or refer for abortion. Opinion #385 also obligates the protection of the liberty interests of the pregnant women over the life and health of the unborn child, regardless of what the provider believes is in the best interests of both patients. This is a worrisome departure from professional standards set by state legislatures and other professional medical organizations such as the American Medical Association (AMA). The AMA House of Delegates policy on abortion states: "Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles." Currently, nearly all states recognize the right of physicians to refuse to provide abortions.

We are aware that member physicians and civil rights organizations have requested for clarification on Opinion #385. We, as Members of the House of Representative are asking the same and want assurance that OB-GYNs will not face severe consequences, including decertification, for refusing to perform or refer for an abortion on grounds of conscience. In light of these concerns, we request a clear explanation of whether Opinion #385 represents the official position of ACOG and what outcomes were intended by those who crafted Opinion #385. Furthermore, as the largest American association of OBGYNs, we ask that you provide further clarification by

explaining the general intent, import and force of ACOG Ethics Opinions as applied under ABOG's 2008 MOC Bulletin. Finally, please clarify the impact of ACOG Ethics Committee reports on board certification and ACOG membership. We request the courtesy of your response to these concerns by March 29th, 2008.

Sincerely,

Phil Gingrey, M.D. (GA-11)

Trent Franks (AZ-2)

Dave Weldon, M.D. (FL-15)

Ron Paul, M.D. (TX-14)

Paul Broun, M.D. (GA-10)

Tom Price, M.D. (GA-6)

James L. Oberstar (MN-8)

Joseph R. Pitts (PA-16)

Christopher H. Smith (NJ-4)

W. Todd Akin (MO-2)

Mike Ferguson (NJ-7)

Scott Garrett (NJ-5)

J. Gresham Barrett (SC-3)

Barbara Cubin (WY)

Jeff Fortenberry (NE-1)

Jean Schmidt (OH-2)

Cc: Anne D. Lyerly, MD, Chair of Ethics Committee
The American College of Obstetricians and Gynecology

Lucia DiVenere, Director of the Department of Government Affairs
American College of Obstetricians and Gynecologists

# EXHIBIT SIX

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 14 2008

[redacted]
Executive Director
The American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204

Dear [redacted]:

I am writing to express my strong concern over recent actions that undermine the conscience and other individual rights of health care providers. Specifically, I bring to your attention the potential interaction of the American Board of Obstetrics and Gynecology's (ABOG) Bulletin for 2008 Maintenance of Certification (Bulletin) with a recent report (Opinion Number 385) issued by the American College of Obstetricians and Gynecologists (ACOG) Ethics Committee on November 7, 2007 entitled "The Limits of Conscience Refusal in Reproductive Medicine".

The ACOG Ethics Committee report recommends that in the context of providing abortions, "Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive service that patients request." It appears that the interaction of the ABOG Bulletin with the ACOG ethics report would force physicians to violate their conscience by referring patients for abortions or taking other objectionable actions, or risk losing their board certification.

As you know, Congress has protected the rights of physicians and other health care professionals by passing two non-discrimination laws and annually renewing an appropriations rider that protect the rights, including conscience rights, of health care professionals in programs or facilities conducted or supported by federal funds. (See 42 U.S.C. § 238n, 42 U.S.C. § 300a-7, and the Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, 121 Stat. 1844, § 508). Additionally, threats to withhold or revoke board certification can cause serious economic harm to good practitioners.

I am concerned that the actions taken by ACOG and ABOG could result in the denial or revocation of Board certification of a physician who -- but for his or her refusal, for example, to refer a patient for an abortion -- would be certified. These actions, in turn, could result in certain HHS-funded State and local governments, institutions, or other entities that require Board certification taking action against the physician based just on the Board's denial or revocation of certification. In particular, I am concerned that such actions by these entities would violate federal laws against discrimination.

In the hope that compliance of entities with the obligations that accompany certain federal funds will not be jeopardized, it would be helpful if you could clarify that ABOG will not rely on the ACOG Ethics Committee Report, "The Limits of Conscience Refusal in Reproductive Medicine" when making determinations of whether to grant or revoke board certifications.

Thank you very much for your assistance in this matter.

Sincerely,

Michael O. Leavitt

cc:

[redacted]

The American College of Obstetricians and Gynecologists

# EXHIBIT SEVEN

# ABO+G

American Board of Obstetrics + Gynecology

*First in Women's Health*





March 19, 2008

Michael O. Leavitt
Secretary
The US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Norman F. Gant, M.D.
*Executive Director*

Alvin L. Brekken, M.D.
*Assistant to the Executive Director*

Larry C. Gilstrap, III, M.D.
*Director of Evaluation*

The Vineyard Centre
2915 Vine Street
Dallas, TX 75204
Phone (214) 871-1619
Fax (214) 871-1943

Dear Secretary Leavitt:

I am responding to your letter addressed to me asking about the American Board of Obstetrics and Gynecology's stand with respect to a physician's choice "to violate their conscience by referring patients for abortions or taking other objectionable actions, or risk losing their board certification." I can only say that I do not know where you came up with any suggestion, much less documentation, that the American Board of Obstetrics and Gynecology has ever asked anyone to violate their own ethical or moral standards.

Please be assured that the American Board of Obstetrics and Gynecology has taken no stand, pro or con, against individual physicians who choose to or choose not to perform abortions or to refer patients to abortion providers. Moreover, such an issue is not a consideration in the applications or in the examinations administered by the American Board of Obstetrics and Gynecology in any of its certification or in its Maintenance of Certification requirements or examinations.

Best Wishes,

[redacted]

Executive Director

NFG/kd

# EXHIBIT EIGHT

March 26, 2008

Dear Fellows:

Thank you for your comments on Committee Opinion #385, "The Limits of Conscientious Refusal in Reproductive Medicine." The Committee on Ethics is grateful for the thoughtful and considered input of Fellows regarding this document. We received many letters reflecting the importance of this issue to Fellows, as well as a breadth of opinion regarding the role of conscience in professional life.

The Committee on Ethics met on March 17-18, 2008, and discussed the correspondence received since the Opinion's publication. The letters and a summary of the concerns raised were carefully reviewed. Also the Executive Committee of ACOG's Executive Board met and discussed the Opinion and the response to the Opinion on March 24, 2008.

We want to be clear the Opinion does not compel any Fellow to perform any procedure which he or she finds to be in conflict with his or her conscience and affirms the importance of conscience in shaping ethical professional conduct. For example, while this is not a document focused on abortion, ACOG recognizes that support for or opposition to abortion is a matter of profound moral conviction, and ACOG respects the need and responsibility of its members to determine their individual positions on this issue based on their personal values and beliefs. We want to assure members with a diversity of views on this issue that they have a place in our organization.

Ethics Committee Opinions provide guidance regarding ethical issues. This Committee Opinion is not part of the "Code of Professional Ethics of the American College of Obstetricians and Gynecologists." This Committee Opinion was not intended to be used as a rule of ethical conduct which could be used to affect an individual's initial or continuing Fellowship in ACOG. Similarly, it is not cited in the American Board of Obstetrics and Gynecology's "Bulletin for 2008" and "Bulletin for 2008 Maintenance of Certification," and an obstetrician-gynecologist's board certification is not determined or jeopardized by his or her adherence to this Opinion.

Conscience has an important role in the ethical practice of medicine. While this Opinion attempted to provide guidance for balancing the critical role of conscience with a woman's right to access reproductive medicine, the Executive Committee has noted the uncertain and mixed interpretation of this Opinion. Thus, the Executive Committee has instructed the Committee on Ethics to hold a special meeting as soon as possible to reevaluate ACOG Committee Opinion #385.

Thank you again for your thoughtful comments.

Sincerely yours,

President

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

# CIVIL RIGHTS DISCRIMINATION COMPLAINT

| YOUR FIRST NAME | YOUR LAST NAME |
|---|---|
| [redacted] | [redacted] |
| HOME / CELL PHONE (Please include area code) | WORK PHONE (Please include area code) |
| [redacted] | |
| STREET ADDRESS | CITY |
| [redacted] | [redacted] |
| STATE | ZIP |
| [redacted] | [redacted] |
| E-MAIL ADDRESS (If available) | |
| [redacted] | |

**Are you filing this complaint for someone else?** ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

| FIRST NAME | LAST NAME |
|---|---|
| | |

**I believe that I have been (or someone else has been) discriminated against on the basis of:**

☐ Race / Color / National Origin ☐ Age ☒ Religion / Conscience ☐ Sex

☐ Disability ☐ Other (specify): _____

**Who or what agency or organization do you believe discriminated against you (or someone else)?**

PERSON/AGENCY/ORGANIZATION

Washington State Department of Corrections

| STREET ADDRESS | CITY |
|---|---|
| 7345 Linderson Way SW | Tumwater |
| STATE | ZIP |
| Washington | 98501 |
| PHONE (Please include area code) | |
| (360) 725-8213 | |

**When do you believe that the discrimination occurred?**

LIST DATE(S)

10/02/2017

**Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.**
(Attach additional pages as needed)

No reasonable accommodation provided for my religious objection to prescribing hormones to men wanting to transition into women. When other providers offered to prescribe hormones to these patients under my care they were told by DOC leadership that they could not see my patients and no accommodation has been provided. Attached is a more detailed account as well as emails from my Facility Medical director, Chief medical officer, and the health care authority.

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

| SIGNATURE | DATE *(mm/dd/yyyy)* |
|---|---|
| [redacted] | 03/06/2018 |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

**The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.**

**Do you need special accommodations for us to communicate with you about this complaint?** (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| FIRST NAME | LAST NAME |
|---|---|
| | |
| HOME PHONE (Please include area code) | WORK PHONE (Please include area code) |
| | |

| STREET ADDRESS | CITY |
|---|---|
| | |

| STATE | ZIP | E-MAIL ADDRESS (If available) |
|---|---|---|
| | | |

**Have you filed your complaint anywhere else? If so, please provide the following.** (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

EEOC, DOC internal discrimination complaint

| DATE(S) FILED | CASE NUMBER(S) (If known) |
|---|---|
| 02/06/2018, 11/16/2017 | null, null |

**To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).**

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

**How did you learn about the Office for Civil Rights?**

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

**To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.**

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

HHS-699 (7/09) (BACK)

# COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

**In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.**

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: [redacted] Date: 03/06/2018

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): [redacted]

Address: [redacted]

Telephone Number: [redacted]

# NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

**Privacy Act**

The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

**Freedom of Information Act**
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

**Fraud and False Statements**
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

# PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

## HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

## CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

## CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

**CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?**

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

*OR*

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

-April 2017 - Offender Approved by gender dysphoria Care Review Committee (CRC) for hormone therapy. My religious conviction will not allow me to prescribe hormones for this indication. [redacted] provided a reasonable accommodation at that time by taking over the management of this element of the patient's healthcare request.
-September 28th forwarded KITE from NEW offender requesting renewal of hormones for GD to [redacted]
-September 29th 2017 - Annual DOC health care provider meeting. Three hours of education on Gender dysphoria (GD).
-October 2nd - Noticed KITE response from [redacted] to offender saying "follow up with PCP." [redacted] volunteered to manage this issue for the patient.
-October 4th - Medical provider meeting: [redacted] read a series of scenarios asking the providers about religious ethics in the medical field. She gave an example of a Muslim working as a hospitalist who morally objected to hospice care because he viewed it as similar to euthanasia. She gave another example of a Jehovah's Witness working in an ER who morally objected to blood transfusions. (Both of these scenarios are extreme situations that would never happen. You would never encounter a hospitalist who wouldn't be ok with hospice and you would never find an ER provider who was not ok with blood transfusions.) In both of these scenarios she emphasized the "undue hardship" that would be placed on the conscientious objector's colleagues. These were directed at me in front of my colleagues.
-October 9th - Had in person conversation with [redacted] regarding treatment of GD. She stated that it would be the expectation of the provider on site to prescribe hormones and if I decided to stay working for the DOC than I would be expected to prescribe. I expressed that it is not an option for me to prescribe for this due to my conscience and religious beliefs. I expanded that other providers have already offered to do this. (See email chain started on October 9th titled "conversation with [redacted]")
-October 12th - Email from [redacted] forwarding an email to [redacted] and myself stating "forwarding to his primary care providers." [redacted] replied to the email.
-October 18th - Forwarded KITE from offender regarding GD to [redacted] and [redacted]. Phone call with [redacted] (CMO) (@10:44 on state phone) and [redacted] (@13:02pm on work phone [redacted] Told them individually that this is a personal religious conviction that causes me to not be able to prescribe hormones for this indication but that I have found ways to mitigate this through other providers. Both of them stated that if I were to stay with the department I would be expected to prescribe this medication. If they were to allow this then it would be a slippery slope for anyone with religious convictions to not follow department policy.
-October 24th - Email from [redacted] to [redacted] stating "this is [redacted] patient and he needs to see the patient."
-October 26th around 1500 - [redacted] called [redacted] and ordered her not to prescribe any hormone therapy for inmates at IMU and to call her if I asked her to do so. Email from [redacted] with a KITE to the offender stating "Per [redacted], [redacted] is your provider while you are in the IMU"...
-October 31st - Received call from [redacted] who told me that [redacted] called her and told her she was "forbidden" from seeing my patients.
-December 11th - Email from [redacted] stating that the department cannot accommodate to my religious conviction.

-January 4th – Phone call from internal discrimination stating that there will not be an investigation as this is clearly under the rules of discrimination for Washington State.
March 6th – Received call from [redacted] (Program Manager - Diversity & Recruitment) and he states that [redacted] did not believe that my accommodation was reasonable. He did not really address my questions as to why beyond referencing policy 100.500 as their rational. That in some way I was being discriminatory. Did not feel like they addressed the fact that they are refusing to let me refer patients based on a religious belief.

I have never been discriminatory to any patient. In fact, I saw this particular patient regarding other medical issues. I told him that his hormone management would be managed by [redacted] and [redacted]. He was fine with this. I am unable to prescribe or order laboratory tests for this indication because of my conscience and religious objections and it is getting to the point where I am feeling discriminated against for my beliefs. Telling all the other providers that they cannot see any of my patients is discriminatory because this has not been done to any other providers and the reason is because of my religious belief. I am providing access to care and there are willing prescribers to manage this low acuity issue in a small subset of inmates and clearly does not pose undue hardship on anyone. There had been reasonable accommodation for this in the past but is now being taken away. I feel like [redacted] and DOC health services leadership is placing undue burden on me and is being irresponsible by knowing what I have said yet continuing to pass the issue to me as if I am going to change my mind on my deeply held convictions. Attempting to force my hand is creating a hostile work environment for me.

[redacted]

**From:** [redacted]
**Sent:** Monday, December 11, 2017 4:51 PM
**To:** [redacted]
**Cc:** [redacted]
**Subject:** RE: Conscientious objection.

Hi [redacted]

My apologies. [redacted] and I have been playing "phone tag" due to our busy schedules.

After consultation with DOC Leadership, it will continue to be an expectation that you provide all health care to your patient panel. Passing patient care to another clinician due to personal beliefs is not something that the Department cannot support.

While I do respect your personal beliefs, this is something that we cannot accommodate.

[redacted]

---

**From:** [redacted]
**Sent:** Friday, December 08, 2017 2:03 PM
**To:** [redacted]
**Subject:** Conscientious objection.

[redacted]

I wanted to hear from you what your understanding is of my consciences objection to prescribing hormone therapy for transgender individuals. I know that [redacted] was supposed to reach out to you but I have not heard back yet. Is it still leadership's stance that if I stay employed with the DOC I will be expected to prescribe hormones for this indication and that no reasonable accommodation will be provided?

Thanks,

[redacted]

[redacted]

*Monroe Correction Complex*

*Phone:* [redacted]

[redacted]

**From:** [redacted]
**Sent:** Thursday, October 26, 2017 8:26 AM
**To:** [redacted]
**Cc:** [redacted]
**Subject:** RE: [redacted]

Hello,
I want to remind us all that every medical practitioner is expected to uphold the mission of the DOC and provide care to their patients as consistent with Department policies. No one practitioner is allowed to pick and choose those conditions within appropriate scope of practice that they will and will not treat. It is the responsibility of each provider to fully manage each patient's medical needs within their capabilities, escalating or referring care to specialists as appropriate. Intentionally failing or refusing to fully manage each patient's medical needs impedes the care of the patient and may lead to corrective or disciplinary action. Please note that referrals to other providers to manage these patients creates extra work burden for one's colleagues and can create a sense that the patient is being treated differently than others.

[redacted]
Chief Medical Officer
Health Services Division
Department of Corrections
Tumwater, WA 98504-1123

---

**From:** [redacted]
**Sent:** Wednesday, October 25, 2017 12:24 PM
**To:** [redacted]
**Cc:** [redacted]
K. [redacted]
**Subject:** RE: [redacted]

As discussed, you've received training on how to manage these patients, and it is expected of the midlevel providers to provide their direct care. It is not appropriate to wash your hands of this issue, which is what you are seeking to do by sending all these kites to me.

---

**From** [redacted]
**Sent:** Wednesday, October 25, 2017 12:21 PM
**To:** [redacted]
**Cc:** [redacted]
**Subject:** [redacted]

[redacted]

**From:** [redacted]
**Sent:** Tuesday, October 10, 2017 7:42 PM
**To:**
**Subject:** [redacted]

I will be at MCC again this week both Wednesday 10/11 and Thursday 10/12. I will attempt to stop by and see you then.

[redacted] Union Representative
Teamsters Local Union No. 117

[redacted]
We build unity and power for all working people to improve lives and lift up our communities. This is our Union.

Teamsters Local Union No. 117 Confidentiality Statement

This message and any attached files might contain confidential information protected by federal and state law. The information is intended only for the use of the individual(s) or entities originally named as addressees. The improper disclosure of such information may be subject to civil or criminal penalties. If this message reached you in error, please contact the sender and destroy this message. Disclosing, copying, forwarding, or distributing the information by unauthorized individuals or entities is strictly prohibited by law.

-----Original Message-----
From: [redacted]
Sent: Tuesday, October 10, 2017 8:28 AM
To: [redacted]
Subject: FW: Conversation with [redacted]

[redacted]
I am not sure what your role is but I am seeking some legal counsel as I am a teamsters member. Below is a conversation that has started surrounding the gender dysphoria issue in our state. I am a medical provider at Monroe Correctional Complex. I am a blue badge employee and have been for 2 years. The issue is this: I am ethically opposed to prescribing hormone therapy to men for the purpose of "treating" their gender dysphoria but it is the DOCs mission to do this. I am essential being told that I will need to prescribe these medications or find another Job. Do you have any suggestions on a route I should take

[redacted]
I included you because you are my union representative. Feel free to stop by the IMU to discuss further

-----Original Message-----
From: [redacted]
Sent: Tuesday, October 10, 2017 8:04 AM
To: [redacted]
Cc: [redacted]
Subject: Re: Conversation with [redacted]

Hi [redacted]

That's not quite what I said, but if it's what you took away from that conversation, please let me clarify.

You are not being asked to leave. What I said was that as an employee acting on behalf of the state, you are expected to carry out the mission of DOC, which includes providing hormone treatment for gender dysphoria. If you are unwilling to do this, then you need to examine whether DOC is the right place for you.

But as long as you continue in your role as a medical provider for DOC, you will be expected to provide this care.

Your personal beliefs do not enter into the issue, though I do recognize that your decision will be determined by them. And no one is happy that you may choose to leave.

However, if you determine that you cannot support DOC's mission in this regard, we will support you in seeking other employment, and provide an excellent recommendation.

I hope this clarifies things.

Thanks,
[redacted]

Sent from my iPhone

> On Oct 9, 2017, at 9:25 PM, [redacted]
>
> I had a conversation with [redacted] today and I wanted to make sure that I am understanding what you all decided.
>
> Essentially, it is now part of the DOCs mission to treat transgender individuals with hormone therapy and this therapy will be issued by the provider onsite once approved by the gender dysphasia CRC. And if i, the prescriber, cannot align myself with this mission due to my strong conviction that this is harmful to my patients in a medical, social, biblical, and biologic way, I will be asked to find a job elsewhere.
>
> Is this accurate?
>
> Anyone feel free to answer.
>
> Sent from my iPhone

The Washington Department of Corrections is increasing the security level for email messages containing confidential or restricted data. A new Secure Email Portal is being implemented. Outbound email messages from DOC staff that contain confidential or restricted data will be routed to the portal. A notification of the secured message will be delivered to the recipient.

Click on the following web link for more information. http://doc.wa.gov/information/secure-email.htm

[redacted]

**From:** [redacted]
**Sent:** Thursday, October 19, 2017 12:04 PM
**To:** [redacted]
**Cc:** [redacted]
**Subject:** RE: Conversation with [redacted]

Sorry- this was stuck in my outbox from yesterday.

**From:** [redacted]
**Sent:** Thursday, October 19, 2017 12:03 PM
**To:** [redacted]
**Cc:** [redacted]
**Subject:** RE: Conversation with [redacted]

[redacted]

Good speaking with you today. I understand your position and I hope I have been able to clearly articulate the importance of DOC practitioners adhering to the Department policy in treating pat6ients. As we discussed, the next step is for you to speak with [redacted]. I copy both of them as well as their assistants here.
best,
[redacted]

**From:** [redacted]
**Sent:** Monday, October 16, 2017 10:40 PM
**To:** [redacted]
**Subject:** Re: Conversation with [redacted]

[redacted] I initially told you that tomorrow might work for me but I actually will not be in tomorrow. I should be in on Wednesday however if you want to talk. Let me know. We could also just do a phone call sometime
Thanks,
[redacted]

Sent from my iPhone

On Oct 11, 2017, at 10:44 AM, [redacted] wrote:

> Hi [redacted]
> [redacted] is out of the office so I will respond.
> Thank you for reaching out and sharing your understanding of the conversation you had with [redacted] regarding the treatment of Gender Dysphoria within the Department of Corrections. It is true that it is DOC policy to provide medically appropriate treatment to individuals with Gender Dysphoria as approved by the Gender Dysphoria Care Review Committee. This includes hormonal treatment according to guidelines consistent with community practice.
> I am happy to meet and discuss your concerns with you. I could come out to Monroe next week on a mutually agreeable date.
> best,
>
> [redacted]
> Chief Medical Officer
> Health Services, Department of Corrections

**From:** [redacted]
**Sent:** Monday, October 09, 2017 9:25 PM
**To:** [redacted]
(DOC)
**Subject:** Conversation with [redacted]

I had a conversation with [redacted] today and I wanted to make sure that I am understanding what you all decided.

Essentially, it is now part of the DOCs mission to treat transgender individuals with hormone therapy and this therapy will be issued by the provider onsite once approved by the gender dysphasia CRC. And if i, the prescriber, cannot align myself with this mission due to my strong conviction that this is harmful to my patients in a medical, social, biblical, and biologic way, I will be asked to find a job elsewhere.

Is this accurate?

Anyone feel free to answer.

Sent from my iPhone

I understand. I will manage these patient by continuing to refer them to either you or one of the other providers in a timely manner just like is done with the hepatitis C patients.

---

**From:** [redacted]
**Sent:** Wednesday, October 25, 2017 12:03 PM
**To:** [redacted]
**Cc:** [redacted]
**Subject:** RE: [redacted]

[redacted]

As you've been told separately by me, [redacted] you are expected to manage patients' transgender issues while they reside on your unit, as is expected of all providers.

Thanks,

[redacted]
Facility Medical Director, MCC
[redacted]

---

**From** [redacted]
**Sent:** Wednesday, October 25, 2017 9:50 AM
**To:** [redacted]
**Cc:** [redacted]
**Subject:** RE: [redacted]

I did see the patient in regard to his Ensure request and ear pain. I told him that [redacted] would be managing his transgender issue. He had no issue with another provider seeing him for this. He was quite frustrated that he only received 2 responses from the 12 kites he has sent. Please see this patient at your convenience.
Thanks.
[redacted]

---

**From:** [redacted]
**Sent:** Wednesday, October 25, 2017 8:30 AM
**To** [redacted]
**Subject:** FW: [redacted]

Hey [redacted]
FYI
Thanks,

[redacted]

---

**From:** [redacted]
**Sent:** Tuesday, October 24, 2017 4:10 PM
**To:** [redacted]
**Subject:** RE: [redacted]

This i[redacted]atient and he needs to see the patient.

---

**From:** [redacted]
**Sent:** Tuesday, October 24, 2017 3:00 PM
**To:** [redacted]
**Cc** [redacted]
**Subject:** FW: [redacted]

Hi [redacted],
Would you like me to see [redacted] in the IMU or would you like to?
Thanks,
[redacted]

---

**From** [redacted]
**Sent:** Tuesday, October 24, 2017 11:32 AM
**To:** [redacted]
**Subject:** RE: [redacted]

Not sure. I asked this morning but they don't know. Could be for a few more weeks.

---

**From:** [redacted]
**Sent:** Tuesday, October 24, 2017 11:32 AM
**To** [redacted]
**Subject:** RE: [redacted]

Any idea on how long she will be in the IMU?

---

**From** [redacted]
**Sent:** Tuesday, October 24, 2017 11:19 AM
**To:** [redacted]
**Subject:** [redacted]

[redacted]
Is wanting some follow up regarding his hormones. He is not happy that his testosterone is so high. Ill defer to you.

No reasonable accommodation provided for my religious objection to prescribing hormones to men wanting to transition into women. When other providers offered to prescribe hormones to these patients under my care they were told by DOC leadership that they could not see my patients and no accommodation has been provided. Attached is a more detailed account as well as emails from my Facility Medical director, Chief medical officer, and the health care authority.

ACLJ
American Center for Law & Justice

May 9, 2018

RECEIVED
MAY 11 2018
HHS/OCR HQ

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

**Attn: Conscience and Religious Freedom Division**

**Re: Complaint for Discrimination in Violation of 42 U.S.C. § 300a-7(c)(1) ("Church Amendment")**

*Contact attorney for complainant:*

Francis J. Manion, Esq.
Geoffrey R. Surtees, Esq.
American Center for Law and Justice
6375 New Hope Rd.
P.O. Box 60
New Hope, KY 40052
502-549-7020
fmanion@aclj.org

*Complaint filed on behalf of:*

[redacted]

*Person/Agency/Organization committing discrimination:*

The University of Vermont Medical Center
111 Colchester Avenue
Burlington, Vermont 05401
802-847-0000

*Date and nature of discriminatory acts:*

In 2017, the complainant, [redacted] RN, was coerced by her employer, University of Vermont Medical Center, Inc. ("UVMMC") into participating in an abortion. Ms [redacted] a Catholic, had previously informed her employer that she

6375 New Hope Road
New Hope, Kentucky 40052
(502) 549-7020
(502) 549-5252 (Facsimile)

could not participate in such procedures as a matter of religious belief. Her employer deliberately misled [redacted] about the nature of the procedure, and then, after [redacted] confirmed that she was, in fact, being assigned to an abortion, refused her request that other equally qualified and available personnel take her place. Fearing a charge of patient abandonment which could bring with it loss of employment and revocation of her nursing license, [redacted] participated in the procedure under duress. She suffered immediate emotional distress, attempted to suppress the event psychologically, and has been haunted by nightmares ever since. In addition, her employer has created a hostile environment targeting [redacted] and other employees who conscientiously object to participating in abortion procedures.

The coerced-participation event described above appears to have been related to a change in UVMMC policy regarding the hospital's performance of abortions. Under the leadership, since 2013, of a hospital board President with decades-long experience in senior leadership of Planned Parenthood facilities in Vermont, Portland, Oregon, and New York City, UVMMC reversed a longstanding policy which limited abortions in its facilities to those considered "medically necessary." While the policy appears to have been changed *sub silentio* at some point even before 2017, hospital staff, including [redacted] and other nurses, were only formally informed of the change in October of 2017. Thus, it is highly possible that other staff and, perhaps, [redacted] herself, have been deceived into participating in other abortion procedures which were misleadingly labeled as "miscarriages" or "medically necessary" but which were, in fact, purely elective abortions.

In addition, following public controversy which arose after the formal disclosure to staff of the hospital's new policy in the Fall of 2017, UVMMC, in February 2018, adopted a revised "Conflict of Care" policy. (Copy attached hereto). This policy is sharply inconsistent with existing federal conscience laws and inappropriately continues to leave the conscience rights of hospital employees to the virtually unbridled discretion of supervisors who, as [redacted] and others will attest, have a history of demeaning, belittling, and failing to respect the views of conscientious objectors.

The Church Amendment protects the conscience rights of individuals and entities that object to performing or assisting in the performance of abortion or sterilization procedures if doing so would be contrary to the provider's religious beliefs or moral convictions, and prohibits discrimination in employment of "any physician or other health care personnel . . . because of his religious beliefs or moral convictions respecting sterilization procedures or abortions." 42 U.S.C. §300a-7 *et seq.*

It is clear that [redacted] (and perhaps others employed at UVMMC) has suffered and continues to suffer discrimination and violations of her conscience rights under federal law. We urge your office to immediately initiate an

investigation of these charges and order appropriate remedial and corrective actions as soon as possible.

Our investigation has disclosed identities and contact information of individuals in addition to our client who have information pertinent to this matter. That information, to the extent said individuals have already spoken publicly about it or authorize us to disclose it, will be provided upon request.

Respectfully submitted,

Francis J. Manion
Senior Counsel
American Center for Law & Justice

Date: May 9, 2018

Documents Status: **Approved**

| | |
|---|---|
| IDENT | HR-F-09 |
| Type of Document | Policy |
| Applicability Type | Corporate |
| Title of Owner | Dir Human Resources |
| Title of Approving Official | VP Human Resources |
| Date Effective | 2/5/2018 |
| Date of Next Review | 2/5/2021 |

THE University of Vermont MEDICAL CENTER

**TITLE**: Conflict of Care: Staff Conscientious Objection

**PURPOSE**: UVM Medical Center respects workforce diversity and the cultural values, ethics and religious beliefs of our staff. In situations where a conflict may exist between the employee's cultural values, ethics, and religious beliefs and their participation in any aspect of patient care, UVMMC supports a process by which an employee may request to be excused from performing specific duties.

Patients and their families' perspectives and choices are valued and honored in all phases of care. Accordingly, all patients are entitled to comprehensive, quality care, without regard to their diagnosis, race, color, sex, sexual orientation, gender identity or expression, ancestry, place of birth, HIV status, national origin, religion, marital status, age, language, socioeconomic status, physical or mental disability, protected veteran status.

UVMMC encourages open dialogue between the employee and their leader.

**POLICY STATEMENT**: Employees may request to be excused from participating in a type of care/treatment in situations where that care/treatment conflicts with the employee's cultural values, ethics, or religious beliefs. Procedures/treatments which may present conflict may include but are ***not limited*** to the following:

- Blood and blood component administration
- Elective termination of pregnancy
- Initiation and cessation of life support
- DNR/Life support issues for critically ill/terminally ill populations
- Assisting with the harvesting of human organs
- Sterilization procedures
- Reproductive technologies

Alternative staffing arrangements will be considered, and if appropriate, arranged. At no time will staff be allowed to act in a manner that negatively impacts the patient's care or treatment.

**PROCEDURE**:

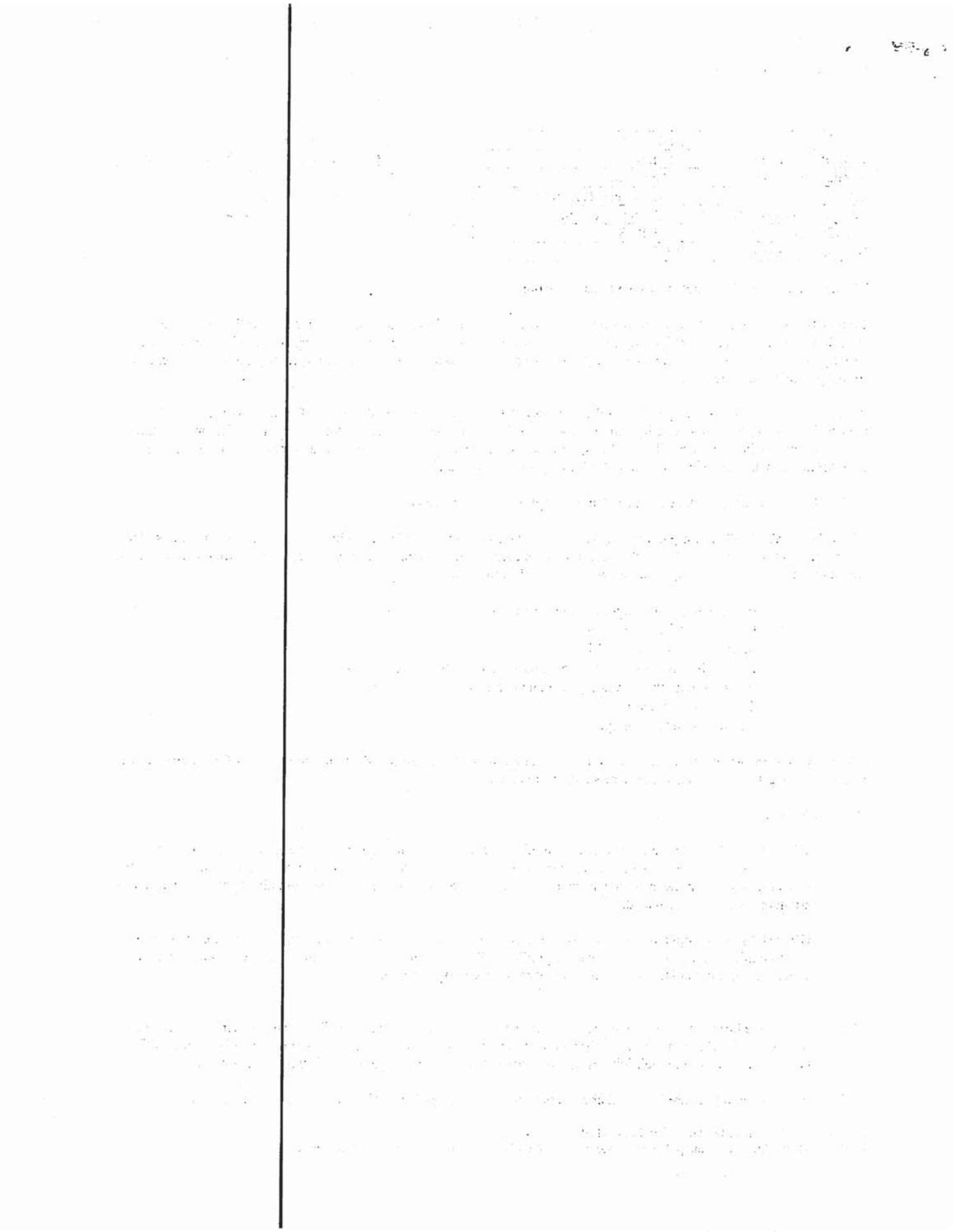
I. When the need to provide care or treatment of a patient is in conflict with an employee's cultural values, ethics or religious beliefs, the employee may request to be reassigned to other duties and not participate in the specific type of care or treatment. In the event a conflict of care arises, care of the patient will be maintained until alternate staffing arrangements can be provided.

II. UVMMC supports open dialogue between the employee and their leader when a conflict exists for the employee. We recognize that not all conflicts can be predicted. When possible we encourage employees to proactively raise concerns about potential conflicts in order to minimize impact to patient care.

III. During the hiring process, the hiring manager shall discuss the typical scope of practice and service within the department in which the candidate has applied to work. Employees are expected to perform all the duties of their positions as set forth in their job descriptions, given to them at the time of hire or whenever revised.

IV. All new employees are informed about this Conflict of Care policy during new employee orientation.

Printed on: 4/12/2018 11:00 AM By: [redacted]
DISCLAIMER: Only the online policy is considered official. Please compare with on-line document for accuracy.



Documents Status: **Approved**

V. The direct Supervisor/designee shall be responsible for administering and monitoring a process to accommodate an employee's cultural values, ethics, and religious beliefs regarding treatment of patients.

a) An employee who desires to be reassigned from a specific type of care or treatment shall submit the request in writing to the Supervisor/designee. Written request may be received on the form provided in this policy OR via an email addressed to the Supervisor/designee containing the details as requested/outlined on the form.

b) The written request will be acknowledged by the Supervisor/designee and maintained in the appropriate unit resource binder for scheduling purposes within the unit. The Supervisor/designee will assign staff as necessary for appropriate patient coverage. The written request will be placed in the employee's electronic personnel file by the Supervisor/designee.

c) Any conflict which may occur in an emergent situation for which staff may not have previously submitted a written request, may be brought to the Supervisor/designee. Alternative coverage may be sought at the discretion of the Supervisor/designee. The written request shall be submitted by the employee directly following the event and the request will be placed in the employee's electronic personnel file by the Supervisor/designee.

d) Any employee who is excused from an aspect of care will be re-assigned to other responsibilities.

e) In any scenario where circumstances prevent arrangements for alternate coverage, the staff member will be expected to provide the assigned care to ensure patient care is not negatively impacted.

f) Refusal to perform assigned job functions will be addressed in accordance with established corrective action procedures by the supervisor, in consultation with leadership and/or Human Resources.

VI. All employees have access to the Ethics Consultation through UVMMC's Director of Clinical Ethics and can request input on ethical issues by contacting Provider Access Services (847-2700), ask who the ethics consultant on call is and should then contact that consultant by phone or in person.

VII. An employee experiencing ongoing conflict of care issues should seek a transfer to a department or position where conflict of care issues are less likely to occur.

**MONITORING PLAN:** N/A

**DEFINITIONS**: N/A

**RELATED POLICIES:** Code of Conduct B1N; Clinical Ethics Consultations ETH15; Compliance & Privacy Plan B31

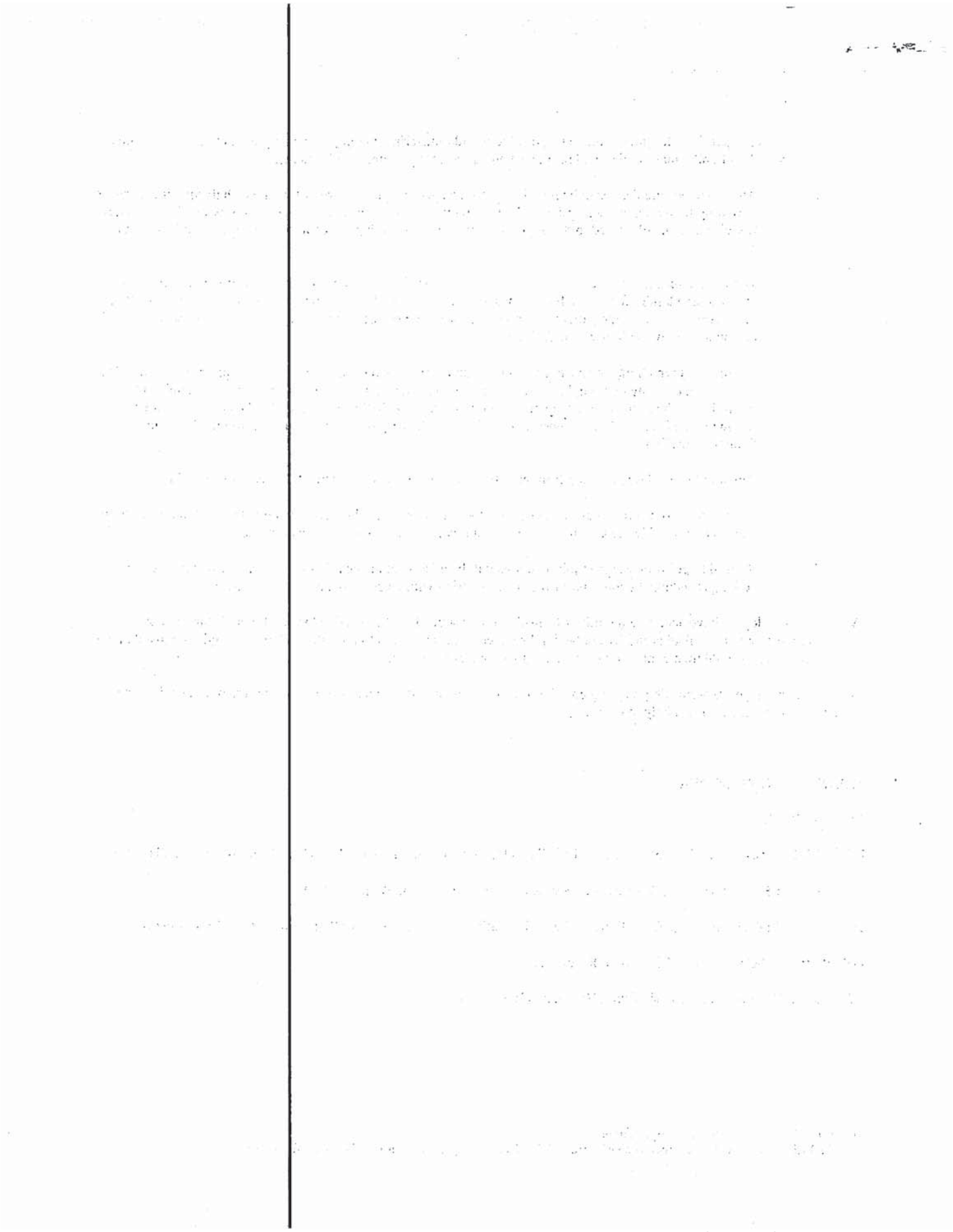
**REFERENCES:** 2017, Hospital Accreditation Standards, The Joint Commission LD.04.02

**REVIEWERS:** [redacted]

**OWNER:** [redacted], Dir Human Resources

**APPROVING OFFICIAL:** [redacted] Human Resources

Printed on: 4/12/2018 11:00 AM By: [redacted]
DISCLAIMER: Only the online policy is considered official. Please compare with on-line document for accuracy.



Documents Status: **Approved**

## Conflict of Care Disclosure Form

To be completed by the employee making the request: *Make a copy of this form for your records and then give this form to your leader.*

Your Name: _____ (Please Print)

Your Signature: _____ Date: _____

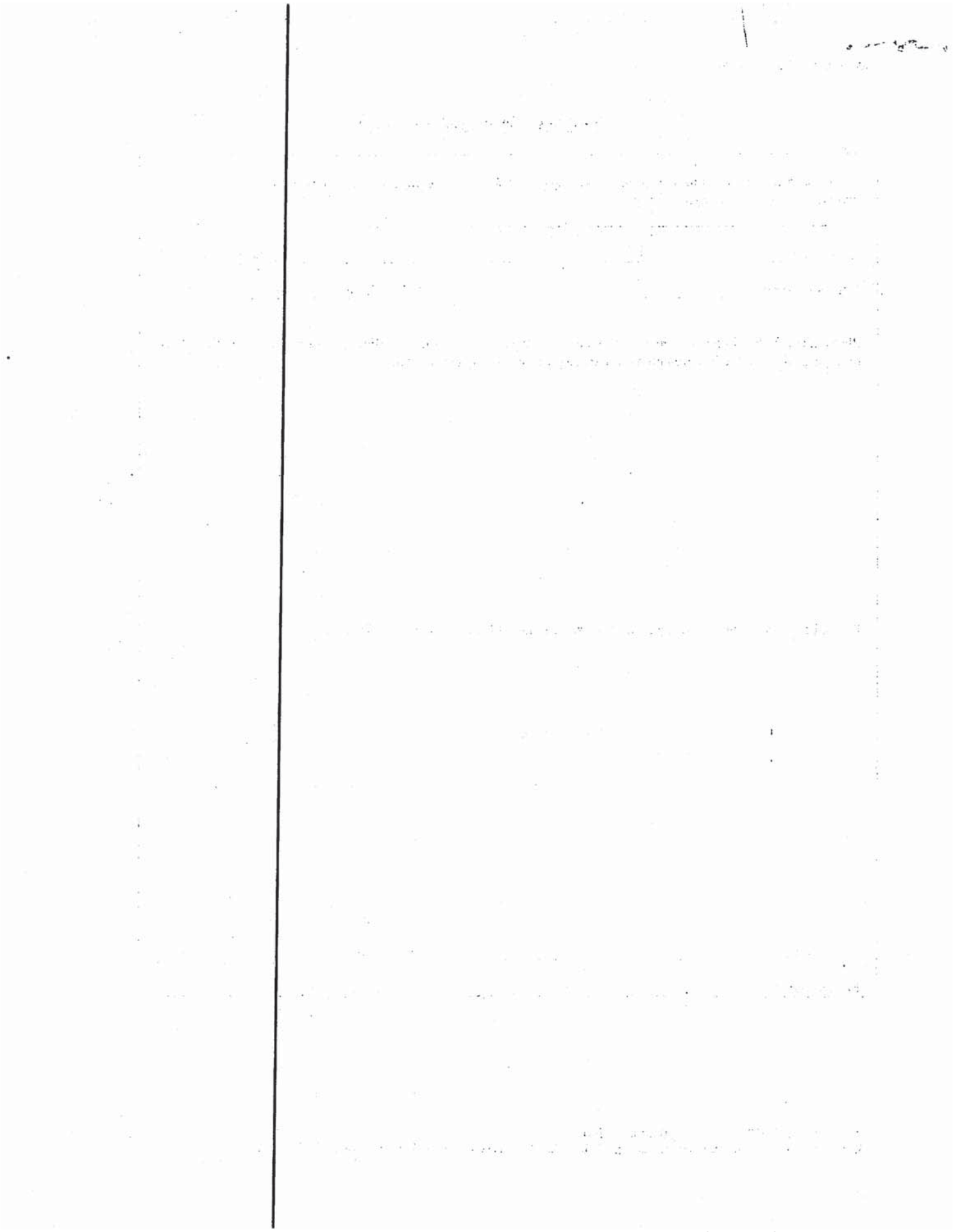
Please identify the clinical circumstances where you experience personal conflict. Please provide specific details regarding which procedure/treatment you are requesting to be excused from.

Please briefly provide your reasons for requesting removal from the patient's care team.

Received by:_____ (Please Print)

Leader Signature _____ Date Received _____

Printed on: 4/12/2018 11:00 AM By: [redacted]
DISCLAIMER: Only the online policy is considered official. Please compare with on-line document for accuracy.



## CERTIFICATE OF SERVICE

I hereby certify that on April 27, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

*s/ Leif Overvold*
Leif Overvold